Clinical educators' experiences with older adults and the perceived influence on physiotherapy practice and clinical education

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Abstract

Background

Managing older adults within acute care is challenging due to their complex presentation. Experiential learning, via clinical placements and the input of clinical educators, is central to enabling physiotherapy students to manage this population effectively.

Purpose

To explore physiotherapists' experiences with older adults, how these experiences may have informed their clinical practice, and how these experiences may in turn influence how they educate physiotherapy students.

Methods

Purposive sampling was used to recruit physiotherapists working in clinical areas that included interactions with older adults. Data were collected through semi-structured interviews using a phenomenological approach. Audio recordings were transcribed verbatim and thematic analysis undertaken.

Results

Fifteen physiotherapists were recruited from a secondary care hospital in the UK. Six themes were identified. *The Participant Journey; Approach to Practice; The Older Patient and Family; Challenges of and Changes in Practice; Communication; The Educational Experience*.

Discussion

Participants articulated largely positive perceptions of older adults, based on past and current experiences. However, there was some evidence of unconscious ageism, and some explicitly articulated perceptions of othering and ageism within the organisation. Participants described a complex older patient population, the effective management of whom required significant physiotherapeutic knowledge and skills. Participants recognised the importance of experiential learning and their approach to student education reflected personal approaches to practice and previous experiences with older adults. However, there was a mismatch between participants' understanding of challenges faced by students, and their requirements of students while on placement.

Conclusion

There was evidence that previous experiences with older adults influenced participants' current practice and their education of physiotherapy students. The findings indicate that a range of educational strategies are required to enhance student learning and to avoid a mismatch between educator expectations and student performance, which may negatively impact on both the student and educator experience.

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Chapter 1: My journey to this point

My interest in the healthcare management of older adults and the attitudes of healthcare professionals towards these older adults stems in part from a clinical career in gerontology and in part from my experiences after moving into higher education: I found my physiotherapy students to have somewhat negative attitudes towards older adults in general and in relation to the value of rehabilitation with this age group. My Masters-level studies highlighted the conflicting research evidence with regard to the attitudes of both healthcare professionals and healthcare students towards older adults and the influence of university and clinical education on these attitudes. Further exploration identified a predominance of quantitative research into this subject. However, quantitative studies are often highly specific and definitive in nature, seeking to test theory and unable to prove significant information above and beyond hypothesis testing (Sim and Wright, 2000: p46). Therefore, these studies could not answer my questions about *why* students might view older adults as they did and what factors may have influenced or continue to influence these views. Thus, my Masters research utilised a qualitative, focus group approach to exploring my students' perceptions of older adult rehabilitation and how physiotherapy education might influence these perceptions (Watkins and Waterfield, 2010). A key finding from this research was that the clinical environment was a significant factor in influencing student perceptions, positively or negatively. This finding echoed previous quantitative research by researchers such as Taylor and Tovin (2000), Sheffler (1995) and Treharne (1990) but went further by providing more detailed potential explanations for this finding around factors such as the attitudes of clinical staff towards older patients and the 'feel' of the clinical environment (Watkins and Waterfield, 2010).

My ultimate research aim was always to explore whether the education of our pre-registration physiotherapy students was preparing them effectively to work with older adults within the healthcare system. However, it became clear that to achieve this aim I needed to gain further insight into the clinical education environments in which we place our students. Clinical educators have a key role in delivering the clinical education experience and, therefore, potentially have significant influence over students' perceptions of older adults. Healthcare professionals' experiences with older adults, both personal and professional, has been shown to influence their *attitudes* towards this population both positively and negatively (Abrams et al., 2015; Chonody et al., 2014). However, there is very limited research into healthcare clinicians' *perceptions* of their older patients and older adults more generally and the factors that might influence those perceptions. Thus, I wanted to explore the way in which older adults have been and are perceived by our physiotherapy clinical educators in various situations across their life course, utilising an approach that would enable interpretation of these experiences by listening to the different stories of these participants. Defined as denoting the immediate and subjective everyday lived experiences of an individual through which meaning is made, the exploration of these 'lived experiences' generates narrative knowledge that enables the researcher to make sense of the complexity of human lives and interactions (Lucherini and Hanks, 2020). These lived experiences can be described as socially situated constructions that identify the differences, depth, and texture of experienced life (Lucherini and Hanks, 2020). The hope, then, within my research was that participants' descriptions of their experiences with older adults would provide evidence around personal and professional identity construction and reconstruction, the potential social discourses and experiences that may have impacted on their knowledge creation (Etherington, 2011), and the influence of these experiences not only in relation to their clinical practice but also in their approach to student education and their perceptions of the students they encountered. This knowledge and understanding could then form a basis for informing the development, restructuring and enhancement of physiotherapy education (both in terms of university-based and clinical education) in order to better prepare students for the realities and demands of clinical practice and the successful management of older patient populations.

It is within this context that I set out to design and carry out a study that I hoped would inform my understanding of clinical educators' experiences with older adults and the perceived influence on both their physiotherapy practice and their clinical education of physiotherapy students.

Chapter 2: Introduction

2.1 Introduction

This chapter will provide an overview of the statistics in relation to the ageing population, and a description of clinical frailty presentations in older populations and considerations in the management of an increasing ageing and frailer population within healthcare services. It will introduce the role of physiotherapy within health and social care for older adults, particularly within acute care services, and the importance of the clinical environment to pre-registration physiotherapy training in providing experience and developing skills in managing a complex older population.

2.2 An ageing population

Worldwide, the population of people living longer is increasing, with a projected rise from 1 billion in 2020 to 1.4 billion by 2030 and 2.1 billion by 2050 (World Health Organization (WHO), 2022). The number of those aged above 80 is expected to triple between 2020 and 2050 to 426 million (WHO, 2022). Within the United Kingdom (UK) alone there were 11.8 million adults over the age of 65 in 2016 (18% of the total population) with 1.6 million (2% of the total population) being aged over 85; and it is anticipated that by 2066 this will increase to 20.4 million aged over 65 (26% of the total population) and 5.1 million aged 85+ (7% of the total population) (Office for National Statistics, 2018). Older age is characterised by increasing comorbidities and more complex health presentations, meaning that with increasing age older adults are more likely to require significant input from health and social care services (WHO, 2022). Thus, as the global and UK populations age in increasing numbers so they will place greater demands on these services.

2.3 Ageing and frailty

Frailty can be defined as “a clinically recognizable state of increased vulnerability, resulting from aging-associated decline in reserve and function across multiple physiologic systems such that the ability to cope with everyday or acute stressors is compromised” (Xue, 2011: p1). Fried et al. (2001) describe a frailty phenotype consisting of five criteria: unintentional weight loss, exhaustion, low physical activity, slowness, and weakness. These authors cite a categorisation whereby individuals presenting with three or more of these criteria are defined as frail, whilst those presenting with one or two of the criteria are considered pre-frail. There is an increased incidence of frailty with ageing (Mudge and Hubbard, 2019) due to age-related changes to multiple physiological systems, particularly the neuromuscular, neuroendocrine, and immunological systems (Strandberg & Pitkälä, 2007, cited in Clegg, 2011). A quarter of those aged 80+ are frail, and a higher prevalence of frailty can be found in those with specific conditions or diseases such as cancer and Alzheimer's disease and in residential and nursing home residents (Kojima et al., 2019).

One key clinical feature of frailty is sarcopenia, defined as progressive and generalised loss of skeletal muscle mass and strength and categorised as: primary sarcopenia – considered to be age-related when no other cause evident other than ageing itself – and secondary sarcopenia, which is considered to be activity-, disease-, or nutrition-related (Wakabyashi, 2014). Sarcopenia in older adults is multifactorial, with disuse and deconditioning further complicating a clinical presentation of both primary and secondary sarcopenia, with a resultant loss in physical function adversely impacting upon their ability to maintain an independent life and perform activities of daily living and resulting in an increased risk of adverse outcomes such as physical disability and poor quality-of-life (Wakabyashi, 2014).

However, in contrast to models such as Fried Frailty Phenotype, which focus on the physical aspects of frailty, some authors argue that frailty should be viewed more broadly and that there is a biopsychosocial presentation whereby not only the physical but also the psychological and social aspects of frailty need to be considered. Thus, frailty increases with an accumulation of physical, psychological, social problems and deficits (Bunt et al., 2017); these cumulation of deficits models therefore recognise the impact of factors such as social relationships and social environment on the ability to perform activities of daily living and maintain an independent life.

2.4 Older adults and acute care healthcare services

Older adults with multiple chronic conditions often require acute care interventions to manage disease progression and/or exacerbation, and, for those who have functional and/or cognitive impairment alongside these alterations in physiological status, admission into acute care can often be problematic (Hickman et al., 2007). In addition, patients who are frail have poorer health care outcomes and are more vulnerable to deterioration in health and functional status in comparison to less frail peers, with their lower physiological reserve and increased vulnerability to minor stressors (such as change in medication or a urinary tract infection) increasing the risk of admission to hospital (Mudge and Hubbard, 2019). These older adults may be admitted into acute care services in a range of clinical areas including emergency, medical, and surgical settings (Hickman et al., 2007). Current acute healthcare systems are primarily designed to manage individual disease- or organ-specific problems and are less prepared to deal with the chronic and complex medical needs of more elderly and frailer older patients (Kojima et al., 2019). In addition, the challenges of managing this more complex population are often exacerbated by high patient turnover and time and workload pressures within these organisations (Lindsay et al., 2008), which can result in more frequent and earlier discharge from acute care (Nilsen et al., 2019). Thus, not only is this frail and more complex older population at increased risk of hospitalisation in comparison to a younger adult population with similar conditions (e.g., infections), but they are also at increased risk of poor health outcomes following discharge from hospital, often resulting in an increased risk of readmission (Hickman et al., 2007). A range of factors have been shown to be associated with early readmission, including health conditions (such as chronic disease, higher levels of frailty and poor functional ability) and organisational factors (such as short length of stay and discharge destination); and older patients readmitted 14 days post discharge have been found to have significantly increased rehabilitation needs (Lin et al., 2022).

Evidence suggests that a multidisciplinary approach to the management of older adults within a specialist (gerontological) ward setting, and with patients manged by staff with gerontological expertise, is the best approach to managing this population successfully within acute care (Hickman et al., 2007). Teamwork is fundamental to high quality patient care, effective rehabilitation, and more successful discharge planning, and the gerontological team of healthcare and social care professionals is likely to consist of, amongst others, gerontologists, nurses, physiotherapists, occupational therapists, pharmacists, and social workers (Körner, 2010). These teams may be multidisciplinary, where all professionals work parallel to each other, with clear role definitions and high professional autonomy, or interdisciplinary, where there is a high degree of communication and collaboration between team members and more blurred role boundaries (Körner, 2010). Within acute care gerontology services, team working has traditionally been more multidisciplinary in nature (Hickman et al., 2007). Crucially though, the patient and their family/carers need to be part of this team and have influence in decision-making processes (Ellis and Sevdalis, 2019).

2.5 Role of physiotherapy in acute care older adult management

Physiotherapists are considered core members of the multidisciplinary team managing older adults within acute care services.

Physiotherapy is a healthcare profession defined as "a science-based profession taking a 'whole person' approach to health and wellbeing, which includes the patient's general lifestyle. Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease" (Chartered Society of Physiotherapy (CSP), n.d.).

Physiotherapists working within acute care services require a depth and breadth of knowledge across multiple body systems, the ability to navigate complex medical systems, and to demonstrate proficiency in working with numerous and often diverse specialist colleagues (Gorman et al., 2010). Several key characteristics for effective physiotherapy practice within acute care have been identified: the collection and analysis of medical information; the application of specialised physiotherapy knowledge; effective communication; the ability to work in a fast-paced environment; and effective clinical reasoning and decision-making (Masley et al., 2011). A focus on functional activities has been demonstrated to be a priority within acute care settings (Jette et al., 2009). The above cited role requirements reflect the challenges of managing the complexity of presentation of older adults within acute care effectively, the need for effective team working to meet the requirements of this population, and the ability to work in a fast-paced environment with time and workload pressures - challenges that will be explored further in the literature review.

2.6 Education of physiotherapy students

Physiotherapy pre-registration training consists of two main elements: the acquisition of knowledge and skills within the higher education environment, and the translation of both knowledge and skills into clinical practice via experiential learning (Smith and Crocker, 2017). Experiential learning provides student practitioners with opportunities to consolidate learning within the real world, enabling transformation of learning (Higgs, 1993). Thus, clinical education, where students can engage in learning in the context of clinical practice, is the best arena in which skills and attitudes can be taught and refined (Strohschein et al., 2002). The School of Allied Health Professions at Keele University has two pre-registration physiotherapy programmes: a four-year integrated Masters programme, and a two-year accelerated Masters programme (Keele University, n.d.). Within both, gerontological content is taught in relation to normal ageing, common clinical conditions and presentations in an older population, and the integration of ageing into more complex clinical scenarios. All students during their clinical placements will have contact with older adults either via gerontological-specific placements or in a range of other clinical areas where older adults will form part of the overall patient population, thus facilitating transfer of gerontological knowledge and skills into their clinical practice. Students on placement are supervised by experienced physiotherapy practitioners (clinical educators), whose role includes facilitating learning and enabling effective transfer of prior learning to ensure the achievement of clinical education goals (Higgs, 1993). Experienced clinical educators have been shown to base their current practice at least partially on their previous experiences with patients and in turn use these experiences in educating their physiotherapy students (Kelly, 2007).

Recognising the skills required to manage an older adult patient population effectively, the Chartered Society of Physiotherapy clinical interest group for physiotherapists working with older adults (AGILE) published core learning objectives for physiotherapy students on older adult clinical placements (AGILE Thames, 2002). These include not only assessment and management strategies but also a focus on effective communication with the older patient, the multidisciplinary team (MDT) and all others involved in care, respect for autonomy and dignity, and an understanding of discharge planning – highlighting not only the range of knowledge and skills required but also the importance of clinical education in developing and consolidating these skills. However, these objectives also highlight the potential challenge to students in having to demonstrate this range of knowledge and skills, and to clinical educators in facilitating this learning.

Watkins and Waterfield (2010) found that clinical education experiences influenced physiotherapy students' perceptions of older adult rehabilitation, and clinical educators are a central part of these experiences. Given the challenges they face both clinically and in relation to student education, and the evidence suggesting that their practice is influenced by their prior patient experiences (Kelly, 2007), it would be valuable to explore physiotherapy clinical educators' approaches to educating their physiotherapy students and how previous experiences may have influenced this practice in order to gain a more detailed understanding of gerontological clinical education.

2.7 Aim of the research in this thesis

The aim of this thesis was to explore physiotherapists' experiences with older adults, how these experiences may have informed their clinical practice, and how these experiences may in turn influence how they educate physiotherapy students.

2.8 Objectives

1. To identify physiotherapy clinical educators' previous experiences with older adults throughout their life course
2. To explore these experiences with older adults within the context of the underlying meaning of these events and activities, both in relation to their own clinical practice and their approach to the education of physiotherapy students
3. To explore the implications of these findings for current and future physiotherapy education

2.9 Summary

This chapter has provided an overview of the context in which physiotherapy practice with older adults takes place within acute healthcare organisations. It has introduced the role of the physiotherapist, including the knowledge and skills required for effective practice when working with an older adult population within acute care. In relation to the role of clinical education in the training of pre-registration physiotherapy students it has introduced the importance of the clinical environment in providing students with the experience to develop and consolidate the knowledge and skills required to manage a complex older population effectively. The next chapter will review the literature around factors influencing clinical practice and student education within the clinical environment.

Chapter 3: Literature Review

3.1 Introduction

This chapter will explore current evidence around the role of physiotherapy in acute care and gerontology, including the skills and attributes required for effective physiotherapy practice within this environment. It will explore the evidence in relation to student education (university based and clinical) to identify the requirements for better preparing students for managing an older patient population within acute care services effectively. Finally, it will explore the concepts of ageism and othering and their relevance to healthcare in general, and to physiotherapy more specifically.

3.2 The acute care environment and the older patient

Parker et al. (2006) highlight that the diversion of less complex or less severe acute care management of older patients into community services has resulted in an increase in illness severity and complexity amongst those older adults who are admitted into acute care services. Thus, within acute care, older patients are more likely to present with increasing frailty, cognitive dysfunction, and clinical challenges such as loss of mobility, falls, incontinence and polypharmacy – often triggered or exacerbated by acute illness (Parker et al., 2006). In addition, older adults have an age-related increased risk of conditions such as stroke, osteoarthritis and chronic obstructive pulmonary disease that may require admission into hospital for effective management (Mudge and Hubbard, 2019). The acute care focus on ‘cure’ and speed of throughput does not necessarily tie in with the needs of a more chronic and complex older adult presentation, many of whom will require physiotherapy input in managing the underlying reason for admission and/or rehabilitation to enable safe and appropriate discharge (Cheek, 2004). An understanding of what it means to be a healthcare professional in a particular context is at least partially dependent on understanding the place in which healthcare is given, so this acute care environment will provide context to the role of the physiotherapist in managing the older patient (Cheek, 2004).

3.3 The acute-care physiotherapist

Much of the current evidence for the role of the physiotherapist within acute care comes from the United States. Gorman et al. (2010) developed The Acute Care Physical Therapy Practice Analysis Survey, with survey sections addressing knowledge areas, professional behaviours, and patient/client management approaches. They surveyed physical therapists who identified themselves as having extensive experience in acute care practice and who were predominantly hospital-based. Respondents (n=245) reported treating patients of all ages but cited older adults (aged 65+) as the patient population most frequently encountered (38.6%). The survey found that an extensive range of requisite knowledge and skills were identified by participants, which included being able to: accurately evaluate a patient’s present and past medical states; formulate and implement an individualised, evidence supported rehabilitative plan of care; demonstrate proficiency in communicating, collaborating, and advocating at advanced levels with numerous specialist colleagues; ensure provision of maximal levels of patients’ mobility and physical performance; and help patients and their families navigate the health systems within their organisations – all whilst being able to ‘integrate a patient’s dynamic and fluctuating medical status, concomitant comorbidities, health preferences and beliefs, and available resources (both human and fiscal) when prioritizing key examination findings reflecting multisystem involvement’ (Gorman et al., 2010: p1458). The authors concluded that therapists in acute care practice need to possess depth and breadth of knowledge not only across multiple body systems but also specific for acute care service requirements and for managing patients with acute illnesses.

Masley et al. (2011) undertook a qualitative study where a convenience sample of 18 physical therapists working in three acute care settings were interviewed about their roles, the clinical reasoning processes they utilised in practice, and the context of practice within the acute care setting. Their participants described a process of complex information collating and clinical reasoning, driven by the acute care setting, with patients who were medically unstable and presentations that could quickly change. Not only were a range of physiotherapy-specific knowledge and skills required in multiple areas of practice, reflecting the Gorman et al. (2010) findings, but a range of more general diagnostic and clinical presentation factors needed to be integrated into the clinical reasoning and therapeutic management of their patients. Continual dynamic assessment was a key feature of their practice. Physical therapists described the importance of understanding the patient's needs, wants, and goals in terms of rehabilitation, but reported that the typically short lengths of stay for their patients required an early focus on discharge planning. The acute care setting was presented as an intellectually complex environment and participants reported that this complexity was compounded by the high frequency of daily interactions with other healthcare professionals that was required to help ensure effective patient-centred care. There was a theme around professional accountability, excellence, and duty of care to the patient, but participants also described their role in the acute care setting as being misunderstood by other healthcare professionals and having to explain their scope of practice to others. Ultimately, however, the findings showed that although the acute care setting was a complex one in which to work, and required complex clinical reasoning and problem-solving, the major concerns of these physical therapists were about ensuring patient safety and functional mobility - similar to the focus of physical therapists in other clinical settings (Masley et al., 2011). The participants in the Masley at al. (2011) study represented a wide range of years in clinical practice (2.5 to 32 years) and a range of years working in acute care settings (2.5 to 29 years). Although areas of clinical practice were not identified, most did not have certified specialisation (certified specialisation being a characteristic of physiotherapeutic clinical practice in the United States), with only one participant holding the certified specialisation in geriatrics. However, given the increasing number of older adults requiring admission to acute care services, as evidenced by the Gorman et al. (2010) statistics in terms of older adult caseload for their participants, it could be argued that these Masley et al. (2011) participants would be highly likely to be involved in the acute care physiotherapeutic management of older patients.

An earlier observational study by Jette et al. (2009) also highlighted a focus on functional activity and discharge planning in relation to physical therapist management of patients in acute care. Reviewing clinical visits for 896 patients (the majority of whom were over 60 years of age) carried out by 50 practitioners (45 physical therapists, two physical therapy assistants, and one unknown) over a two-week period, they found that across all clinical areas more than 80% of patients were trained in functional activities and over 75% received educational interventions. This finding reflects that of Curtis and Martin (1993) who found in their study that the majority (88%) of the surveyed 188 acute care physical therapists described functional activities, such as transfer or gait retraining, as either frequently or always a focus of physical therapy management within acute care. The authors link this finding to challenges identified by their sample, including staffing shortages, large caseloads, and a limited time to work with patients prior to discharge, all of which were felt to interfere with patients achieving physical therapy goals. As such, a focus on functional activities and educational interventions would be likely to be more effective than addressing physical impairments such as loss of strength, range of motion and endurance, which could take considerable time for physical therapists to influence in any meaningful way (Jette et al., 2009).

There is some evidence to support the effectiveness of older-adult targeted physiotherapy interventions within the acute care setting, for example, in reducing the rate of falls in hospitalised older patients as part of multi-factorial approach (e.g., Morris et al., 2022). Hartley et al. (2016) carried out a retrospective observational study of the association between average physiotherapy frequency and outcomes in older patients admitted to acute care, defining high-frequency physiotherapy as ≥0.5 contacts per day. They analysed data from 358 eligible patients and found that high-frequency physiotherapy was an independent predictor of functional improvement, shortened length of stay and an increased likelihood of being discharged without requiring a formal care package. These findings suggest that, even with a functional rehabilitation focus, high workloads, time pressures and short length of stay may negatively impact on functional recovery and post-discharge needs due to a more limited frequency of intervention. In addition, Lin et al. (2022) found that rehabilitation post discharge from acute care meant older patients were significantly less likely to be readmitted to hospital within three months post discharge. Thus, physiotherapists need to engage in effective discharge planning processes, including appropriate consideration of post-discharge rehabilitation needs.

Falvey et al. (2019) surveyed 264 physical therapists working within acute care in order to determine their participation in discharge planning for older adults. They found that more than 95% of respondents actively participated in discharge planning via provision of discharge recommendations, predominantly to case managers or social workers. Jette et al. (2003) interviewed seven physical therapists and three occupational therapists (OTs), all working in acute care settings, to explore their decision-making processes when recommending discharge destinations for their patients. Their findings identified several factors that informed their clinical reasoning and decision-making processes: the patient’s level of functioning and disability (described by the authors as the core construct informing decision-making); the patient’s wants and needs; the patient’s ability to actively participate in the discharge planning process; and the physical, social and attitudinal environment in which the patient lived their lives, including their support network. The clinical reasoning and discharge planning process was further influenced by the therapists’ experiences, input from the rest of the healthcare team and by the discharge options available. The study found that the physical therapists focused more on the mobility aspects of functioning and disability in comparison to their OT colleagues who had more of a cognitive and activities of daily living (ADL) focus, and that physical therapists with more limited clinical experience tended to make more conservative decisions and recommend more formal supportive care than their more experienced colleagues. However, despite their consideration of a range of factors in influencing discharge planning, Falvey et al. (2019) found that their participants had limited communication with post-acute care providers in terms of referral for rehabilitation post discharge. This suggests that, whilst the clinical reasoning processes supporting discharge planning are reflective of the overall more complex clinical reasoning and decision-making underpinning physiotherapy management of older patients within the acute care setting, patients may have unmet rehabilitation needs post discharge. This, alongside the short length of stay experienced by so many older adults within acute care, may go some way towards explaining the increased risk of readmission in older patients (Hickman et al., 2007).

3.4 Physiotherapy and the older adult

The literature explored thus far has focused on the role of the physiotherapist within acute care and, whilst some of the evidence, such as that around discharge planning, is older adult focused, some of the other studies cited reflect the role of the physiotherapist in acute care more broadly. The current literature pertaining to knowledge, skills and attributes required for *gerontological* physiotherapy tends to reflect the rehabilitation requirements of more specific physical, cognitive, and social challenges faced by older adults such as: falls, frailty, and management of those with dementia. Whilst this literature is extensive and does include management of these clinical presentations within the acute care environment, there is much more limited exploration of the role of the physiotherapist in gerontology more broadly. Prokopchuk et al. (2021) identify the impact of ageing processes, including both healthy ageing and clinical presentations that are age-related, on the rehabilitation of older adults. They describe the ultimate goal of rehabilitation as restoring independence and improving quality-of-life and well-being and cite a range of more general physiotherapeutic strategies for use with this older adult population such as exercise, functional rehabilitation, manual therapy, and other therapeutic modalities. They highlight the breadth of physiotherapeutic assessment and management strategies appropriate in the rehabilitation of an older population, the caveat being the need for the physiotherapy practitioner to have a clear understanding of the impact of the older adult's often complex presentation on the strategies utilised.

The range of knowledge, skills and attributes required by physiotherapists in managing an older patient population has, however, been defined by professional bodies such as the International Association of Physiotherapists working with Older People (IPTOP) and the Academy of Geriatric Physical Therapy, a subgroup within the American Physical Therapy Association (APTA). Whilst there is currently no equivalent within AGILE (the CSP subgroup for chartered physiotherapists working with older people) who focus more on guidelines for specific areas of practice such as falls and frailty, the Standards of Clinical Practice (IPTOP, 2021) and American Physical Therapy Association (APTA) Essential Competencies in the Care of Older Adults (Wong et al., 2014) provide an appropriate guide to the general requirements for effective practice with the older patient population. The core roles (IPTOP) and domains (APTA) are summarised below in Table 1.

The key feature of both the IPTOP (2021) and APTA (Wong et al., 2014) documents is that the range of knowledge, skills and attributes very much reflects the requirements for depth and breadth of knowledge across multiple body systems, communication skills, complex clinical reasoning and decision-making, discharge planning skills etc. identified as required by acute care physiotherapy practitioners. However, they also require gerontological physiotherapists to demonstrate an in-depth understanding of the specific physical, functional, cognitive, and social challenges experienced by older patients more specifically – both within acute care services and more broadly – and it could be argued that they reflect a therapeutic approach that may not always be fully achievable within the acute care environment with its focus on functional rehabilitation and early discharge.

Table 1: Summary of core roles and domains for practice

(IPTOP, 2021; Wong et al., 2014)

IPTOP: core roles within practice	APTA: domains of practice
Core roles: 1. Clinical practice – includes screening, assessment, evaluation, diagnosis, prognosis, intervention, prevention and professional collaboration 2. Professional development – includes innovation, research participation to further education, and promotion of the profession 3. Professional leadership and mentoring - includes education, leading projects (innovative or technology concepts), and entrepreneurial and service development work *Standards list a wide range of skills and competencies within each role descriptor	Domains: A. Health and safety B. Evaluation and assessment C. Care planning and coordination across the care spectrum (including end-of life care) D. Interdisciplinary and team care E. Caregiver support F. Healthcare systems and benefits *Each domain details several essential competencies required to manage older patients effectively within that domain

3.5 The expert practitioner

Given the above information, the range of physiotherapy-specific and broader knowledge and skills identified in the literature, in relation to the management of older adults within acute care and more broadly, appears extensive. These knowledge and skill requirements are also informed by experience (Jette et al., 2003). However, duration of clinical experience does not necessarily equate to expertise. Resnik and Jensen (2003) interviewed six therapists classified as expert and six classified as average and identified several characteristics in relation to being an expert therapist practitioner. These included:

- being more likely to reflect a patient-centred approach to care, described as resulting from an interplay of clinical reasoning, therapist knowledge values and virtues that, together, guide the clinician’s style of practice
- possession of a broad, multidimensional knowledge base informed not only by clinical experience but also by factors such as continued education, teaching experience and experiences with colleagues and patients
- effective clinical reasoning and collaborative problem solving
- reflection on practice
- possession of values and virtues that included a love of clinical care
- an approach to patient management that placed patient education central to practice, and individualised patient management

Experts do not necessarily have a significant number of years of clinical experience; indeed, years of experience are less critical than a sum total of knowledge base. Thus, some physiotherapists with more limited years of clinical experience can still demonstrate the attributes of an expert practitioner (Resnik and Jensen, 2003).

However, in reviewing the factors that influenced clinical decision-making (CDM) in novice and experienced physical therapists, Wainwright et al. (2011) found that experience *was* essential for the development of CDM skills and abilities. Their participants were three pairs of clinicians each consisting of one novice physical therapist (<1 year of experience) and one experienced physical therapist (> 8 years of experience) at three acute rehabilitation centres. The researchers utilised videotaped excerpts of therapist-patient interaction (one evaluation and one treatment), which were discussed and analysed by each participant during interviews. Several themes were identified as being impactful on CDM: prior professional experience including academic experience; clinical experience; clinical mentorship and teaching; and continued education. The experienced participants were all able to identify instances where learning and clinical reasoning had been enhanced by these experiences. In terms of sources of information, novice practitioners were much more dependent on written information such as medical records than experienced participants, who relied much more on patient observation and interaction. The authors identified that both experiential knowledge and conceptual knowledge were necessary for effective CDM and, because novice clinicians had more limited experience in both, they evidenced a trial-and-error approach that was absent in the expert practitioner.

3.6 The student physiotherapy practitioner

Given that the older adult population is increasing and that this group is more susceptible to a decline in health and independence (Ross et al., 2018), physiotherapy students need to be prepared appropriately during their training to work with this population. The Chartered Society of Physiotherapy (CSP, 2020) highlights that learning derived from both university and practice-based settings is of equal importance and that practice-based learning is an integral and indispensable part of student learning. Experiential learning within practice-based settings allows students to learn and develop their clinical skills in a ’real world’ practice setting, enabling them to practise on individuals who have real impairments (Mai et al., 2013), and clinical placements make up a significant part of any physiotherapy programme. As such, physiotherapy students are likely to encounter older adults within many settings, including acute care.

Reflecting the guidance on the knowledge skills and attributes required by qualified physiotherapists working with older adults, efforts have been made to identify the objectives students should meet when working with this older population. Simpson et al. (1993) identified objectives for students working with older adults within acute care including:

- Effective assessment and identification of functional problems
- Realistic goal setting and treatment planning
- An understanding of how to modify physiotherapy appropriately depending on the older adults age-related physical presentation
- Effective communication with patients, families, carers and the multidisciplinary team
- An understanding of community services available
- A recognition of the older patient’s autonomy and the need for a biopsychosocial approach to rehabilitation.

The objectives published by AGILE Thames (2002) reflect those published by Simpson et al. (1993) but with an updated recognition of the need to adapt input dependent on clinical presentation rather than age. What becomes clear from reading these publications is that they reflect many of the skills and competencies identified by IPTOP (2021) and APTA (Wong et al., 2014) as essential for effective gerontological physiotherapy practice. In addition to the range of skills identified as necessary for working with older patients, physiotherapy students have to contend with the challenges of working within the acute care environment. Hayward et al. (2015) utilised a qualitative approach to explore the experiences of 33 physical therapy students working in inpatient settings and found that students themselves highlighted the challenges of working in a fast-paced environment with medically complex patients. They identified complex clinical reasoning and decision-making, excellent communication skills, and flexibility of approach as essential attributes evidenced by their clinical educators and which they tried to emulate.

Physiotherapy students often do not feel well informed about ageing even when they have graduated, despite the inclusion of academic content related to older adults, and inconsistency in terms of gerontological teaching has been reported across different physiotherapy programmes (Ramklass et al., 2010). Given the importance of clinical placements in enabling transference of academic teaching into clinical learning it is therefore important that programmes are enabling students to develop the requisite knowledge, skills and attributes to manage older adults, including in acute care. Yet, as the previous sections have demonstrated, these requirements are extensive and complex. There is significant literature relating to both academic and experiential learning strategies in preparing students for clinical practice with an older patient population, but much of this is related to facilitating more positive attitudes towards this population rather than the development of knowledge and skills more generally. However, there is evidence to support a more focused programme design approach to healthcare student learning. Scherer et al. (2008) surveyed 222 nursing students and found that over half of them were only somewhat comfortable with their knowledge about managing a range of clinical presentations and in being knowledgeable about preventative healthcare in older adults. These findings resulted in the development of an interactive module specific to geriatric management, which introduced the students to successful ageing, health promotion, maintenance of functional capacity and quality of life as well as communication skills, and the principles and skills for effective assessment and management of this population both within acute care and other environments. Within physiotherapy, service learning (an educational methodology that provides students with opportunities to practise and refine affective, cognitive and psychomotor skills in a community-based setting with older adults), in combination with a geriatric course, has been shown to reduce self-perceived anxiety and improve student confidence in assessing falls risk (Nordon-Craft et al., 2017) and facilitate critical thinking skills and enhance knowledge of and attitudes toward the older adult (Beling, 2004). Lorio et al. (2017) evaluated an intensive 12-hour multimodal learning module on dementia, surveying 33 physical therapy students, and found that their students reported an increased confidence in working with those with dementia and an increased understanding of the challenges associated with treating this patient population. However, there are challenges in implementing a more focused training component within an established curriculum, particularly when students need to be prepared for practice in a wide range of clinical specialities; whilst the evidence is that learning can be enhanced with targeting gerontological teaching, the challenge may often be around maximising the current available learning opportunities for students within both the academic setting and the clinical environment.

Finally, the clinical education environment itself plays a major role in educating students and influencing their approach to manging older adults. Watkins and Waterfield (2010) used focus groups to explore physiotherapy students’ perceptions of the gerontological clinical environment and found factors that had the potential to negatively impact on the student experience including: a rehabilitation approach focused on immediate management rather than addressing long standing problems; staffing shortages; and more negative and stereotypical attitudes in those working with older patients. However, for their participants, these factors seemed to have made them more determined to be proactive in the rehabilitation of older adults. Neville and

French (1991) surveyed 40 physiotherapy students about their clinical education experiences and found that, in addition to their clinical educators' more personal attributes, students valued student-centred teaching and learning methods, frequent constructive feedback, a varied and carefully planned case load to maximise their learning. In comparison, the 64 clinical educators surveyed identified more of a focus on student characteristics such as: being interested, questioning, knowledgeable and evaluative; able to put theory into practice; and able to demonstrate good interaction and rapport with patients This suggests a potential mismatch in expectations that may itself influence student learning. Thus, the evidence suggests that the acute care clinical environment *and* the clinical educator-student relationship both have the potential to positively and negatively influence learning, and this may be further influenced by the demands of the acute care environment and the complexity of older patients.

3.7 Ageism and othering

Butler (1969, cited in Widrick and Raskin 2010) first coined the term ageism and described ageism as constituting negative attitudes and behaviours directed at a specific group, in this case older adults. It is argued that society in general has developed and perpetuated negative attitudes towards older adults and that the causes of this negativity are multifactorial and complex (Weir, 2004). Ageism is considered by many to be a socially constructed phenomenon and is described as a complex set of social relations that serve to discriminate against older adults, setting them apart from others by defining them and understanding them in a very simplified and general way (Minichiello et al., 2000). Unlike other stigmatised groups, the social sanctioning of negative attitude expression towards older adults is almost completely non-existent (Levy and Banaji, 2002).

Healthcare practitioners are likely to demonstrate some of these societal attitudes given that they are themselves a part of society and therefore cannot be immune to prevailing social attitudes and behaviours (Herdman, 2002; Wade, 1999). The beliefs and values of healthcare professionals can greatly influence the quality of care delivered to older adults, as this group often require significant input from the health and social care systems within which these professionals work (Wade, 1999). Weir (2004) coins the term ‘new ageism’ to specifically describe the negative attitudes of healthcare professionals who, she argues, should be promoting anti-ageist views but instead demonstrate a negativity that permeates health and social care, influencing the decisions made in relation to the older age group. Medical practitioners have been shown to be less respectful, less engaged, less patient, and less optimistic when dealing with older patients and demonstrate less joint decision making with this patient group (Greene et al., 1996, cited in Minichiello et al., 2000). Minichiello et al. (2000) identify that the older adults in their study were aware of discriminatory practices within healthcare and recognised that this was wrong, but also felt for the most part powerless to challenge or change this behaviour. As long as healthcare focuses on issues of stereotypical dependency of older adults then there cannot be the truly individualised, age neutral care that will most benefit this group (Phelan, 2011).

One approach to overcoming ageism within healthcare has been to focus on the use of gerontological teaching and experience within undergraduate healthcare training to promote more positive attitudes towards older adults, with researchers exploring the gerontological education of a range of healthcare professionals. Examples include Lookinland and Anson (1995) - nursing students; Giles et al. (2002) – physiotherapy and occupational therapy students; and Intrieri et al. (1993) – medical students. However, evidence relating to both the theoretical teaching of gerontology and the value of clinical exposure to older-adult focused healthcare environments has proved conflicting, with some studies identifying more positive attitudes post gerontological education and experience (e.g., Intrieri et al., 1993) whereas other researchers, such as Treharne (1990), have found the opposite.

The concept of othering refers to the processes by which individuals and groups are treated and viewed as different and inferior from the dominant social group, and therefore excluded (Griffin, 2017), and was originally explored by Edward Said in relation to imperialism and race (Khalil, 2004) and in relation to feminism (de Beauvoir, 1949). The concept of othering could therefore be interpreted as defining some 'other' group in relation to one's own group. Nelson (2002: preface) describes how people tend to automatically categorise others in terms of race, sex, and age, and describes ageism as the third 'ism' (alongside racism and sexism). If within discussions around race and gender the concept of othering has been explored, then it might seem logical to extend this concept into age and ageism.

The work of Michel Foucault, the French philosopher and historian, can be argued to have much to contribute to the exploration of why ageism might occur and how older adults become othered. Foucault's belief was that identity is not fixed but is instead a 'discourse' mediated by our interactions with other people (Urbanski, 2011). Foucauldian theory defines discourse in a specific way, as a group of statements that provide a language for talking about a particular topic at a particular moment in time (Hall, 1997). Foucault argues that discourses construct topics and govern the way topics are meaningfully talked about and as such constitute reality (Hall, 1997). These discourses are therefore covert agents of power, exercised at point of contact via complex networks (Phelan, 2011). Phelan (2011) argues that the discourses produced in relation to older adults may be 'steeped' in ageist assumptions, which then affect how such subject positions are constructed by society, with this understanding of older adults being constituted via complex and multifaceted discourse-power-knowledge relationships (with knowledge, e.g., of older adults, constructed both culturally and historically). She argues that selected dominant discourses may then cause the constitution of more ageist normalised subject positions relating to older adults. Examples of how various discourses may influence these normalised subject positions include: the use of chronological classifications of age, which label adults of a certain age as ‘old’; biomedical discourses, which view ageing as a degenerative process requiring interventions to sustain the body’s preservation; and political discourses, where older adults are presented as becoming dependent on the state for support and as placing an increasing burden on society as their numbers grow (Phelan, 2011).

One way in which ageism and othering may be facilitated and perpetuated is by labelling (Palmore, 1999: p111). Widrick and Raskin (2010) collated research findings into the labels given to older adults and found that, whilst there were a few labels associated with a positive perception of older adults (sageism, retired person, grandparent), the vast majority of terms used were found to be negative in connotation (e.g., frail, less competent, disagreeable, dependent, vulnerable, needy). Old age is associated with labels to do with ill-health, cognitive decline and a negative shift in personality (Wiles, 1999, cited in Weir, 2004), and many of these labels can be seen to relate to those dominant discourses identified by Phelan (2011) and cited above.

Foucault emphasised that discourses have a profound impact on the way in which society is constituted and the ways in which individuals are treated in that society (Mohr and Neely, 2009). He discusses the concept of normalisation as the creation or specification of a general norm in which the uniqueness of an individual or group is in some way recognised, characterised, and standardised in relation to that norm (O’Malley, 1996: p189). Thus, the multiple negative societal discourses related to ageing, and the prevailing societal discourses emphasising youth as the accepted norm, suggest that older adults are constructed as a marginalised group within society who require particular assistance in multiple areas such as health, economics, and welfare (Phelan, 2011). As these become the norm within society, the ultimate result is that older adults are seen as ‘other’ in relation to the prevailing norms.

Healthcare services are made up of human components who live and function within this diversity of discourses within society (Weir, 2004). The prevailing negative discourses around ageism and health within society as a whole cannot but influence how healthcare professionals perceive older adults, and the discursive practices within healthcare may tacitly promote stereotypical ageist perspectives and practices (Phelan, 2011). These stereotypical perspectives may well be reinforced by experience, given that the majority of older adults who enter the healthcare system do so because of a deterioration in their health status (Tadd et al., 2012). The negative labels given to older adults as identified by Widrick and Raskin (2010) are frequently found in medical discourses, with words such as ‘frail’, ‘dependent’ and ‘disabled’ accepted as normalised medical terms (Phelan, 2011). Ageist acts by healthcare professionals are not on the whole blatant but instead pervaded by a sense of treating older adults as unimportant (Minichiello et al., 2000). Negative stereotyping may result in older adults being expected to bear physical discomfort, due to the prevailing societal and medical discourses around old age as a time of inevitable decline, and older adults themselves may expect symptoms such as pain to be a part of the ageing process rather than something to be actively managed; these negative discourses can therefore cause and perpetuate power differentials in the therapeutic relationships between healthcare professionals and older adults (Phelan, 2011).

So, returning to the issue of the use of gerontological teaching and experience within undergraduate healthcare training to promote more positive attitudes towards older adults, Foucauldian theory can also be used as a basis for the potential changes required in educational practice. In accepting Foucault’s theories around knowledge, power and discourse, it must be accepted that student healthcare professionals enter their training having been exposed to the negative discourses around older adults, argued to be the norm within society. Foucault argues that the medicalisation of health, the evolution of the medical expert over time and formation of institutions of medicine has resulted in medical institutional power/knowledge (Hancock, 2018). Thus, students will have clinical exposure to a healthcare environment where this medical institutional power/knowledge, and prevailing medical discourses may further reinforce an ageist approach to the healthcare management of older adults. Whilst addressing societal discourses may be beyond the realms of healthcare education, healthcare education and practice will need to rely on more innovative ways of demonstrating the heterogeneity of old age and focus much more on facilitating more positive interactions with older adults (Phelan, 2011). Healthcare education will also need to challenge the normative perspectives and taken-for-granted discourses of old age and facilitate a recognition of the potential for stereotypical care, so that students can move beyond this to develop the individualized, age neutral care required (Phelan, 2011). Foucault believed that discourses can either constrain production of knowledge and dissent or enable new knowledge and difference (Pinkus, 1996). The hope would therefore be that changes to the discourses within healthcare education and practice might enable new knowledge and a positive difference in practice. Thus with a focus on a more balanced approach to old age, with a recognition that old age is not simply a time of decline, and that whilst medicine cannot cure ‘old age’ it can take on a more proactive, positive and collaborative role where older adults are partners in their care, these more positive discourses might then construct a new ‘valid’ knowledge within the healthcare professionals of the future, which in turn will influence students as they move into the healthcare environment.

3.8 Summary

This chapter has explored current evidence around the role of physiotherapy in acute care and gerontology, including the skills and attributes required for effective physiotherapy practice within this environment. It has highlighted the knowledge, skill and attribute demands for students working with older adults in acute care environments and the evidence around educational strategies (both academic and experiential) in developing the requisite skills etc. to better prepare students for managing an older patient population within acute care effectively. In addition, it has explored the concepts of ageism and othering and their relevance to healthcare in general, to physiotherapy and to physiotherapy education. This aim has been to set the scene for the reader and provide the background and context for this current research and its educational relevance.

Chapter 4: Methodology

4.1 My ontological standpoint

A constructivist/interpretive paradigm asserts that there is no single reality or truth, and that reality is created by individuals within their societal groups (Crotty, 1998: p42). Young and Collin (2004) posit that ‘constructivism’ as a more generic term subsumes both constructivism and social constructionism, with the former focusing more on meaning-making and construction of both our social and psychological worlds through our individual cognitive processes. Social constructionism in contrast places greater emphasis on those worlds being made real, or constructed, through social processes and interactions. As such, social constructionism argues that individuals create their reality but ‘this created reality in turn creates the individuals’ through a process of socialisation – social influences thus facilitating an internalisation of social norms and knowledge (Alvesson and Sköldberg, 2018: p28). In having this social focus, social constructionism considers that knowledge is therefore ‘the product of our social practices and institutions, or of the interactions and negotiations between relevant social groups’ (Gasper, 1999, cited in Young and Collin, 2004).

Lock and Strong (2010: p6-7) attribute four core tenets to social constructionism. First, meaning and understanding are the central feature of our activities. Second, our meaning and understanding begin in our social interactions. Third, because our meaning-making is inherently embedded in socio-cultural processes it will be specific to particular places and times, with the result that the meanings we place on particular events and the ways we understand them will vary depending on the situations we are in. Finally, if who we are is fashioned as described above then we are instrumental in creating the discourses we use to define ourselves – we are ‘self-defining and socially constructed’ participants in our shared lives.

A social constructionist ontology asserts that for my participants their encounters with older adults along their life course, and the impact of these experiences on their roles as clinical educators, will have created a reality where their understanding and meaning-making will have been directly influenced by their social interactions, both personal and professional, and contextualised within relevant socio-cultural processes. As such, to discover the underlying meaning of events and activities experienced by my participants, I needed to focus on them as social beings who have made sense of their experiences by what they themselves and those around them have constructed and kept meaningful (Lock and Strong, 2010, p6-7). Literature on social constructionism and medical sociology (Bury, 1986), construction of professional identities within physiotherapy (Hammond et al., 2016), social construction of ageing (Powell and Hendricks, 2009), social construction of physiotherapists' accounts of older adult rehabilitation (Wallin et al., 2008) and the social construction of learning (Davis et al., 2017: p51) all supported the use of a social constructionist ontology for this study.

4.2 My epistemological and theoretical standpoint

A social constructionist ontology required an epistemological and theoretical stance that enabled me to explore the multiple realities implied by an ontological constructionist/interpretive paradigm The following sections explore the epistemology of phenomenology, the process by which phenomenological interpretivism crystallised as my theoretical perspective and how these choices informed my methodology and methods.

Table 2. Summary of my epistemological and theoretical standpoint

Paradigm	Ontology	Epistemology	Theoretical perspective	Methodology	Method
Constructivist / interpretive	There is no single reality of truth. Reality is created by individuals in groups	Therefore, reality needs to be interpreted – to discover the underlying meaning of events and activities	Interpretivism Phenomenology	Phenomenological research	Interviews

Adapted from Crotty, 1998 (p5)

4.2.1 Defining phenomenology

Phenomenology as a movement was originally initiated by Edmund Husserl as a new philosophical approach based on the use of rationality (critical reflection) in studying the universal structuring processes of consciousness (Hein and Austin, 2001). In Husserl's approach an individual's subjective perception is the truest form of experience they can have in perceiving it, allowing the examination of phenomena as they are originally given to an individual's consciousness (Husserl, 1913). Husserl argued that, because humans go about their daily lives without critical reflection on their experiences, a scientific approach is required to bring out and explore the lived experiences specific to groups of people and to bring out the essential components of those lived experiences (Lopez and Willis, 2004). An assumption of Husserl's approach is that there are features of an experience that are common to all those who share that lived experience, which Husserl called universal essences or structures of experience (Hein and Austin, 2001), and which he considered representative of the true nature of any phenomenon, an objective reality (Husserl, 1913). For Husserl, the purpose of phenomenology was to describe these structures or essences of consciousness, their constituent parts and their interrelationships (Hein and Austin, 2001). However, for

Husserl, human beings were free agents, bearing responsibility for influencing their environment and culture (Cohen and Omery,1994: p136). As such the impact of society, culture etc. on individuals was not central to his approach, with reality seen as objective and independent of context or any presuppositions (Husserl, 1913). Husserl's approach was thus to systematically remove the perceived inessential aspects, symbolic meanings, societal, cultural and other context etc to leave only the essences of consciousness (Husserl, 1913). However, as a social constructionist this epistemological position did not ring true for me.

Heidegger, a student of Husserl, moved away from this philosophical standpoint to instead interpret 'existence' as the experience of 'being-in-the-world' rather than simply 'being' (the Husserlian concept). He referred to this experience of 'being-in-the-world' as the hermeneutics of existence (Hein and Austin, 2001). Heidegger and other proponents of hermeneutic phenomenology assert that, as individuals, we cannot escape from this being-in-the-world, and as such our lifeworld and social world cannot be separated – we affect other people just as they affect us (Berndtsson et al., 2007). Therefore, because we engage with and actively participate in the world, we in turn come to know and understand the world through this participation (Hein and Austin, 2001). Consequently, the focus of hermeneutical inquiry is on 'what humans experience rather than what they consciously know' (Solomon, 1987, cited in Lopez and Willis, 2004). So, whilst the Husserlian approach is one of simply describing and categorising the real, perceived world of participants as narrated by them (Husserl, 1913), the hermeneutic phenomenologist focuses on exploring the meanings of the participants being-in-the-world and the ways in which these meanings influence the choices they make (Lopez and Willis, 2004). As such, whilst the Husserlian approach is one of *descriptive* inquiry, the focus of hermeneutic inquiry is the *interpretation* of participants' narratives within their relevant social, historical and political contexts. As a social constructionist, the placing of these contexts as central to inquiry dictated the need for an interpretive/hermeneutic phenomenological approach to my research.

In summary, the aim of phenomenology is to ‘focus on people’s perceptions of the world in which they live and what it means to them’ (Langdridge, 2007: p4), offering a way of accessing the human experience, exploring how individuals orient their lived experience, and understanding the hidden meanings and essences of those experiences (Kafle, 2011). Phenomena are explored through the way in which they are perceived by an individual in a situation or situations, with interpretation of these experiences by listening to the different stories of participants (Bound, 2011). The uncovering of meaning within an individual’s experience occurs via a focus on a concrete experiential account, which is grounded in the individual’s everyday life (Langdridge, 2007: p4).

Wilson (2014) highlights the challenge of exploring these lived experiences given that, whilst in some instances we may be explicitly aware of them, at other times our experiences may simply be taken for granted and, as such, tacit awareness and understanding is lacking on our parts. Taking a phenomenological approach can, by turning the individual’s attention to those experiences, facilitate reflective awareness, and whilst a phenomenon will be experienced by an individual in a way unique to him or her, the experience will be lived within a shared context that can be understood by the researcher (Cassidy et al., 2011). Thus, a two-stage process occurs – participants’ own interpretation of their experience and the researcher’s sense-making of the described experience, using their own resources and experience. For me as a researcher, my own experiences working in healthcare and in education offered a biographical presence (Smith, 2004) that would enable me to use my own experiences as sources of insight during this sense-making process. Yet these same experiences might also jeopardise the research, should my preconceptions drive the sense-making process (Cassidy et al., 2011), and key to this sense-making would be an explicit acknowledgement of how my own perspectives may have influenced my analysis and interpretation of my participants' experiences (of which more later).

The next section will explore how my understanding of phenomenology as a hermeneutic philosophy translated into the phenomenological approaches through which the lived experiences of my participants could be explored.

4.2.2 Epistemological perspective

A researcher's epistemology is summarised as their theory of knowledge, which serves to decide how the social phenomenon in which they are interested will be studied (Groenewald, 2004). My understanding of phenomenology as a philosophy and my epistemological position that the data generated would be contained within the lived experiences and subjective eyes of my participants, all indicated that a phenomenological research approach was required.

To confirm that a phenomenological approach really was the 'best fit' approach for my research, I utilised the criteria identified by Creswell (2007: p78-79): first, researchers considering using this approach must ask themselves if they have a clear phenomenon to explore – in my research, this was the perceptions of older adults held by clinical physiotherapists; second, the type of research problem best suited to a phenomenological approach is one where it is important to understand several individuals' shared experiences of a phenomenon. Whilst it could be argued that my participants may have a range of personal experiences of older adults beyond the healthcare system, they share a commonality of experience in working within the National Health Service and within one organisation. Finally, the research should culminate in the researcher gaining an '*essence*' of what the participants have experienced and how they experienced it (Creswell, 2007: p79). In relation to my participants' experiences of older adults, this essence would be crucial in enabling me to make sense of how the research findings could then be related back to the physiotherapy curriculum and to explore whether the curriculum *was* effectively preparing physiotherapy students to work with older adults within the healthcare system.

Creswell (2007: p77) describes phenomenology as a 'philosophy without presuppositions' and cites as a key feature of phenomenology the suspension of all judgments about what is real until these assumptions can be based on a more certain basis, meaning that data collection traditionally precedes theory development. To support this approach, an exploration of the qualitative literature around the focus of this research study identified little available research evidence on the lived experiences of healthcare staff in relation to older adults. However, within the broader area of ageism and healthcare there was already significant research evidence and theory generation with regard to the presence of ageist attitudes within both society in general and healthcare, meaning that some interpretation of what is real was already a possibility. It was therefore important to resolve this dichotomy between a methodological stance where data collection would normally precede theory, and a substantial existing research and theoretical dataset addressing ageism, healthcare, and healthcare education, which would all be relevant to this research study. The approach of empirical phenomenology suggested a way of marrying the two, given that, in this approach, choosing a theory is an integral part of the early stage of the research process, and that the theory exists to guide the researcher and help identify which aspects of a topic are relevant (Aspers, 2004).

4.2.3 Empirical phenomenology

Empirical phenomenology differs from other phenomenological approaches in that it is both grounded in the philosophical traditions of phenomenology and considers core insights of social science research such as existing theory (Aspers, 2009). As such, the approach produces explanations that are grounded in the experiences of real people but goes beyond just delivering descriptions of these experiences to explore ‘how and why’ people think about the phenomenon under exploration. Empirical phenomenology starts from an assumption that scientific explanations must be grounded in the ‘meaning structure’ of participants (Aspers, 2009) and, as such, their perspective must be central to the analysis process. It also proceeds from the assumption that the social world is socially constructed. Finally, this approach acknowledges the central role that theory plays in research (Aspers, 2009). As such, theory is used by the researcher as a frame of reference to provide focus for the research study. Lopez and Willis’s (2004) assertion that in hermeneutic inquiry it is appropriate to use theory to focus the research and make decisions about sample, subjects and the research questions further supported this choice of approach.

Key characteristics of empirical phenomenological research include an emphasis on the structure or commonality of the phenomenon being explored: whilst this commonality may present the phenomenon in diverse ways, the structure or meaning will reveal the nature of the phenomenon as a lived human experience (Hein and Austin, 2001). Furthermore, empirical qualitative research relies on the actual words used by participants to communicate experiences (hence the use of the term ‘empirical’) and requires a robust methodological process, with issues of verifiability and replicability being of high importance, and a requirement for a systematic data analysis process (Hein and Austin, 2001). However, whilst empirical phenomenologists may emphasise the rigour of this research approach, hermeneutic activity (interpretation) must form ‘an intrinsic part of the research process’ (Hein and Austin, 2001: p8).

An empirical phenomenological approach offered me a methodological stance that allowed consideration of theory, enabled a hermeneutic approach and inductive analysis and remained focused on the lived experiences of participants. As such, it offered a research approach that would answer the challenge of meeting both the underpinning epistemology of this research and the need to adopt a phenomenological approach to carrying out the research. However, Aspers (2004) cautions that whilst theory may guide the researcher to particular empirical domains, lead them to address particular themes and guide them in asking particular questions, the researcher must ensure that the theory does not overly dictate the gathering of empirical evidence. The empirical evidence should be allowed to reformulate, alter, or add dimensions to the theory. Therefore, whilst the theory garnered prior to this study (for example in relation to ageism within society and within healthcare) guided me towards the study’s aim and research questions, it was important to let the empirical evidence speak for itself rather than have a predetermined set of concepts to be used, in Aspers words, ‘as boxes to be filled with empirical material’ (Aspers, 2009: p6). Patton (2002: p44) also highlights the need for this emergent flexibility within qualitative research to ensure the researcher does not get locked into a more rigid research design that precludes responsiveness to new routes of discovery as they are identified from the data.

Aspers (2009) identifies a seven-step process to empirical phenomenology:

1. Define the research question (guided by the interests of the researcher and initial theory)
2. Conduct a preliminary study (to determine the feasibility of addressing the research question and to determine whether the theory to be used is appropriate and/or the most suitable). Aspers (2009) identifies a range of

mechanisms for this process including interaction with those in the field (in the case of this research this included discussions with practice educators and students, some of which was based upon my Masters dissertation process and findings) and reading the literature within the field of the research

3. Decide upon the theory to be used and use this as a scheme of reference for the research (which would give further focus to the study)
4. Study first order constructs (via studying the research participants or 'actors' in some way that will enable the researcher to understand them e.g., interviews or observation) and bracket the theories (i.e., using theory to guide the research but ensuring that the data are allowed to speak for themselves)
5. Construct second order constructs (relate first order constructs to theory)
6. Check for unintended effects (to construct a picture of the participant's life world that connects their meaningful actions with both intended and unintended effects/consequences)
7. Relate the evidence to scientific literature and to the empirical field of study (e.g., via respondent validation)

The above process is iterative, and the researcher may move between earlier and later stages several times to establish 'secure footholds for knowledge' (Aspers, 2009: p5). Ultimately, the aim of empirical phenomenology is to ensure that the participants' perspectives come through in the research and that, whilst theory may guide the research questions and focus, no scientific explanation should exist unless what is studied is clearly related to the first order constructs of the participants themselves (Aspers, 2009). Therefore, the method chosen to explore the research questions for this study needed to be one that would allow the voices of the subjects to speak for themselves, via a suitable methodological framework that would enable application of an empirical phenomenological approach.

4.2.4 Factors influencing methodological choices

Three key factors dictated my choice of methodology. Firstly, the potential for utilisation of an empirical phenomenology approach, as explained in the previous section; and secondly, the need for participants who demonstrated some homogeneity of professional practice experiences and of working within clinical education environments that are accessible to our students for clinical placements – this homogeneity being a key requirement for utilising a phenomenological approach (Creswell, 2007: p82). Thirdly, the application of government healthcare policy, such as the National Service Framework for Older People (Department of Health, 2001), is translated into practice via local policies and practices, which may vary slightly in ethos between different healthcare providers. It would therefore further aid homogeneity to seek a sample from one healthcare institution where the institutional ethos in managing older adults will influence practice at the ward or department level in which these physiotherapists will operate. Phenomenology is concerned with interpreting meaning in relation to commonalities that are embedded in cultures involving shared languages, practices, and practical knowledge about a phenomenon, incorporated in their common day to day experiences (Sorrell and Redmond, 1995). The selection of participants from one healthcare institution who shared some homogeneity of professional practice experiences would thus ensure the commonality required and meet the assertion that a phenomenological approach is one where it is important to understand several individuals' *shared* experiences of a phenomenon (Creswell, 2007: p82). A number of large secondary care institutions across the West Midlands educate physiotherapy students, incorporating large general hospitals with a significant number of wards managing a range of clinical specialties. As traditional institutional structures within healthcare, a significant number of these institutions exist within the West Midlands and within the United Kingdom (UK) as a whole, meaning that the intensive analysis of participant experiences within one institution could feasibly be argued to enable inference to similar secondary care institutions within the UK.

The following chapter details the methods used in the study, with choices considered in light of the above factors.

Chapter 5: Methods

5.1 Study aim

As stated in the introduction, the aim of this study was to explore physiotherapists' experiences with older adults, how these experiences may have informed their clinical practice, and how these experiences may in turn influence how they educate physiotherapy students.

5.2 Objectives

1. To identify physiotherapy clinical educators' previous experiences with older adults throughout their life course
2. To explore these experiences with older adults within the context of the underlying meaning of these events and activities, both in relation to their own clinical practice and their approach to the education of physiotherapy students
3. To explore the implications of these findings on current and future physiotherapy education

5.3 Study design

As identified in Chapter 4, interpretive phenomenology is situated within the philosophy of interpretivism or hermeneutics, which is concerned with what it means to be human (Nicholls, 2017a). Phenomenology requires that each person is viewed as unique, and that the researcher should be concerned with each person's particular world view given that each individual will interpret the world in their own unique way. Thus, within phenomenological research the researcher must go on a journey to explore the meaning of each individual participant's experiences (Nicholls, 2017b).

This study was therefore exploratory, utilising one-to-one semi-structured interviews to collect the data. Interviews are frequently used as a data collection method in exploratory research and are used to gather information relating to participants' views, beliefs, and experiences about a phenomenon of interest (Lambert and Loiselle, 2008). They generate deep contextual accounts of both participants' experiences and their interpretation of them (Schultze and Avital, 2011, cited in Doody and Noonan, 2013) and as such are a key research tool within phenomenological approaches (Creswell, 2007: p81). In-depth interviews are one of the most important means of generating data when taking an empirical phenomenological approach to research (Aspers, 2009). Whilst other data collection methods, such as focus groups, were considered, given the nature of the research questions, the epistemological and methodological choices and the potential sensitivity of the subject matter, interviews were chosen as the most appropriate means of generating the data required to answer the research questions. Complex experiences are best addressed in a one-to-one interview format to enable a depth of focus, detailed understanding, and opportunities for clarification that a focus group format cannot facilitate (Lewis, 2003).

5.4 Ethical approval

Ethical approval was gained from the Keele University Ethics Review Panel on 6th August 2015 (appendix 1). Research and Development approval from the relevant National Health Service (NHS) Trust was subsequently gained in December 2015 (appendix 2), confirming NHS approval and permission for the research to proceed.

5.5 The choice of interview approach

There are three types of interview: structured, semi-structured and unstructured (Doody and Noonan, 2013). Whilst structured interviews provide comparable, standardised responses, they severely limit the type and scope of data generated and are therefore largely unsuited to a phenomenological approach. However, semi-structured interviews (based around a set of predetermined questions but allowing flexibility in terms of asking these questions and allowing for probing) and unstructured interviews (non-directive, flexible and based around themes rather than specific questions) are two approaches that are ideally suited to qualitative research methodologies (Doody and Noonan, 2013). Both these types of interview enable the researcher to explore emerging issues, allow flexibility within the interview, enable a more conversational style of questioning, and facilitate the collection of rich data, and both have merits and challenges. The use of an interview guide in semi-structured interviews can facilitate collection of similar data types from all the research participants and help create a sense of order for both researcher and participant (David and Sutton, 2004). However, semi-structured interviews may restrict the questions being asked about a phenomenon and may stifle the potential vivid picture of the lived experiences of the research participant that an unstructured interview can generate (Sorrell and Redmond, 1995). Yet unstructured interviews, using only topics as opposed to an interview guide, can be challenging for a novice researcher. For example, the researcher using an unstructured approach must think on their feet, with the need to think fast enough to select questions, decide when to probe further and decide whether to chase new leads in the limited timescale of an interview (Price, 2002). For both semi-structured and unstructured interviews a combination of a consideration of the ordering of questions in terms of ‘least’ to ‘more’ invasive in nature, the use of a notebook to jot down areas that may merit further exploration at some later point in the interview, and a skill in reading participants’ body language (to judge whether each answer indicates interest or discomfort in the developing narrative and whether topics should be pursued or deferred) can enable the researcher to overcome the above challenges (Price, 2002). In addition, interview skills need to be developed prior to data collection, as a lack of skill in facilitating interviews can adversely affect the success of the data collection process and indeed be of detriment to the participant, for whom the experience might be at the very least unrewarding and, if discussing sensitive or emotive issues, may be traumatic to the participant if not handled sensitively (McConnell-Henry et al., 2010).

Thus, it is important to train interviewers in the skills required for successful interviewing and, where possible, expose novice interviewers to the type of interview to be undertaken (McConnell-Henry et al., 2010).

Upon reflection on the issues raised above, semi-structured interviews were chosen as the most appropriate data collection method. They would allow some focus to questioning via the use of an interview guide but also enable a degree of flexibility for further exploration of issues raised by the participants and for movement between topic areas depending upon the direction taken in the individual ‘conversation’ with each participant. In recognition of the potential challenges faced by novice interviewers, I utilised the strategies identified above, sought support and training from researchers more experienced in the use of interviews as a data collection tool, and used the pilot study to develop/hone my interview skills.

5.6 Population

Phenomenological research involves searching for commonalities across individuals and individual experiences (Patton, 2002: p106). Given that older adults have higher rates of hospital admissions than the general population, have higher rates of readmission due to complications, and experience significant functional decline whilst in hospital (Courtney et al., 2011) requiring physiotherapy input, I chose as my recruitment site one of the large secondary care hospitals within the West Midlands that educates Keele physiotherapy students. These secondary care institutions traditionally have a large number of physiotherapy staff with a range of age, clinical experience, and grade. Most importantly, these institutions have a long history of providing clinical education experience for physiotherapy students, and a large number of the patients managed within these institutions are older adults.

Given the research aim and objectives it was clear that my study sample must have experience working with older adults within the secondary healthcare environment *and* some experience of clinical supervision of physiotherapy students. Traditionally, physiotherapy practice educators have tended to be clinical specialist physiotherapists with several years of experience and holding a more senior position within the organisation. However, in more recent years the traditional hierarchical structure of physiotherapy within institutions has changed somewhat and, whilst rehabilitation within clinical areas is still managed by more specialist higher grade staff, there are now a significant number of more junior staff working on a daily basis with physiotherapy students. Thus, the number of clinical physiotherapy staff, with whom the physiotherapy students interact and work alongside on an hour-by-hour basis, is larger than would have been the case several years ago. Therefore, alongside the use of a large secondary care institution for the research, there was also a larger potential study population of qualified physiotherapists who were working within that institution, treating older adults and supervising physiotherapy students – further facilitating the homogeneity of sample required for a phenomenological approach (Creswell, 2007: P82).

5.7 Sampling strategy

Purposive sampling enables researchers to choose the most appropriate participants to meet the requirements of their research study and ensures that this sampling should be reflective of the population of study (Seawright and Gerring, 2008). The researcher selects their sample individuals because the characteristics and experiences of those individuals can purposefully inform an understanding of the phenomenon that forms the basis for the research study (Creswell, 2007: p155). Within secondary care, physiotherapists work in a range of specialities where older adults may form at least part of their daily caseload, and where physiotherapy students may be placed for clinical education. In addition, as identified earlier, a number of different grades of physiotherapy staff, from lesser to more experienced, work in these clinical areas and supervise physiotherapy students. My sampling strategy was therefore to:

- Recruit participants who worked in or across a number of clinical areas where older adults would form part of their clinical caseload
- Recruit physiotherapists across a mix of grades/experience

5.7.1 Inclusion criteria

Participants were qualified physiotherapists who fulfilled the following criteria:

- Had a minimum of one year’s experience of working in any clinical areas where physiotherapists would encounter older adults.
- Had worked within the last year in clinical areas where physiotherapists would encounter older adults.
- Had a minimum of one year’s experience working with Keele physiotherapy students.

5.8 Sample size

5.8.1 The challenges of determining sample size

Since the aim of using a qualitative phenomenological approach is to gain in-depth ‘rich’ data, the sampling approach should aim to retain depth of data collection rather than breadth in terms of sample size (Ritchie et al., 2003). However, different arguments with regards to the rationale behind sample size selection are evident in the literature. Mason (2018: p71) argues that the right number for a study sample simply depends on what it is the researcher wants to compare/explore and the extent to which the sample will enable this. Morse (2000) stresses that the decision should be based upon factors such as the scope of the study, quality of data, amount of useful information obtained from each participant and the design and methods used. Dworkin

(2012) identifies that discussions in the literature about sample sizes for exploratory research can suggest anywhere between five and fifty participants as being adequate, whilst Creswell (2007: p157) cites phenomenological studies with a range of sample sizes from one individual to ten. In a review of 11 education focused phenomenological studies Guetterman (2015) found that the mean sample size was 15 and ranged from 8 to 31.

Sim et al. (2018) argue that sample size in qualitative research cannot be determined *a priori* as the development of themes during the nuanced analysis required within a qualitative approach means that some participant accounts may contribute more to the development of these themes and developing theoretical insights than others. Therefore, aiming simply for a number of accounts is inadequate as a determinant of sample size.

Malterud et al. (2016) argue that whilst an approximation of sample size is required for the purposes of planning, the final sample size needs to be constantly reviewed as the research progresses. They propose the concept of ‘information power’ where the larger the information power a sample holds the smaller a sample will need to be and cite five distinct factors as influencing information power, all of which will impact on each other:

1. Study aim: a narrower study aim will require a smaller sample to offer sufficient information power than a broader aim
2. Sample specificity: the specificity of knowledge, experiences, and properties of a sample
3. Use of established theory: a study supported by more limited theoretical perspectives may require a larger sample than one with more theoretical underpinning
4. Quality of dialogue: in qualitative studies the empirical data are co-constructed during the interaction between researcher and participant, with a range of

factors including researcher skill and participant articulateness determining the quality of the resultant dialogue

5. Analysis strategy: exploratory cross case analysis will require more participants than in-depth analysis of narratives from a few select participants

Charmaz (1990, cited in Dworkin, 2012) places more emphasis on the need for an adequate sample size to ensure data saturation. Originating in grounded theory, saturation is now argued to be a broad concept encompassing *theoretical saturation* (related to grounded theory), *inductive thematic saturation* (related to the emergence of new codes and/or themes), *a priori thematic saturation* (the degree to which previously identified codes or themes are exemplified within data) and *data saturation* (the degree to which new data repeat what has been expressed in previous data) (Saunders et al., 2017). The result of *data saturation* is informational redundancy where no new information becomes available from any further sampling (Braun and Clarke, 2019). Data saturation itself can depend on a number of factors, including the homogeneity/heterogeneity of the sample population, the timescale available for the research and the degree of experience of the researcher in eliciting relevant information from the participants (Dworkin, 2012).

5.8.2 Sample size for this study: the determinants

Consideration of the research aim and objectives within the context of the factors discussed above identified: a relatively narrow study aim; relative sample specificity, given that my participants were working with older adults within one healthcare institution and only supervised Keele physiotherapy students; a study design that was focused on in-depth analysis of accounts; and the use of a phenomenological approach where the underlying inductive analytical approach was thematic and within the context of interviews involving a number of participants, which meant that data saturation could be utilised as a determinant of the final sample size. Given these considerations I aimed to recruit fifteen participants, whilst recognising that the final number of participants could only be determined once the study was underway (Sim et al., 2018) and that the number required would also depend on factors such as my ability to elicit a quality of dialogue within my participants (Malterud et al., 2016).

5.9 Study procedure

Initial recruitment was via e-mail (appendix 3) to the Therapy Manager for the NHS organisation approached. This e-mail requested permission to send the recruitment e-mail (appendix 4) and further information to that manager for forwarding on to the physiotherapy staff group within the organisation. The recruitment e-mail had the participant information sheet (appendix 5) and consent form (appendix 6) attached and offered an invitation to respond by e-mail should potential participants wish to take part in the study.

In actuality, only one person responded to the initial e-mail and one other to the reminder e-mail. It became clear after discussion with some of the physiotherapy clinicians that high workloads meant that staff did not prioritise e-mails and would tend to delete those not immediately relevant to their work. This necessitated the introduction of an additional recruitment strategy, with recruitment occurring via an ongoing process of my handing out the Participant Information Sheet to staff when at the organisation. Verbal discussion with my supervisor and the university governance officer confirmed that I did not need to submit a revised ethics application for this change in recruitment strategy. However, as it was extremely important that I could not be construed as targeting individuals in any way, I ensured that I gave the participant information to all physiotherapy clinicians I came into contact with and also asked them to pass this information on to others they were working with. No attempt was made to persuade any potential participants to take part. In addition, as the research progressed and without any input on my part, participants spoke to colleagues about the research and this informal snowballing recruitment resulted in more physiotherapists expressing an interest in the research. As the research progressed, potential participants were reviewed based upon my purposive sampling strategy to ensure that they offered a mix of experiences based upon both clinical area and grade of role.

If potential participants fitted my purposive sampling strategy and decided to take part in the research, they were invited to participate in a one-to-one interview, which took place at a mutually agreed venue, date, and time. Before the interview, participants were given the opportunity to ask questions and to confirm that they were happy to proceed with the interview before signing the consent form.

5.10 Data collection tool: the interview guide

Within phenomenological interviews the aim is to get the participants to describe rather than interpret their experiences so that the researcher can gain a holistic understanding of these experiences as part of the participant's daily life. Thus, the questions should enable participants to share their stories and elicit a rich picture of the lived experience (Sorrell and Redmond, 1995).

Given the exploratory nature of the research, the interview questions within the interview guide, whilst reflecting the aims of the study, were deliberately designed to be broad in nature. As such they provided a basis for exploration of the topics and yet allowed me to explore emerging issues, ensure flexibility within the interview, and achieve a more conversational style of questioning – thus facilitating the sharing of experiences and stories, enabling the collection of rich data (Doody and Noonan, 2013).

The interview guide (Appendix 7) was generated using the research question as its basis. It involved me identifying key topic areas that would need to be explored in order to answer the research question, and then the development of questions to facilitate discussion related to these areas. Discussion between myself and my supervisor helped to focus the topic areas and questions further and to develop suitable wording for these questions in order to ensure open questioning was achieved.

As the interviews progressed some participants identified other potential topics for discussion, and these were added to the end of the interview schedule. For example, participant 8 suggested that I ask future participants whether they *liked working with* older adults and differentiated this from *liking* older adults. Whilst I needed to amend the question so that it would be less likely to produce a social desirability bias, this topic was raised and discussed with later participants.

5.11 Data collection

The interviews were carried out either in a room on the hospital site or within the School of Health and Rehabilitation, Keele University and lasted between 57 minutes and 85 minutes. As recommended by Creswell (2007: p164), an interview guide with open ended questions/topics was used to facilitate the interview process. The interviews were audio-recorded, with some additional notes made by me during each interview to highlight relevant issues raised which could then be explored further as the interview progressed. Respondent validation was achieved initially by my summing up at the end of each interview the key issues that had been discussed and inviting additional comments/requesting confirmation of the accuracy of the summary from the participant. As the interviews progressed this summarising became a more intuitive process occurring at the end of the discussion of each main topic area. The success of this approach was evidenced by a number of participants either adding additional information to this summary or clarifying meaning where they felt the summary had not fully or accurately captured the discussion.

Immediately after each interview, I wrote a reflective account of the session noting key features and themes of the session as well as identifying potential areas for exploration in the next interview. This reflective process also included analysis of my interview technique to identify any procedural problems which needed rectified for the next interview and to check for potential areas where I may have inadvertently led the discussion in a particular direction. Although rare, where inadvertent leading was perceived to have occurred, I practised rephrasing questions/responses to minimise the chance of this leading occurring in future interviews.

5.12 Data analysis

The audio-recordings were transcribed by an audio-typist and I then checked them for transcription accuracy via comparison with the audio-recordings. Doody and Noonan (2013) highlight the importance of familiarity with the audio recordings and written transcripts when analysing qualitative data, enabling the researcher to immerse him or herself in the details and gain a sense of the interview as a whole before breaking it down into parts (Creswell, 2007: p183). Normally the transcription process would form an integral initial stage of this familiarisation process, but my hearing impairment meant that the challenges of transcription outweighed the benefits of this process. To compensate for this, I compared each transcript against the relevant audio recording to check for accuracy and listened to the audio recordings and read the transcripts several times to ensure familiarity with the interview as a whole before the data analysis process for each transcript began.

Respondent validation has been discussed earlier (section 5.11). Due to the potential problems inherent in allowing participants to review the transcripts (such as poor recall and differing perceptions about content – Johnson & Waterfield, 2004), and particularly with the time delay inherent in getting someone else to transcribe, transcripts were not given to participants for checking.

5.12.1 The analytic perspective

Nicholls (2017b) asserts that whilst different exploratory methodologies may have differing prescriptions about the data analysis process, ultimately it is up to the individual researcher to utilise an approach that best suits their data whilst remaining true to the underlying philosophy of their research. As identified earlier, the constructivist/interpretive paradigm asserts that there is no single reality or truth, and that reality is created by individuals within their societal groups (Crotty, 1998: p42). Therefore, a constructivist approach to data analysis must place priority on the phenomenon being studied, with both data and analysis being created from shared experiences (Charmaz, 2014: p13). This study utilised the constant comparative analysis (CCA) method, which is an iterative and inductive data analysis approach that reduces the data through a constant recoding process where all data 'are systematically compared to all other data in the data set' (Fram, 2013), thus ensuring that all data are analysed, and none potentially disregarded on thematic grounds. Whilst CCA was originally sited within traditional grounded theory, Charmaz (2001) argues that the classic grounded theory approach to CCA has become untenable as other dominant theoretical perspectives such as interpretivism have become established and she has developed a constructivist approach which has advanced CCA from a technique to a method (Charmaz, 2001; cited in Fram, 2013). Modified CCA approaches have been utilised by a number of researchers working outside grounded theory (Fram, 2013). Fram (2013) argues that the value of CCA is that it ‘maintains a focus on data at the concrete level’, and within a constructivist framework it allows the maintenance of an emic (participants view as an insider) perspective, as well as the concrete associations essential to the analysis of data.

As a general process, qualitative data analysis consists of ‘preparing and organising the data, then reducing the data to themes through a process of coding and condensing the codes’ before finally presenting the data using means such as tables, figures and descriptive text (Creswell, 2007: p180). Boeije (2002) highlights that there is no explicit format for constant comparison and that researchers can take a pragmatic approach to breaking down CCA in order to answer their research question. However, the general process of CCA is one of open coding leading to development of categories, with ongoing data reduction and recoding allowing core categories or themes to be identified whilst constantly and systematically comparing data to all other data within the data set (Fram, 2013). Thus, the whole data analysis process is both systematic and iterative, with the researcher moving both forwards and backwards (revisiting/reviewing/reanalysing) to ensure comprehensive exploration and analysis of all data in the data set (Ngulube, 2015: p7).

The purpose of coding is to ‘break down and understand a text and to attach and develop categories, subthemes and ultimately themes - putting them into an order in the course of time’ (Flick, 2002: p178). A code is a section of text that symbolically assigns a ‘salient, essence-capturing and/or evocative attribute’ to a portion of text (Saldana, 2009: p3) and codes can be of various sizes from words to sentences to whole paragraphs of text (Miles and Huberman, 1994: p56). Coding is a transitional process between data collection and more extensive data analysis, is heuristic in nature and links data to ideas and ultimately to all relevant data across the data set related to that idea (Saldana, 2009: p3).

5.12.2 CAQDAS

For the purpose of this study, NVivo (a computer-assisted qualitative data-analysis software tool, or CAQDAS) was utilised to assist in the coding process. Hoover and Koerber (2011) argue that CADQAS automates the more routine and mechanical aspects of data analysis, increases the efficiency of analysis, allows more transparency of the whole data analysis process, and enables the researcher to focus more on the interpretive and creative aspects of their work. In discussing the use of NVivo when taking a constructionist approach, Kikooma (2010) emphasises its value in terms of evidencing transparency and thus enhancing rigour. In this study the ease of accessing and reviewing codes, nodes (categories) and subthemes and the ability to move between different datum (interview transcripts and audio files) meant that constant comparison was a much less challenging process using NVivo than if the data coding process had been paper based, and the development and revision of subthemes and themes was more intuitive and flexible. The ability to save differing versions of the programme as the data coding process proceeded/evolved meant that review and scrutiny of the ongoing process was possible for both the researcher and others (as identified later in this chapter), enhancing credibility, dependability, and confirmability, and forming part of the audit trail. The annotation and memo features in NVivo also facilitated a more intuitive and reflexive recording of thoughts and ideas as the coding process evolved.

5.12.3 The analytic process

After familiarising myself with the data via listening to the audio recordings and reading the transcripts (separately and together) and jotting down any initial thoughts (both on the process and the data generated) each transcript was coded manually on paper copies, highlighting any data pertinent to the research, and ascribing basic labelling based upon what each code appeared to be saying on initial review. Nicolls (2017c) describes this as a form of naïve coding that represents the initial, unreflexive ideas of the researcher.

The transcripts and audio files were uploaded into NVivo and, using the paper copy coding as a basis, first stage coding was carried out electronically. NVivo's node feature allowed the creation of categories and subthemes, a process of segregating and grouping data based upon the demonstration of similar characteristics (Saldana, 2009: p8): codes were reviewed, and initial node categories developed over the process of this first stage of electronic coding. Each node was ascribed a label that served to summarise the general meaning or relationship of the codes within it. As this first stage coding progressed, I regularly reviewed the content of each node to ensure that further coding to each node reflected the content within it already. Where data did not fit an existing node, further nodes were created. Where it was challenging to determine which node a code should be ascribed to, review of the node content facilitated the decision-making process. Ngulube (2015: p8) stresses that it is possible to use codes in more than one category, and where it was felt that a code related to more than one node then it was coded to each of those relevant nodes. This first stage electronic coding served to scrutinise the text more closely than the initial naïve coding, whilst the initial naïve coding in turn served to facilitate this more detailed scrutiny.

To enhance credibility, ensure that the coding process was comprehensive, and in an effort to minimise bias, the research supervisor independently coded transcripts one and two and the two independent sets of coding were then compared. For both transcripts it was apparent that the same data had been coded very similarly, adding reassurance that the coding process was comprehensive and robust. Part way through the coding process, to gain further assurance that coding remained robust, transcript nine was independently coded by a peer and the two sets of coding were again reviewed together. This second independent review also highlighted a similarity of coding. In this instance there were a couple of small sections of transcript that I had not coded but which were relevant to the research, and these were then reviewed and coded. A note was made to revisit transcripts three to eight to double check that no relevant data had not been coded, and this subsequent review identified no uncoded data relevant to the research.

A second stage coding process then took place where the transcripts were again reviewed and all codes in each transcript were scrutinised in relation to the nodes in which they had been placed (see appendix 8 for example). This process enabled refining of the initial coding process, with some codes being added to or removed from nodes. The facility in NVivo to review all nodes relating to an individual transcript and to easily move between nodes made this process easier. At this point, an additional node labelled ‘Respect’ was created when it became more apparent that across several transcripts there were substantial data where this topic was explicitly articulated, and all transcripts were reviewed to identify any relevant codes related to respect. This rearrangement and reclassification of the coded data into different (or new) categories is a vital aspect of the ongoing data analysis process and is the beginning of the process of transcending the ‘reality’ of the data and progressing towards the ‘thematic, conceptual and theoretical’ (Saldana, 2009: p11).

Before progressing onto the development of subthemes and themes and with the aim of continuing to ensure rigour in the coding process, a decision was made to review each node for homogeneity of content. An independent peer reviewed each node and highlighted any codes that appeared heterogenous to the rest of the content. This review served as an external check on the coding process (Nowell et al., 2017) and facilitated further review and scrutiny of the decision-making process by which codes had been allocated to individual nodes. In some instances, discussions between researcher and peer supported the initial coding decision, whilst other instances merited a recoding.

During these stages, the annotation facility within NVivo was used within each transcript to capture researcher thoughts and ideas and to inform the ongoing coding process. These later became extremely valuable in informing the thematic, conceptual, and theoretical aspects of analysis.

The final stage in the coding process was to collate nodes into potential subthemes and themes, with an ongoing process of review for each theme to check that the final subthemes and themes worked in relation to the coded extracts, the validity of themes in relation to the data set and that the final themes were an accurate reflection of the whole data set (Braun and Clarke, 2006). As per CCA, this whole process was both systematic and iterative, with me revisiting, reviewing and reanalysing to ensure that the finalised themes reflected the results of comprehensive exploration and analysis of all data in the data set (Ngulube, 2015: p12). Examples of each stage of analysis in NVivo, including use of the annotation facility, can be seen in Appendix 8.

5.12.4 Analytic memoing

Analytic memos (notes added to coded segments) serve to document the researcher's reflections and thoughts about the data, with the process providing a rapid way of capturing the researcher's thinking throughout the data condensation and analysis process (Miles et al., 2014: p95). These authors highlight that memoing is not simply a descriptive summary of data but rather a process of ascribing higher level analytic meaning. The memos facility in NVivo meant that as transcripts were reviewed and throughout the coding process I was able to use memos to summarise ideas, pose questions and reflect on the meaning of data (see appendix 9 for example). These memos in turn served as a key stratagem in informing the data analysis and reporting process.

5.13 Rigour

Ryan et al. (2009) identify the need for effective verification – presenting possible explanations and conclusions that can be made from the data and demonstrating evident rigour or trustworthiness. Rigour refers to concepts such as credibility, dependability and transferability (Koch, 2006) and it is important that the researcher can demonstrate an awareness and minimisation of bias within the research. Johnson and Waterfield (2004) cite a transparent research process and appropriate methods of data collection and analysis as two of the features upon which sound qualitative research is based. Various strategies were used to try to ensure rigour and minimise bias, including: a demonstration of clear themes for exploration at interview and how these evolved as the interviews and review of transcripts proceeded; gaining respondent validation during each interview; ensuring integrity in the use of data by continually returning to the participants' own words during data analysis and discussion to endeavour to stay true to their words and experiences; and ensuring a clear audit trail throughout the research process by which the research and the decisions made can be followed by others, including evidencing these via memos and reflective accounts (Balls, 2009).

5.13.1 My impact as a researcher: minimising bias

I was known to the participants in my role as a physiotherapy lecturer at Keele, and for some as a visiting tutor for clinical placements. This may have resulted in a social desirability bias, with the participants wanting to provide the response that they envisaged I wanted to hear, or they may have been concerned about revealing some details about their experiences with older adults. I tried to overcome this issue via stressing my role as researcher, emphasising how anonymity and confidentiality would be maintained, and reassuring participants that should they be concerned about revealing certain details about their experiences then they were free to ask me to move on to another question, pause the interview or discontinue the interview if they so wished. Equally it was important to recognise that my roles as a physiotherapist, lecturer and visiting tutor may have enabled me to more easily start with a base of trust which in turn could motivate participants to engage more actively with my research and result in more candid data (Creswell and Miller, 2000, cited in Attia and Edge, 2017). As such, recognising and addressing the potential for social desirability bias could in turn have a positive impact not only on the data gathering process but on the trustworthiness of the study findings.

Researcher bias occurs when a researcher unconsciously affects the research due to subjective influence. Nicholls (2017c) points out that personal bias is an essential part of any researcher’s humanity and Darawsheh (2014) highlights that this bias will therefore inevitably influence the data collection and analysis process. Charmez (2014) cites the need for constructionists to be aware of their own presuppositions so that they can try to avoid unconsciously importing their own values and beliefs into their work. In any phenomenological interview the interviewer will not only shape the interview but in turn be shaped by the process, with the result that an interview is not conducted but participated in by both participant and interviewer (Sorrell and Redmond, 1995). Reflexivity acknowledges that the researcher is not an outside observer of a phenomenon but instead is a participant in the process of knowledge construction (Patnaik, 2013). Researcher reflexivity about personal interpretations and meanings can therefore make the constructionist more aware of how these may affect the research. To try to minimise researcher bias, I produced a reflective account prior to the data collection process identifying my own experiences, beliefs and perceptions of older people. I also reflected after each interview on both process and data generated so that I could make more explicit to myself any ways in which I may have potentially influenced the interview (see appendix 10). Mays and Pope (2000) argue that personal and intellectual biases which are made plain by a researcher during the reporting of research can actually enhance the credibility of the research findings.

5.13.2 To bracket or not to bracket?

Bracketing refers to the conscious efforts made by a researcher to suspend or set aside preconceptions, presuppositions, biases, and other knowledge of a phenomenon to ensure they are fully open and receptive as possible to participants' own descriptions of their lived experience of the phenomenon being explored (Hein and Austin, 2001). Koch (1995) argues that in the hermeneutic phenomenological approach preunderstanding cannot be bracketed as the researcher, like their participants, cannot jettison their lifeworld, and that their past experiences, knowledge, and understanding should instead be viewed as a valuable resource within the research process. Given that social construction of research requires a researcher-participant interaction where both sets of past experiences, knowledge and understanding interact, the focus in the research process should therefore be more about the researcher being honest about their own presuppositions and biases so that any reader is made aware of the perspective from which the research was conducted and can therefore more effectively determine whether or not the phenomenon was explored from a particular perspective (Hein and Austin, 2001). My researcher perspective was demonstrated via ongoing reflective accounts of my own beliefs and perceptions relating to older people and the ways in which my interpretation of research evidence, experiences of clinical practice and experiences within physiotherapy education may have potentially influenced data collection and analysis.

5.14 Pilot study: refining the research process

The timescale for completion of the pilot study made the recruitment of current practice educators challenging due to the lengthy process of applying for ethical approval. Creswell (2007: p165) highlights the value of a pilot study in refining the research process, whilst Arthur and Nazroo (2003: p135) emphasise the role of the pilot study in allowing the researcher to assess whether the process is likely to enable participants to give a full and coherent account of issues under discussion without constraint. Thus, the decision was made to recruit a Keele academic with similar characteristics in terms of profession and clinical experiences of working with students, and to use the pilot study predominantly as a means of testing the feasibility of the methodology - process/procedure, interview questions etc.

The aims of the pilot study were:

To determine the feasibility of the study methodology
To develop my skills in interviewing
To produce relevant data to inform the main study.

Reflection on the pilot study experience confirmed that the pilot study methodology and resultant generation of data seemed to meet the needs of the main study research effectively.

The post-interview discussion with the pilot study participant (who had some research experience) confirmed the relevance and comprehensiveness of the methodological process and the information provided. As such, there was no need to amend the consent form, participant information sheet etc. other than to reflect the differing aims of the main study. In terms of the suitability of the interview questions and topic areas, all the questions proved suitable, generated discussion related to the research focus, and generated relevant data. The topic guide served as an effective aide-mémoire, which helped ensure that issues were explored systematically but allowed flexible and responsive investigation.

Anticipated issues such as the potential for bias (social desirability and researcher bias) were not borne out in actuality. Review of the transcript and my reflexive notes identified that, whilst the discussion on the whole met the researcher’s expectations, there were also some more negative responses that had not been anticipated, such as the description of older adult services facilitating an element of dependence when discussing the differences in management between older and younger patients with the same problems. Given that the participant felt able to express both more positive and more negative perceptions throughout the interview this would suggest that bias was minimised within the pilot study process and analysis.

In terms of developing my skills at interviewing, the interview process went well, with the participant very quickly relaxing into the interview and happy to talk about a range of issues with minimal prompting. Robson (2011: p282) identifies that a key skill in interviewing is to listen more than speak, and a review of the pilot study transcript showed that the ratio of interviewer:interviewee talking was approximately 10%:90% - suggesting not only that the questions were sufficient to facilitate detailed responses from the participant but also that the participant felt comfortable and able to provide those responses during the interview.

The data generated some interesting themes that were taken forward for consideration in the development of the main study. These included strong identified themes regarding the separation of clinical experiences into those with ‘vulnerable’ and ‘active’ older adults; the interrelationship between the participant’s early experiences of older adults and a career choice of physiotherapy; and a mix of both negative and positive discourses around ageing. The participant had gained varied clinical experiences with older adults and during discussion identified several perceived institutional constraints and strictures imposed on older adults particularly within acute healthcare settings, suggesting a theme around medical institutional power (Turner 1997: p ix). Similarly, the notion of acute services not being suitable for older adults potentially linked to the concept of the ‘othering’ of older adults within healthcare. The participant’s discussion around the need for physiotherapy students to understand and apply holistic management strategies when working with older adults tied in very much with a consistent theme throughout the interview of meeting the full needs of patients rather than just the immediate problems that had brought them into hospital. However, it should be noted that the primary aim of the pilot was to test the mechanics and practicalities of carrying out an interview, and no formal data analysis process took place.

A review of the pilot study did indicate a few areas for further consideration in progression onto the main study. There were elements of repetition present in the transcript where topics had been returned to. I had not recognised this repetition and therefore not moved the interview on at these points as effectively as I could have done. I had also misjudged the timing somewhat, meaning that less time was spent on the later questions in comparison to the earlier questions. These issues were noted for consideration as the main study interviews commenced.

5.15 Ethical issues

There are inherent challenges in carrying out qualitative research in general and in using interviews. Whilst the one-to-one interview is a social interaction it is not a conversation, the relationship between interviewer and interviewee is not equal and there are thus ethical and procedural concerns that may challenge the validity of the research findings (Ryan et al., 2009).

5.15.1 Power

In my role as a lecturer and visiting tutor, I may have been perceived as having a position of power, with the result of magnifying any potential negative impact of myself as the researcher on participants' willingness to share perceptions or experiences perceived by them as less socially desirable. The methods used to reduce this power included those identified above relating to minimising bias.

5.15.2 Anonymity

All participants were identified throughout the research process by a number. My supervisor and I were the only people who had access to the names of the participants and this information was stored securely on a password protected computer. All the information from the interviews was transcribed without using participants' names (numbers were allocated) and I ensured that participants were not identifiable in any way in any of the research material or in the final thesis.

5.15.3 Confidentiality

All participants were informed that any information that identified them would remain confidential and my supervisor and I were the only people who had access to this information.

Data storage

All data, including recordings, were stored and, where appropriate, destroyed in compliance with the Data Protection Act (1998).

For any data containing personal information, hard copy data (such as interview notes, consent forms and initial audio recordings of the interviews) were stored in a locked filing cabinet in my office to which only I had access. All electronic personal information was stored securely on a password protected computer (with a back-up on the Keele network Drive) and on an encoded memory stick. The only people who had access to this data were myself and my supervisor. Keys used to link anonymised data to personal information were also stored as identified above. All personal data were destroyed at the end of the research project.

All anonymised data were stored either in the filing cabinet in my office (in the case of any hard copy data) or, for electronic data, on a password protected computer (with a back-up on the Keele network Drive, again password protected) or an encoded memory stick. All anonymised data were to be kept for a period of 5 years beyond the end of the research project.

Consent

All volunteers were provided with an information sheet and given the chance to ask any questions prior to taking part in the research. Those who wished to participate in the research were given consent forms to sign prior to the interview taking place. If participants wished to withdraw from the research, they had up to four calendar weeks after their interview to notify me that they wished to have their data (recordings and transcribed data) removed from the study. In actuality, there were no requests for withdrawal and all data collected were analysed and used to inform the research.

5.15.6 Professional ethical considerations

As a healthcare professional, I am governed by professional and regulatory standards, and must work within the confines of current legislation over such matters as privacy and confidentiality, data protection and human rights and so offers of confidentiality may have potentially had to be overridden by law. For example, if I had been made aware of possible unlawful activity, such as abuse either to the participant or another, I would have been obliged pass this information to the relevant authorities. Participants were made aware of this in the participant information sheet and again prior to consenting to take part in the study. Given that it was not the aim of the research to probe into specifics of experiences, it was not anticipated that any information provided would meet the criteria for breaching the maintenance of confidentiality of the participant and this proved to be the case.

5.15.7 The potential for emotional distress of participants

There was potentially a slight possibility that discussing their experiences might bring back some memories or emotions that participants would prefer not to revisit. If this had been the case then participants were free to ask me to move on to another question, pause the interview or discontinue the interview if they so wished. Had participants felt that they required further support then I would have advised/encouraged them to access appropriate support services (for example, staff counselling services at the organisation where they work). However, during the data collection process no participants requested the above.

Chapter 6: Findings

6.1 Introduction

As stated in the preceding chapter, the aim of this research was to explore physiotherapists' lived experiences with older adults, how these experiences may have informed their clinical practice, and how these experiences may in turn influence how they educate physiotherapy students. This chapter will first present the demographic data gained from participants in order to provide the reader with background information about the study sample, followed by presentation of the themes. These themes will highlight issues discussed by the participants and utilise quotations from the interviews to illustrate these issues (see Table 3 for key to notations relating to quotes).

Table 3: Key for notations used during the presentation of direct quotations

…	Pause in speech
/…./	Section of transcript omitted to facilitate clarity of content
________	Section underlined to highlight where participant displayed strength of feeling
[text]	Identifies topic area being discussed where this is not clear within the quotation
Letter in capitals and number	Identifies the participant speaking
(l:___)	Line or lines of transcript from which quotation is taken

6.2 My participants

Fifteen physiotherapists were recruited to the study, and all completed their interviews. There were no withdrawals post interview and the data from all 15 interviews are therefore included in the study. Recruitment took place over an 18-month period due to challenges in engaging with and recruiting suitable participants from the organisation, predominantly due to clinical workloads.

Table 4: Participant demographics at time of interview

Participant	Gender	Number of years qualified	Band	Older adults specific (OAS) or older adults related (OAR) role	Length of time supervising students (years)
1	M	8.5	7	OAS	6
2	F	30	8a	OAR	20
3	F	8	6	OAR	4
4	F	9	7	OAR	8
5	M	7	7	OAR	5.5
6	M	3	6	OAS	1
7	M	2	5	OAS	1
8	F	2.5	6	OAR	2
9	F	26	7	OAR	23
10	F	19	8a	OAR	17
11	F	6	7	OAS	5
12	F	4	6	OAR	2
13	F	5	6	OAS	2
14	F	18	7	OAR	17
15	F	7	7	OAS	4

Eleven of the participants were female and four were male. The length of time participants had been qualified as physiotherapists ranged from two years to 30 years (median (IQR) 7.0 (4.5, 13.5)). For male participants length of time qualified ranged from two years to 8.5 years (mean 5.1 years) whilst for female participants the range was from 2.5 years to 30 years (mean 9.8 years).

Six participants (Bands 5 and 6) were in rotational posts and working with older adults in their current clinical areas at time of interview and had also done so in some previous clinical areas. The remaining nine participants (Bands 7 and 8a) were based in one clinical speciality, but all had completed rotational posts prior to specialising. For reader context, Table 5 below identifies these NHS band descriptors.

Table 5: National Health Service banding descriptors

Band	Role descriptor
Band 5	Physiotherapist
Band 6	Physiotherapist Specialist
Band 7	Physiotherapist Advanced / Specialist Physiotherapist / Physiotherapy Team Manager
Band 8A	Physiotherapist Principal

(NHS Employers, 2005)

At the time of interview six participants were working in clinical areas that were older adult specific: three in static senior posts and three in rotational posts. The remaining nine participants were working in clinical areas where older adults formed part of the overall patient caseload: six in static senior posts and three in rotational posts. These clinical areas had a neurological, orthopaedic, or respiratory focus.

The length of time participants had been involved in supervising students, defined as any involvement in student supervision/education, ranged from 12 months to 23 years (median (IQR) for this variable 5.0 (2.0, 12.5)).

6.3 Themes

Six themes were identified following data coding and analysis.

Table 6. Themes and Subthemes

Theme	Subthemes
The participant journey	Pre-training and personal frames of reference Career to point of interview Attitudes, perceptions and feelings
Approach to practice	Being an older-adult practitioner The broader picture
The older patient and family	The older patient The family
Challenges of and change in practice	Practice challenges Othering and ageism Positive change
Communication and engagement	Impactful skills Being an effective communicator The novice communicator
The clinical education experience	The clinical education environment The clinical educator role The student learner

Within the presentation of each theme the findings from each subtheme will be presented followed by the exploration of the findings from that subtheme, before moving onto the next subtheme.

6.3.1 Theme: the participant journey

This theme explores the participants' experiences of interacting with older adults up to the point of interview and the potential impact on them both personally and professionally.

6.3.1.1 Subtheme: pre-training and personal frames of reference.

For all bar one participant (P10), their pre-training and personal frame of reference in relation to older adults was predominantly their relationship with their grandparents. Eight participants still had one or more grandparents living, whilst the other seven did not. The relationships described by the participants were defined by a range of factors including geographical distance, the degree and nature of contact, age, health, and physical and social activity/participation.

Some participants described relationships with grandparents who lived close by and were often involved in their daily lives:

> they'd always been there when I was younger, so they'd help bring us up /…. /so they were there to help out (P3, I: 39).

Whilst for others the nature of these relationships was defined more by distance:

> they never lived with us closely but when we used to go and visit you'd enjoy…you were excited about going and spending time with them (P14, I: 32-33).

For some participants there were contrasting experiences that depended on factors such as grandparent age and parental commitments:

> I had ones that lived further away and they were be the more holiday grandparents, so we'd go and spend time with them/…./ and then on my mums side they were slightly younger but they were more hands on and when my mum and dad were at work - my mum and dad both worked full time - so they would often do the school run and any days I was off sick and things like that they would always pick up the pieces, so I spent a lot of time with them after school waiting for mum and things like that (P12, I: 56-61).

A number of participants described grandparents who remained in good health or had experienced good health until only shortly before they died. Grandparents being ‘fit and well’ was largely described in terms of physical and/or cognitive functioning and social activity rather than being defined by the presence or absence of health conditions:

> my granddad is turning 90 this year he is still fully active, he’s only got diabetes, nothing more, still fully cognitive, yeah living by the sea, enjoying retirement (P11, I: 68-70)

This discussion around physical and social activity/participation was often framed around a perception of ‘older’ as being predominantly behavioural (active) rather than chronological. P13 described the difference between her own grandfather who became isolated after his wife’s death and her partner’s grandfather who in the same situation had actively sought out new friends and hobbies – emphasising for this participant the value of social activity for a more positive ageing process. Where chronological age was discussed the age of the grandparent/older adult was largely cited as something to be admired or as an achievement, for example “*they’re still <u>active</u> for their age*” (P15, I: 74) or “*he’s another one who’s very good for his age*” (P13, I: 144-145). These descriptions seemed to imply a general expectation of deterioration with ageing - that this healthy ageing was not the anticipated norm but rather an exception to the norm.

Where participants did cite their experiences of a gradual decline in grandparents’ health this was largely framed within a positive narrative in which they cited health issues but placed emphasis on what their grandparents could still actively achieve in terms of functional abilities and independence. However, there were some contrasting perceptions of health behaviours. P1 described grandparents who had significant illness but were “*incredibly strong people who no matter what was going on with them wouldn’t be beaten*” (I:18), characteristics that suggested a perception of strength or resilience in the face of ill health. P15 discussed the difference in physical ability between one grandmother "*who is doing an eight mile walk and going to the gym to do yoga twice a week*" (I: 30-31) and the other "*who is only able to walk a mile or so before she is breathless and stopping*" (I: 29-30) and cited very different health behaviours as the basis for these differences. For P15, much of this variation in behaviour was explained by her grandmothers' differing levels of education. P6 also cited negative health behaviours when referring to grandparents as having "*smoked themselves within an inch of their life*" (I:54-55) and contrasted this with experiences with "*very active*" older adults. For P14 the perception of her grandmother as her health deteriorated was one of her having adopted a "*sick role*" (I: 86).

Where participants described grandparents who had experienced significant ill health before death it appeared that family had often shielded them from the full experience of seeing their grandparent(s) deteriorate. P4 was one such participant who during the interview described very positive experiences of healthy ageing but went on to reflect on family situations where this was not the case – a grandmother with dementia, grandmother with fractured hip, and grandfather whose death was 'complicated'. However, she was aware that she had been largely protected from these experiences where deterioration was marked.

Three participants explicitly articulated a differentiation between their grandparents and the general older population. For P2 and P5 this took the form of seeing them as a grandparent rather than an older adult i.e., seeing the role rather than the chronological category. In addition, P5 explicitly articulated a perceived separation between his relatives and his older adult clinical caseload:

> you see them as a parent rather than an elderly person, whereas perhaps in the healthcare role I've assumed they're an elderly person rather than them be a family member to me (I:120-122).

For P9, who described the difficulty in watching her grandfather struggle post stroke and having a grandmother who had Alzheimer's disease, the familial relationship remained central to the way she saw these grandparents:

Eight participants described personal experiences with older adults who were not family members. These ranged from one-off experiences to more long-term involvement, either personal or work-related (prior to qualifying). For two participants (P6 and P11) this contact had been with active older adults and the experiences served to reinforce their perceptions of older adults as active both physically and cognitively and, in the case of P6, also served as a comparator to the perceived more negative health behaviours of his grandparents. For P15 her experience as a member of a church was very focused on enabling the older members of this community to engage more fully in social activities.

Two participants described experiences of working with older adults prior to starting their physiotherapy training. For P12 there had been a contrast in experiences where one job had involved engagement with a less well but largely independent older adult population and the other with older adults in long-term care. The latter had made a significant impact on her perceptions of older adults, with her describing the experience as "*the first shock I've seen*" (I: 88) and "*a reality check*" (I: 93) when discussing the physical disabilities/impairments she encountered – a stark contrast to her previous experiences with more independent older adults. P5 had worked in a hospital environment with older adults who had been acutely unwell and more dependent. For both participants these experiences were felt to have better prepared them for the realities of working with older adults in their physiotherapy practice:

> probably predisposed me a little bit more to unwell older people, so I think coming into physio I already probably had some experience of dealing with unwell elderly patients from that (P5, I:30-32).

> I felt it was a lot easier for me coming into physiotherapy having done… having worked with elderly people before, having spoken to the general public before, having been in healthcare scenarios before. I'd just felt more at ease with them (P12, I: 568-571).

Finally, two participants described closer relationships with older adults who were not grandparents. For P10, who had not grown up with grandparents, her contact with older adults had been in her teens via a charitable organisation where she had done volunteer work with more isolated older people. Reflecting back on these experiences she described an alteration in perception of those experiences, contextualised by her current understanding and experiences:

> fairly normal [then] but now it kind of seems… nice to have done it but then it seems sad that we have to do it and that somebody feels so lonely and doesn't have the people around or the contact to help and the support (I: 62-64).

P8 described her closest relationship as being with someone who was not immediate family – an older adult with whom a friendship gradually evolved into a significant caring role and ultimately both practical and emotional support through hospital admissions, terminal illness and until death. She painted a picture of a resilient older woman whose first hospital admission was at 97 and who, whilst coping with major health challenges, ultimately died quite suddenly at 99 – a death described in positive terms by P8 as "*probably like a nice way for her to go*" (I: 153). This participant's only memory in relation to grandparents was one grandmother who had lived with her family during high school years due to the need for additional support but who was "*fully functioning*" (I: 55). As such, her relationship with this older non-family member was acknowledged as her most formative experience with older adults due to both the length and the closeness of the relationship as it progressed from friendship to a contiguous caring role involving both social and health related support.

Pre-training and personal frames of reference – exploring the findings.

The majority of participants described a pre training and personal frame of reference characterised by relationships with grandparents and these relationships were largely framed as positive. This type of personal contact, familial and often close, with older adults has long been identified as a positive influence both on attitudes to older adults and on an interest in working with this population, with numerous studies supporting this assertion (e.g., Kalu et al., 2018; Duthie and Donaghy, 2009; Gorelik et al., 2000). Blackwood et al. (2014) found that qualified physiotherapists in their study demonstrated more positive attitudes towards older adults than student physiotherapists but that both qualified and student physiotherapists demonstrated positive attitudes. They posit that whilst the higher positive score of the qualified staff may be related to more clinical experience with older adults, the overall positive findings could at least partially be related to quality time and experiences with largely healthy older adults experienced by both groups. Positive intergenerational contact, such as that described by several of my participants, can reduce prejudice in relation to older adults (Abrams et al., 2015) and having personal contact with non-family members has been shown to have a greater impact on interest in ageing than contact with family members - attributed to a more active decision to build and define the terms of those relationships (Gorelik et al., 2000). This attribution would fit with the experiences of participants such as P10, P6 and P8, all of whom described their relationships with non-familial older adults in positive terms. Even when P8 described the eventual deterioration in health of her friend this was framed within the context of resilience and a good death.

Our individual and demographic differences are likely to affect our attitudes towards older adults because we have different vantage points, experiences, and thus normative expectations about ageing (Abrams et al., 2015). A significant number of experiences described by participants were with largely healthy older adults and where there was a gradual decline in health this was still largely framed within a positive narrative of retained functional abilities and independence despite failing health. However, the most common ageing stereotype is one of physical and cognitive functioning declining with age (Abrams et al., 2015) and this stereotyping seemed implicit in participants' descriptions of the successful ageing of their grandparents and friends by their contrasting this to normative expectations. Examples include as P15's description of her grandparents as being still active for their age and P13 describing someone as being very good for their age. Gendron et al. (2016) found similar findings in their study of intergenerational mentoring where their younger sample expressed similar views to those described above in relation to a perceived exceptionality in the activities of the older adults who were mentoring them. The authors labelled this as 'uncharacteristic characteristics' – the concept of certain behaviours and actions being outside the perceived norm. An alternative interpretation in relation to my participants might be that of a socialising effect in those working with unwell older adults, fostering a perception that older adults are dependent and less able (Phillipson and Strang, 1986), a notion supported by Crutzen et al. (2022) who found that healthcare professionals working with the frailest older adults held more negative perceptions of older adults. Whilst my participants expressed a mix of more positive and negative perceptions of their clinical population this contrast between unwell clinical and healthy personal older adult experiences may have served to emphasise a stark contrast in abilities and reinforced any perceived divergence from healthcare and societal normative expectations. An example of this is P12, who describes her perspective on the abilities of her grandmother as "*slightly skewed because I'm saturated in the unwell people*" (I: 326-327).

There was an additional narrative around health behaviours, which spoke to an anticipated expectation and approval of active engagement in maintaining good physical and mental health. The contrast in grandmothers' approaches to health management described by P15, the admiration for his grandparents' resilience in the face of ill health articulated by P1 and the negative terms used where grandparents did not appear to demonstrate positive health behaviours all speak to a perceived expectation that those older adults with whom they have personal relationships should engage in positive health behaviours. Abrams et al. (2015), in discussing how personal characteristics such as age can lead to generalised assumptions about a population, identify that differences within a population can be perceived across a number of personal characteristics, and this could include health. Given that some participants articulated a distinction between those adults they knew personally and the general older adult population, it may be that there was a perception of difference in health-related characteristics between the two populations, which extended into a differing expectation of health behaviours. This may be compounded by a desire for those they knew personally to avoid the ill health encountered in the older adults they worked with. Physiotherapists may regard community dwelling older people, such as their grandparents, as different from those they encounter in an institutional environment, and this may be reinforced by the boundaries between their professional and personal experiences (Morris and Minichello, 1992). Finally, when participants described not having perceived their grandparents as older adults this may suggest that familial and emotional relationships trump chronology, resulting in participants seeing the general older population is ‘’other’ to family - an interesting slant on the concept of othering as applied to age.

6.3.1.2 Subtheme: Career to point of interview.

When exploring with participants their reasons for choosing physiotherapy as a career three commonalities emerged. For several participants their participation in sport was the main factor in their career choice, with the initial intention of going into practice in the field of sports physiotherapy once qualified – often within their own chosen sport. For some this choice had been a simpler process – P1 described himself as "*the 17-year-old failed rugby player who wanted to become a sports physio*" (I:9-10) – whereas others had explored several options before making the final decision.

The second common thread was expressed as a desire to help people and make a difference to people's lives. For some, physiotherapy was their immediate choice of route to achieve this aim:

> that's why I wanted to become a physio really, just like the rehab side of things that's what has really interested me and just making sure people are keeping their independence (P13, I: 215-217).

Others cited the influence of other healthcare professionals within their families – predominantly medical practitioners and/or nurses. For several of them this experience of the roles of their family members had served to consolidate a decision to do something different career-wise, as described by P15:

> Both my parents are nurses and they thought I'd follow in their footsteps, and I always liked the idea that doctors and nurses can help get them better medically, but physios are the ones that get them home and to the people that they need so that's why. It just kind of completes the loop (I: 239-242).

Two participants described a career choice based simply on a review of potential career options. For P2 this choice was instantaneous – "*I came across this [card] on physio and I thought 'hmm I'll do that… I like the sound of that' /…/ That was it*!" (I:119-

120), whereas for P3 physiotherapy was simply a suggestion she engaged with when she had no idea about what career she wanted.

When exploring participants' experiences of working with older adults, some discussed events and experiences early in their careers that had impacted on them personally and/or professionally. This included appreciating the multidisciplinary nature of practice, the degree of positive impact physiotherapy could have on older patients and the opportunity to spend more time and get to know patients and their families. P11 recalled a previous Early Discharge role, which required a breadth of understanding and an appreciation for holistic management that went well beyond physiotherapy-specific practice, gaining experiences and skills, which had carried forward into her current role:

> Gained loads… gained loads… not only just the therapy but holistically looking at a patient and picking up the end nursing needs as well as care needs and therapy needs (I: 139-141).

P1 had initially worked in sport once qualified but upon moving into the NHS the experience of working in an older adult environment had made an instant impact:

> I <u>loved it</u>…you know – I swiped on to the ward on my first day and just said 'there you go' – it was <u>great</u> (I:60-61).

P4, who had anticipated a sports physiotherapy career, gave an account of her first placement, an older adult placement, and the influence it had on her:

> I remember that very vividly from my first placement was just 'oh wow this is really interesting' not from a physio point of view but from talking to people and communicating with people (I: 126-127).

However, for one participant working in this area had been a very different experience. P8 described a very dependent population with significant physical and/or cognitive decline and whilst she did discuss positive aspects of working with more able older adults on that ward the overall experience had been more negative, with her describing some of her physiotherapy input to these patients as "*pretty pointless*" (I: 213) and stating:

> I just felt sorry for them being a bit bored and forcing them to do things that they didn't want to do really (I: 230-231).

Whilst for six participants their gradual exposure to and involvement with older adults had informed their practice over time, nine participants described particular seminal experiences that had been extremely impactful in either their practice or career. Whilst P11 cited her experiences in the Early Discharge role as key in developing a more holistic approach to patient care and a rethinking of her practice, P1 relayed two instances where patient contact had been particularly influential. In one, in the musculoskeletal outpatients department, he had placed significant time and effort in trying to educate a patient about exercises only to have the patient ignore his input. In the second, he described the successful rehabilitation of a very elderly patient on intensive care for whom very little recovery had been expected by other staff. The stark contrast had prompted the decision to focus on working with older adults:

> *that's why I do what I do as opposed to sitting in an outpatients clinic saying have you done your exercises?* (I:174-175).

Experiences with or about older adults with dementia resulted in learning opportunities for two participants. For P4, the anxiety of not knowing how to respond when a confused older patient mistook her for a family member led to her exploring strategies to enable her to cope more effectively in similar situations. For P6, a dementia training event where the trainer explained dementia in "*real world terms rather than learning it academically or clinically*" (I:202) engendered a radical rethink about the way he managed this population, with a recognition of the impact on his practice, saying the "*increasing knowledge and a changed understanding has improved me as a clinician*" (I:313-314).

For participants P14 and 15 their experiences with an individual patient had caused them to think more broadly about the need to see the person rather than the patient. For P14 this was an older woman with frequent admissions where the team had failed to explore further *why* these were occurring. When she spent time establishing a strong relationship with this patient, she was able to explore this further and engage them much more effectively in their physiotherapy management, with a successful outcome. For P15 it was simply a tattoo on an unconscious patient which made her realise that "*every person has a story*" (I: 260).

Two of the strongest narratives, for differing reasons, came from P2 and P8. P2 recalled interviewing older stroke patients who described a feeling of loss of dignity and control over their rehabilitation, with the physiotherapists dictating what they could and could not do. For her this had resulted in a profound change in her approach to rehabilitation:

> "I stopped being...as prescriptive and as controlling…and then changed my practice to…with a far greater emphasis on giving back the patient some form of independence and some form of dignity…no matter how that came basically (I:214-216).

For P8 the traumatic experience of being involved in the ultimately unsuccessful resuscitation of a very elderly and extremely frail patient had highlighted for her the need for clarity in notes and, more importantly for this participant, an emphasis on quality of life rather than resuscitation regardless of the individual’s health status.

In addition to some of the experiences described above, for those participants who had chosen to work on older adult specific wards, the decision to take this career pathway seemed predominantly influenced by the satisfaction achieved when working with this patient population – not only in terms of getting to know the patients and their families and utilising their skills in managing long term conditions, but also in the more holistic approach to rehabilitation and goal setting. As P15 explained:

> we’re not just rehabilitating older adults from a physical point of view but also functional, emotional and socially as well (I: 225-226).

Career to point of interview – exploring the findings.

Harman et al (2021), in exploring physiotherapy students’ reasons for choosing their career path, found two distinct themes – making a difference in peoples’ lives and having a sporting focus – and these were reflected in the rationales for career choice in the majority of participants within my study. For some, their personal involvement in sport made physiotherapy a logical option and, similar to the Harman et al. (2021) findings, coming from a sporting background was perceived as a way of integrating their activities into a career – often with the intention of going down the sports physiotherapist route once qualified. For others, their career choice was predicated on a desire to help people and make a difference to people’s lives which is likely to be more aligned to personal beliefs and values, with physiotherapy being perceived as a rewarding profession to join (Harman et al., 2021). For the participants in the Harman et al. (2021) study, the choice to pursue a career in physiotherapy required a conscious decision *not* to pursue a career in a different health profession and, for some of their sample, their perception of the negative attributes of these other professions were gained from personal experience. This very much reflects the discussions of some participants within this current study where their family members had healthcare careers and participants' observations and experiences of these careers led to a conscious subversion or rejection of familial expectations of following in their footsteps. Interestingly, Harman et al. (2021) cite all their participants as making an active choice of physiotherapy as a career but for one of my participants (P3) this was very much not the case, and she described choosing physiotherapy based on her mother's suggestion. An active choice implies some degree of research into a career or at the very least a perception of what physiotherapy entails and P3's description of physiotherapy as "*better than I thought it would be*" (I:86) suggests that this was not the case for her.

Two participants in particular (P5 and P12) had significant experience working with unwell older adults prior to starting their training. The research evidence around prior exposure to unwell older adults and attitudes towards working with this population is mixed. Whilst most of the research around factors influencing a choice to work with older adults focuses on those already training as healthcare professionals, there have been some studies investigating broader experiences with this population. Some authors, such as Chonody et al. (2014), cite evidence that early experiences with an unwell older population can have a negative impact on perceptions of and a desire to work with this population, whereas others such as Dunkle and Hyde (1995) cite evidence suggesting the opposite. P5 described experiences working with an acutely unwell population, whilst for P12 there were contrasting experiences working with older adults in a GP surgery and in a nursing home. Nursing homes have been identified as the least preferred environment in which to work with older adults (Morris and Minichiello, 1992) and may adversely influence attitudes towards older adults (Weir, 2004). In contrast, acute care environments are regarded more positively as areas in which to work with older adults (Morris and Minichiello, 1992). Given that both participants (P5 and P12) expressed a view that these pre-training experiences had been valuable preparation for working with unwell older adults it would appear that for P12, who described working in the nursing home as "*a reality check*" (I: 93), this experience both was tempered by the alternative experience with a more able older population, and served as a motivating factor in trying to prevent others from having to go into long-term care. Morris and Minichiello (1992) argue that exposure to older adults in a workplace may help sensitise practitioners to the specific needs of older patients/clients and this would seem to be the case for both participants.

Early career exposure to an unwell older population was described by many participants as a positive experience and one which for some, such as P1, P4 and P11, had influenced their choice of career progression as all had originally intended to work within sport. For some participants it was the experience of close multidisciplinary working to achieve the best outcome for the patient, whilst for others it was the breadth of rehabilitation – physical, functional, emotional, and social – that drew them towards working with these patients. Those early experiences were often framed very much as significant learning events that were often about gaining a deeper understanding about this unwell older population in some way. One of the most important factors in influencing attitudes to the care of older adults is having positive clinical experiences in caring for people who are older (Øster et al., 2019). Several participants described seminal experiences that had significantly impacted on either their practice or career and, whilst some of the experiences themselves could be perceived as less positive, the outcome was a positive change in practice for all those participants. Schön's theory of reflection-on-action identifies that "the role of reflection-on-action is not only one of learning and informing action, but also the building of theory" (Schön, 1987, cited in Moon, 1999 p44) and for several participants their experiences had led to a reframing of their practice, which seemed to have gone beyond the 'immediate' and led to a reconstructing of their theory of knowledge (StudyCorgi, 2022) - whether this be in relation to their management of dementia (P4 and P6), broadening their appreciation of the capabilities of older patients (P1), holistic perception of their patients (P14 and P15) or the "*profound impact*" (I:205) of P2's research on her approach to rehabilitation.

6.3.1.3 Subtheme: Attitudes, perceptions, and feelings.

When participants were asked to define 'old' many of their responses were framed within the context of their clinical experiences. Several placed a more chronological label on their definitions and often linked this to physical deterioration and frailty. Whilst for P9 old was simply over 80, others separated old into a younger more able population (65 -75 years) and an older less able population (75+ years). For P11, old was very much placed within the context of physical deterioration (a description of a frail older adult) rather than chronology, whilst the chronological definitions offered by participants were also often further contextualised by health status, such as an increase in comorbidities. However, P8 in contrast cited old as "*could be over 50*" (I: 23).

For some participants old was perceived as ability - physical, cognitive, and emotional outlook - rather than age-related, as evidenced by P5:

> you can have a 90-year-old who is as active as I am or you can have a 60-year-old who is inactive and would be considered what I would have considered... previously thought to be… a vulnerable older dependant adult (P5, I:168-170).

One participant, P14, described older adults as "*very experienced and knowledgeable*" (I: 18) and described a breadth of clinical experience with older adults in having seen "*an absolute range of capability and approach*" (I: 344). For her, age was a matter of outlook, with some older adults having a younger outlook on life and others adopting perceived ideas and behaviours of being old.

However, there were some mixed messages. P4 described age as '*just a number*" (I:156) but then went on to list attributes that included being isolated, unable to use technologies, and vulnerable – contrasting these attributes to a younger population with friends and a large support network. P10, after a description that focused on recognition of ability, whether physical or cognitive, went on to state a perception that seemed to indicate the opposite by saying "*there is no fun getting old actually, the fact that you are losing your friends*" (I: 159-160) suggesting a delineation between physical and cognitive function and the social and participation aspects of function.

For some participants, their own ageing or their parents' ageing provided additional context. For P10, as she herself aged, the concept of 'old' increased chronologically, and for P5, whose parents were approaching 65, there was a firm assertion that his parents were not "*approaching older adults' territory*" (I:713).

Reinforcing this more personal frame of reference several participants described a relationship between personal and professional lives. For some, their personal experiences of watching family members age both gave context to the needs and challenges faced by their older patients and served as a reminder of healthy ageing: "*not all older people are unwell*" (P12, I: 322-323). For P8, her friendship with, and care of, an older adult had reinforced the need for quality of life rather than preservation of life regardless of health status. However, for some participants their clinical experiences had engendered a more negative perception of their own and their family members ageing. P6 described not only an anxiety about his own ageing but wanting to delay his parents' ageing:

> "The more I see…the more the ageing side of things frightens me actually" (I:___)/…/They're at the turning point now where they're starting to get weaker, their old injuries are starting to actually have an effect and I don't…I don't want that to happen

> because it’s your parents /…/ when I think about it, the more I think about, the more upset I make myself” (I:102 & 125-129).

These concerns had prompted a move closer to his parents and a conscious effort to contact them more frequently.

This interrelationship between personal and professional lives carried through to some participants’ approach to practice with older patients. P3 saw in her older patients a reminder of her own grandparents and both she and P8 described the desire to give their patients the same service or treatment that they would want their grandparents to receive. P3, when describing patients who deteriorate, indicated a blurring between the personal and professional when she made the following distinction between those she had previously had little involvement with and those she had worked with and got to know well:

> it makes life easier because you don't know them, whereas if it's somebody you've had continued input with sometimes that can be harder because you relate to them as if they're yours, your relative in some ways (I:456-458).

Participants described a range of emotive aspects to their experiences of working with older adults. Three participants highlighted the reward and satisfaction gained from working with this population, as evidenced by P13:

> I feel like I can get more… I can do more for them, even if it’s just they’ve been using a walking stick and they’ve being struggling and give them a rollator frame and they’ve got their independence back. You know I get more reward out of that (I: 796-797).

A number of positive emotions were cited. For example, P3 described an emotive aspect to her older adult contact where:

> [There's] something about an older person that gives me a warm and homely feel and it's like having a cuddle rather than just talking to a thirty-year-old (I:160-161).

Yet, a range of more nuanced emotions were also expressed. Several discussed aspects of emotional attachment to their patients, with some describing how they worried about the perceived vulnerability of their patients. For P12, this was around her experiences of how devalued some patients seemed to be by their families, and she cited experiences with patients who had been neglected or abused by those whose should be caring for them. P4's concern about vulnerability was based on her perception of her patients as frail and isolated, and she described wanting to "*wrap them up in cotton wool and give them everything under the sun*" (I:264-265) but was aware that her excessive anxiety about discharging patients went beyond her professional responsibility to them, suggesting a possible subjective aspect to her discharge planning and decision-making. P14 described challenging emotive aspects to her practice when she said:

> [I] hate to be the person to say you can't go home/.../ I know there's a person at the end of that who's having to listen to this, and it breaks my heart when I have to say that because you see it on their face and it's… it is heartbreaking (I: 751-752; 755-757).

P12 described frustration at a conveyer belt experience when patients were readmitted, which meant that their management had not been sufficient to keep them at home, whilst P6 and P7 expressed frustration when patients would not accept the help and support offered or were non-compliant:

> you walk away frustrated and gritting your teeth but you can't force them into something they don't want to do (P6, I:428-429).
>
> Sometimes its very draining, because you feel like you're just hitting your head against a brick wall /…/ because again you're putting all this effort and work in and you don't see the end result happening (P7, I: 362-365).

Perhaps the most emotionally invested description came from P8 who recounted how she would choose to stay with dying patients who had no relatives with them because she believed that "*no one should die alone really*" (I: 777) and wanted both the patient in their last few minutes and the family to be comforted by the knowledge of her presence. She described this process as "*emotionally exhausting but not emotionally stressful*" (I: 822-823).

During her interview, P8 had made an explicit distinction between liking older adults and liking working with older patients – going on to clarify "*I think the work is boring, but I wouldn't mind the patients*" (I: 444). For her, whilst she quite enjoyed the interaction with an older population, she did not view working with this population as challenging in terms of either knowledge or skills and did not experience any job satisfaction. This issue of delineating 'liking' and 'working with' older adults was therefore introduced in the remaining interviews to explore whether P8's views were shared by others. Some participants expressed concern that anyone should consider this split whilst others recognised that working with older adults was not a career choice for some, although all the remaining participants reported that they themselves liked working with older adults.

In addition to P8, some other participants described negative perceptions of working with older adults either in others or themselves. Working with frail elderly people was perceived as an unpopular rotation in comparison to some other clinical areas:

> I think frail elderly is a ward of dependent adults that needed a lot more input, whereas respiratory you run in and you save the day, MSK you do practical treatments to improve patients who might be already relatively active and you can improve their quality of life relatively quickly, and Neuro you've obviously got from start to finish...there can be quite drastic changes there/…/ it [elderly care] has seemed the less glamorous area (P5, I:551-557).

Prior to working in this area, P6 had expected to only encounter patients with dementia and that the work would therefore lack variety, being "*the same thing day in day out, it's not going to be very interesting*" (I:348-349), whilst P3, when discussing the challenges of working in this area, unconsciously revealed potential negative bias when she joked "*which is maybe why I get lumbered with all of these complicated patients*" (I:730).

However, some participants provided more positive perceptions of working with this population within acute care. Three participants emphasised the positive experiences of working within a multidisciplinary team on the frail elderly wards. P11 stated that:

> the nurses and the staff over there are wonderful /…/ A massive community feeling and actually they love what they do and rightly so because it's a great demographic to work with (I: 896-898).

For others, it was about the patients themselves either in terms of the caseload – mixed and requiring different skills for effective management – or in terms of their perception of that population, many of whom were perceived as inspiring and fun to interact with, which made the work interesting.

Six participants emphasised the need to respect older adults. Five of them described a respect for this older population engendered by close contact with their own grandparents and/or a strong example set by their parents, although none were able to fully articulate how or why this emphasis on their demonstrating respect was facilitated or achieved beyond expressing the view that it was merited due to older adults' extensive life experience. This notion of respect was further personalised by two participants: P7 stated his view that younger adults did not demonstrate the same degree of respect towards the older population, whilst P2 voiced a desire for recognition in future that her own life experiences would be respected in any health-related decision-making processes. P9 did not mention personal experience but in relation to her professional practice emphasised the importance of having respect for both the experiences older adults have had in their lives and the situations they were now experiencing as a frail older person in need of hospital care:

Attitudes, perceptions, and feelings – exploring the findings.

The discussions around defining ‘old’ provided a range of definitions based on three areas: chronology, ability, and outlook. Some referenced ‘old’ within the context of a healthy ageing process and contrasted this with the frailer older adult population they encountered clinically. There appeared to be a tacit understanding of the potential for healthy years life expectancy rather than simply an increased life expectancy. However, several of the discussions around both ‘old’ and participants’ experiences of working with older adults indicated a range of stereotypical perceptions.

Thornton (2002) describes how we categorise the world around us into stereotypes which in turn enable us to make generalised inferences about that world. Age is a socially constructed category used to help us navigate everyday life (e.g., delineating stages of education, defining state pension age) but is also a category that risks us making assumptions and judgements about a population given that age may be categorised inappropriately (Abrams et al., 2015). Hummert et al. (1994) and Widrick and Raskin (2010) cite older adult subtypes of both positive and negative stereotyping. Positive subtypes included ‘*the grandparent*’ whereas negative subtypes included ‘*vulnerable*’. In addition, according to the Stereotype Content Model (SCM) (Fiske et al., 2002) stereotypes include the dimensions of warmth and competence, with older adults often categorised as warm but incompetent. Some participants referenced ‘old’ within ‘*the grandparent*’, more positive, subtype citing attributes in both the older adults in their personal lives - such as “*they /…/ had more experience, you can always learn something from them*” (P6, I:25) - and in their clinical population - such as “*very experienced and knowledgeable*” (P14, I: 18) – an ageist perception termed sageism

(Minichiello et al., 2000). However, for P4 and P12, the subtype of '*vulnerable*' was key in terms of how they perceived their older patients, whether it be in relation to their patient's ill health or to other factors such as neglectful families. P3's description of her older patients as giving her "*a warm and homely feel*" (I:160) seems to fit with the warm but incompetent stereotype described in the SCM, and her description of worrying about her discharged older patients could be viewed as benevolent ageism. Benevolent ageism (Abrams et al., 2015), feeling pity or sympathy for older adults, appears more explicit in P8's description of feeling sorry for her older patients - *I just felt sorry for them being a bit bored and forcing them to do things that they didn't want to do really* (I: 230-231).

Gendron et al. (2016) argue that, with a lifetime of exposure, these stereotypes become normalised and internalised so that we become unaware of them, and whilst explicit bias is considered unacceptable, we are likely to have implicit biases, hidden and unintentional, which are transmitted without us being aware of them. As an example, Klein and Liu (2010) found that their occupational therapy participants perceived that any of their previous ageist attitudes prior to working with older adults had disappeared, yet there was evidence that these ageist views were still present in the way they discussed their clinical experiences. Whilst my participants generally explicitly articulated a range of more positive attitudes and perceptions around ageing and older adults, the more negative stereotyping described above and in various sections of a number of transcripts – such as the mixed messages about ageing articulated by P4 and P10 – could be argued to be evidence of more implicit bias. However, health and social care stereotypes tend to focus on physical, cognitive, and functional decline (Chrisler et al., 2016) and it must be acknowledged that the impact of participants' clinical experiences with frailer, unwell older adults is likely to have had an additional influence on any implicit biases.

For some participants their own ageing or parents' ageing provided additional context around defining old. Age may be unique in being the only social category where an individual progresses from one category (young) to another (old) (Hummert et al., 1994) and, as such, as individuals age, their definitions around ageing also change. There is also evidence that even physiotherapy students' perception of 'old' increases as they move through their professional programme (Kalu et al., 2018), possibly due to greater contact with both fit and healthy and sick, frailer older populations. For some participants, such as P7, their own ageing served to contextualise their perceptions of their older relatives and of ageing per se.

The ongoing and often significant time participants had spent with older adults in both personal life and clinical practice may explain why most defined biological and functional 'old' as 75+. The one exception to this was P8 who defined it as "*could be over 50*" (I: 23). This participant was also the one who expressed the least interest in working clinically in areas that were older adult specific. A number of factors have been associated with more positive attitudes towards older adults and ageing in healthcare staff, including number of years post-graduation and more frequent social contact with healthy older adults (Leung et al., 2011). Whilst two other participants had been qualified about the same length of time as P8 (2-3 years), both of them described more frequent social contact with older adults than her and this may possibly help explain both her definition of 'old' and her lack of interest in working specifically with an older clinical population. Finally, in reviewing the impact of professional on personal lives, P6 described significant anxiety about both his own ageing and that of his parents as a result of his clinical experiences with frailer older adults. The Centre for Ageing Better (2020) identifies that stereotypes around ageing, such as a time of decline and ill-health, can be harmful when they directly influence the way we think and feel about our own ageing and, for this participant in particular, this seemed to be the case. However, whilst he described his anxiety as impacting on his perceptions and relationship with his parents there was no evidence for it adversely affecting his clinical practice.

Linking in with the previous subtheme around career choice, personal and professional experiences with older adults have been shown to be highly influential factors in influencing the decision of advanced practitioner nurses to move into the field of gerontology (Campbell-Detrixhe et al., 2013). Øster et al. (2019) found that for physiotherapy students the most important drivers for deciding on field or area of practice were seeing progress in those they were treating and making a difference, particularly where this impacted on the student themselves – as one of their participants explained, *“feeling that the deeds – or the caring – I do have actually served someone well”*. For those student participants this did not mean gerontology – a field where they did not view themselves as being able to make a difference. However, those of my participants who had chosen to move into older adult specific areas seemed to have done so *to* make a difference, and those working in rotational posts cited similar motivations. P13, a participant in an older adult specific post, explicitly described the feeling of reward experienced when patients get their independence back. A common theme in the literature exploring the attitudes towards older adults of student and qualified practitioners is one where the qualified practitioners demonstrate more positive attitudes than their student counterparts (e.g., Giles et al., 2002). Physiotherapists who do not work with older adults have been shown to have more negative attitudes towards them compared to those working with an older population, and these more negative stereotypes may be primarily based on preconceived ideas rather than direct experience (Morris and Minichiello, 1992). In addition, Klein and Liu (2010) found that gerontological occupational therapists admitted to having ageist attitudes prior to working with older patients but then felt these ageist attitudes had been transformed due to working with this population. This all suggests that, particularly for those working in older adult specific areas, my participants’ personal relationships with older adults and their more positive early career experiences with this clinical population may have directly influenced and restructured possible pre and initial post-qualification perceptions of working with older adults. These more negative perceptions were expressly articulated by some participants in relation to their early careers or in relation to how other staff compared elderly care unfavourably to other areas of practice, which were perceived as more dynamic. This reflects the findings of studies such as Øster et al. (2019) who found that healthcare students wanted to work in areas with a variety of tasks, fast flow of patients and the opportunity to gain a feeling of achievement – which elderly care was not considered to provide. In fact, P8 expressly articulated this perception when she described frail elderly as “*boring*” and not providing job satisfaction because she felt the speciality did not challenge knowledge or skills. Hovey et al. (2017) cite Kolb’s Experiential Learning Theory (ELT) (Kolb, 1984) and posit that learners reflect both during and after concrete experiences, conceptualise these experiences and then use the new knowledge they have gained to problem solve and decision-make. They argue that during these stages of learning attitudes will either change or be reinforced. For P8 her perceptions appear to have been reinforced. However, for participants such as P1, for whom two key experiences led to the change from musculoskeletal physiotherapist to older adult therapist, application of ELT would provide a rationale for how these early negative attitudes were reversed.

P8 was the participant who described liking older adults but not wanting to work with them, which echoes previous findings where some healthcare professionals have described liking old people better than old patients (Liu et al., 2012). However, nurses who have more physical contact time with older patients have been shown to perceive them less in terms of physical ability and more in terms of personality (Cooper and Coleman, 2001) and thus demonstrate more positive attitudes to working with this patient group. Most of my participants described their interactions with older adults in terms of a combination of both physical/functional and cognitive/emotional engagement (see later sections), – suggesting that they perceived them in a more personality focused way. However, P8 described her general experience of working with older adults in a much more stereotypical physical/functional focused context and her description of her physical interactions with frail older adults suggested quite limited physical interactions with those less able patients. This, combined with descriptions of this population which would appear to reflect those earlier described health and social care stereotypes focusing on physical, cognitive, and functional decline (Chrisler et al., 2016) and the contrast with P8's earlier more positive personal interactions, may go some way towards explaining her disconnect between liking older people and disliking working with older patients.

Some other participants did describe negative or more challenging aspects of working with older adults in their more recent clinical experiences, with P6 and P7 expressing their frustration with non-compliant patients. Age bias has been shown to be more prevalent when the behaviour of older patients is perceived as less than ideal (e.g., non-compliant) (Rybarczyk et al., 2001). Non-compliant behaviour is perceived as problematic because it transgresses expected professional beliefs and expectations about the 'proper' role of patient and professional (Playle and Keeley, 1998). Where P6 describes his frustration with non-compliant patients there is an implication that the patient is not passively accepting of the implicit power dynamic in the patient/professional relationship where the therapist knows best (Playle and Keeley, 1998). However, patient non-compliance is not limited to older patients, and it should also be noted that several participants compared older adults more favourably in comparison to a non-compliant younger clinical population (of more later) so it is difficult to discern whether some negative bias towards older adults is present within these descriptions of frustration or whether these frustrations form a part of clinical practice regardless of patient age.

P14 detailed the "*heartbreaking*" (I: 757) challenge of being the person responsible for preventing someone going home, whilst P8 recounted how she would actively choose to stay with dying patients so that they did not die alone. The nature of geriatric acute care means that healthcare professionals are dealing with a population who, due to age, comorbidities, and social situation, are often more likely to face challenges in returning home than a younger unwell population. In addition, those ageing and comorbidity factors in combination with acute illness are more likely to result in death for a small but significant older adult population within secondary care. One of the 6Cs (a set of values for all health and social care staff published by the Department of Health in 2012) is 'compassion' and it would seem that both of these participants exemplify this characteristic in these narratives. For P14, in this instance, there is clear evidence of empathy with those for whom their admission has resulted in a significant change in social functioning. For P8, this compassion would appear to link back to her earlier description of the trauma of being involved in the ultimately unsuccessful resuscitation of a very elderly and extremely frail patient and to the notion of a 'good death' when discussing the death of her friend – an example of how those prior lived experiences may have influenced her practice beyond the normative professional physiotherapist role.

Finally, the need to respect older adults was explicitly discussed by six participants. The Collins English Dictionary (1990) defines respect as 'an attitude of admiration or esteem'. For my participants this was cited predominantly as being merited by older adults' extensive life experiences. Evers et al. (2011, cited in Hovey et al., 2017) explored fourth year nursing students' attitudes and values in relation to caring for older adults and both respect and wisdom were identified as key values expressed by participants. However, this perception of older people as wise is in itself a positive stereotype (Hummert et al.,1994) predicated primarily on the partially erroneous assumption that wisdom increases with age and life experience. Whilst knowledge of life, which could be argued to increase with age, is one of several subcomponents of wisdom (Bangen et al., 2013), wisdom also has a number of components that are not age-related. Given that ageism is considered to be societally constructed (Minichiello et al., 2000), and the assumptions made between respect and the positive stereotype of age-related wisdom, it is perhaps not surprising that respect was discussed by participants with, in addition, some citing their own parents as instilling this notion into them as they grew up. Whilst there are risks inherent in healthcare practitioners automatically ascribing wisdom to all older adults, such as having preconceptions about their level of understanding, respect itself is a characteristic with the compassion component of the 6Cs (Department of Health, 2012) and it is reassuring that participants were able to identify the need to demonstrate this in relation to their older patient population.

6.3.2 Theme: approach to practice

This theme explores a number of factors that participants described as key influences and considerations in their clinical practice with older patients.

6.3.2.1 Subtheme: being an older-adult practitioner.

Several participants described what they perceived as key skills and attributes to successfully work with older patients. These were a mix of practical and what might be described as soft skills such as "*compassion and that empathy*" (P1, I:436). Three participants (P1, P2 & P4) discussed the need to "*think outside the box*" (P2, I:475), which related to a recognition that the complexity of some older patients required a more innovative approach where standard treatment approaches needed to be adapted to best manage these complex clinical presentations. This approach was identified by P1 as requiring excellent clinical reasoning skills and an in-depth knowledge of medicine in order to be successful, and he described older-adult practitioners as needing to be an expert in many fields of medicine.

P12 described the ability not only to start planning discharge from day one of admission but also to be able to make parallel plans for rehabilitation depending on whether the patient might be imminently discharged or be able to stay for further physiotherapy input – a skill that she felt was beyond the scope of students and more junior staff. P8 highlighted the functional nature of physiotherapy assessment and treatment with a frail older population and the ability to liaise with the patient's family and friends.

In terms of the soft skills, P10 discussed the value of therapeutic touch in building relationships with patients:

> it could mean a lot to them because it's the physical contact with somebody but also I think sometimes it does create a bit of a bond that then they'll talk to you about things (I: 470-472).

She summarised the core skills required as being *"your interpersonal skills, building relationships, getting your hands on, they're key to working well with your older patient*" (I: 522-524).

Several participants described skills and attributes related to communication, holistic management, and multidisciplinary working that constituted additional subthemes that will be discussed later.

Each participant described what they saw as key aspects of their approach to managing older adults in their clinical practice. Eight participants identified the importance of engaging their patients in rehabilitation effectively: taking time to get to know their patients, gaining their trust and building a rapport to better enable them to build relationships with their patients, set appropriate goals, empower patients, and facilitate compliance. P14 highlighted the need to recognise that patient non-compliance may be a result of factors other than current health presentation. For her, understanding the patient perspective enabled better management and thus it was important to find concordance. P2 cited the importance of negotiation and compromise, whilst P5 used a coaching and encouraging approach to get the best out of his patients:

> the majority of the role is actually coaching and giving them confidence and giving them education and information around that, so I think there's a lot about the psychological aspect of it /…/ that the role encompasses really (I:293-297).

Three participants (P1, P6 and P9) discussed the need to push their patients as much as possible in terms of rehabilitation rather than simply sending them home with, at most, their previous baseline level of function. Six participants described a broader approach to management than just addressing the immediate physical presentation. For P3 this was very much about finding out as much as possible about each patient immediately upon admission to ensure the best possible action plan could be formulated and to enable her to tick every box prior to discharge to ensure all appropriate services are accessed. P6 emphasised the need to adapt communication to better enable the patients to provide all the information needed to ensure all this could take place. Others described the need to see the broader health picture so as to address all factors that might impact on rehabilitation, including social and emotional, and to enable them to explore why some patients may have recurrent admissions and how this could be addressed in order to reduce the number of readmissions. P8 and P9 described the need to recognise that patients had routines which when disrupted might negatively impact on rehabilitation, whilst for P6 the importance of understanding what was 'normal' for his dementia patients enabled him to adapt the clinical environment so as to make it less challenging for these patients:

Both P7 and P9 discussed the need to give their older patients more time to ensure effective rehabilitation could take place, and P9 emphasised the need for everyone to treat the presenting problems regardless of age. P5 reported using some older patients as role models or examples to younger patients to show that age is not relevant to the rehabilitation outcome: *"what you put in, you get out, not how old you are"* (I:672). P8 described how she treated older patients as if they were her relatives and how she timed treatments to get the best out of her patients. Both P8 and P1 specifically mentioned the behavioural challenges some patients with dementia exhibited and the importance of adapting their management to get the best possible engagement from these patients.

Four participants discussed a focus on ensuring safe discharge. For P13 this was about getting patients home safely, if at all possible, as this was seen as better for the patient, including there being less chance of the patient catching healthcare acquired infections and experiencing deconditioning. P4 described a balance between getting the patient home and recognising potential safety considerations, particularly where the patient did not have much family support. For P12 this balance was between patient safety and the right of a patient to decide to return home even when the healthcare professionals were aware this return home may be unsuccessful. This participant felt that sometimes patients needed to go home to be able to realise that they could no longer cope.

For P15 her overall approach to practice was about maintaining abilities – functionally, physically, socially – including bringing community and social interaction into patient management on the wards. This included exercise and activity groups, outdoor mobility, and walking patients to the hospital shop. Prior to discharge she explored community services that could support her patients, with the aim of not just getting them home but getting them back into society. P4 echoed this need to explore and engage community services prior to discharge, whilst for P6 the focus was very much on being able to facilitate social interaction via broader community services and activities post-discharge. Finally, P9 emphasised her sense of duty of care, describing how she would stand up for her patients: [I would] "*fight my corner for a patient and not think twice about it really*" (I: 789).

Nine participants discussed aspects of person-centred practice. For some participants the focus was on treating everyone as an individual, whether it be in terms of recognising that patients with the same clinical condition or presentation will still have different rehabilitation requirements (P1); require individual consideration of wider factors such as their ability to manage at home (P11); or the need to recognise that patients may have conflicting factors, such as caring responsibilities, which may impede rehabilitation plans (P10). For P5, this person-centred practice was about ensuring that the clinical presentation rather than the patient's age dictated how they should be managed. P2, referring back to the impact of her research in highlighting a lack of patient autonomy, described how her approach to practice was now about achieving a balance between providing the 'ideal' treatment and enabling patient independence and autonomy:

> It wouldn't be to the extent of…robbing that patient of any form of independence until they got the perfect movement…the perfect way of standing up…the perfect way of transferring. I would do a…we'll do this in between to give you your independence back while we still continue to work on improving your overall mobility and your overall function and your overall movement and that's how I would do it (I:245-250).

P3 cited an incident where she had been called to a patient on critical care who had been described by staff as non-compliant with respiratory care. The patient was older and had a broad accent, which made him difficult to understand, and was verbally abusive to staff. P3 felt that this meant that the medics and nurses had not tried to engage with him effectively. She had spent some time with the patient listening to him and talking to him, after which the patient engaged effectively in respiratory physiotherapy. This, for her, was an example of healthcare practitioners not seeing past the obvious to then be able to recognise the patient's anxiety and fear – not truly seeing the individual.

Closely linked to person-centred practice was a narrative around seeing the person and not just the patient as they presented on the wards. Some of the discussions were around seeing the older patient within the context of their overall identity as people or, as P3 expressed it, coming "*to appreciate that there is much more to a person than* *their clinical condition*" (I:102-103). P10 stressed how understanding the person – role, hobbies, life experiences – helped her build relationships:

> I do look at patients and try to get that essence of who they were. I quite like exploring that with them, thinking about who they are, not just that condition they present at the time" (I: 178-181).

P4 described how she didn't see elderly patients as elderly but as just another person – a range of abilities – not age dependent.

> Sometimes you think 'gosh you don't look as old as you say you are' and they're active and they're quite vibrant with life and quite enthusiastic about life and they want to get on and then you've got others who are more disabled and more limited in what they can do and they're just different people and different experiences (I:134-137).

Like P4, two other participants also made references to age perception whilst discussing this need to see the patient as a person, as evidenced by P9:

> they are still people and are still individuals – just because they are older doesn't mean they don't have goals, wishes (I: 478-480).

Finally, P4 also highlighted the need to also see the person behind the condition e.g., challenging behaviours and personality changes in patients with dementia: "*it's not her, so not to take it personally*" (I:259).

Three participants discussed equity of care in relation to their management of older patients. P9, who worked in a non-older adult specific clinical area, expressed her view that management should be based upon individual needs and goals rather than age. However, she also suggested that the physical effects of ageing did actually contribute to differentiation in management:

> on the whole they're just older bodies and I treat them the same no matter what, and you just take into account that they've got older bodies with predisposed problems and that their goals are going to be different (I: 846-848).

The cohorting of older adults within the frail elderly wards was seen as both a positive mechanism for promoting equity of care and a barrier to standardised care. For P3 having older patients on the frail elderly wards meant that they were all treated in a similar fashion, whereas for P4 the very fact that those on the frail elderly wards were being managed by a specialist team detracted from the sense of older adults being treated the same across a range of healthcare specialities:

> [It] sort of neglects the fact that there's an elderly population of patients everywhere and how do you cope with those really, rather than ‘oh yeah look we've got this nice little group of people who are elderly care (I:705-708).

Several participants discussed their professional role and/or identity as older-adult practitioners. Both P1 and P11 described how their role as physiotherapists had expanded to encompass an interdisciplinary remit, identifying an integration of care due to upskilling as a result of having dual competencies, with Occupational Therapy training up to technician level, with patients benefitting from these additional skills. In addition, P11 described a previous, expanded role that included a non-traditional physiotherapy remit where she was carrying out tasks such as medication review, pressure care review and specific cognitive behavioural assessment. However, both participants highlighted a loss of a physiotherapy specific identity. For P11 this was about her current role being predominantly one of assessment and discharge rather than being able to use her core rehabilitation skills, whilst P10 recognised a blurring of responsibilities:

> sometimes is really difficult as where our role starts and begins and I probably blur the edges on that, talking about what our responsibility is (I: 513-514).

P4 also described a perception that physiotherapy skills were being eroded, with no time to carry out rehabilitation effectively. P8 linked her professional role to the use of her physiotherapy skills and highlighted that she felt that other areas of practice, such as critical care, enabled her to utilise physiotherapy specific skills rather than what she perceived as the more generic skills she used on frail elderly wards.

For some participants their professional identity was closely linked to the value placed on them and recognition of their skills by other members of the multidisciplinary team. P3, P12 and P13 described how they felt well respected on the ward and how they were listened to by the rest of the team – an example being when P3 described how no patient was sent home without her agreement, suggesting an added sense of responsibility for practitioners working in this area. However, P15 described how other healthcare professionals perceived the role of the physiotherapist differently from how the physiotherapists did themselves and P11 gave an example of this:

> There are often doctors that are just referring patients just as a ticking box to just say ‘oh well they need to be seen by a therapist before they’re discharged’ even though they’re independently mobile on the ward and they’re managing around (I: 767-770).

Two participants identified potential challenges to professional identity both in terms of self-perception and the perception of others. P14 described the need for junior staff and students to recognise that they have professional legitimacy when working with older patients who may make erroneous judgements about their competence due to their young age. For P7 the perception of the physiotherapy role by others was dependent upon having a “*professional manner*” (I: 472) - although he struggled to articulate what exactly they meant by this - and without this professional manner a physiotherapist would not be taken seriously.

Finally, P6 articulated a difference between his identity as a clinician and his role as a physiotherapist when describing how his dementia training had changed his role and practice. For this participant this training had changed his identity as a clinician but his identity as a physiotherapist had remained unchanged.

Being an older-adult practitioner – Exploring the findings.

Participants identified several key skills and attributes required to work successfully with older adults. One such skill was ‘thinking outside the box’. Defined as ‘to think about something in a way that is new or different and shows imagination’ (Collins English Dictionary, 1990), this was a strategy linked to in-depth knowledge and excellent clinical reasoning skills and requiring an ability to perceive the additional physical challenges faced by a frail older population and adapt rehabilitation strategies appropriately to accommodate these challenges. Clinical reasoning is a core competency for healthcare professions and one of the most complex skills to learn (Ruczynski et al., 2022). A range of factors influence physiotherapists’ clinical reasoning including education and experience, with experienced practitioners being able to base decisions on their tacit knowledge, past experiences, and current circumstances; and physiotherapists’ understanding of their patients and potential options for intervention are constantly being revised by an iterative process of clinical reasoning, with the therapists continuously interpreting and evaluating their patients (Holder et al., 2013). Given the complex presentations of many frailer older adults, this ongoing revision is likely to require extensive knowledge and experience and it is perhaps telling that the three participants who discussed thinking outside the box were some of the more experienced practitioners. This complex clinical reasoning process was also evidenced in P12’s description of the need to be able to make plans for rehabilitation and discharge planning for this population in parallel, with her perception of these skills as being beyond the scope of students and more junior staff.

The physiotherapy practitioners in this current study identified the value of ’soft skills, defined as “intrapersonal traits and interpersonal skills that an individual possesses that make him a preferred provider” (Laari et al., 2021: p1). These included compassion, empathy, and touch, reflecting aspects of the 6Cs (Department of Health, 2012) – compassion being one of the six and empathy a subsection in the Compassion descriptor – and the Chartered Society of Physiotherapy (CSP) Code of Members Professional Values and Behaviours (2019). The ‘caring touch’ is considered to be beneficial in ameliorating some of the effects of hospitalisation such as fear and anxiety (Bush, 2001) and whilst the focus within healthcare for many years was on the ‘hard’ skills of knowledge and practice, there is very strong evidence for the benefits of the soft skills such as compassion and touch in clinical practice (Laari et al., 2021). Older adults within acute healthcare have identified the importance of caring healthcare professionals in experiences of positive rehabilitation, valuing not only the social interactions and engagement from those working with them but describing the negative impact on emotional wellbeing when ‘care’ was missing from patient: professional interactions (Atwal et al., 2007). Patients and family members, when asked about their healthcare experiences, have been shown to make very few comments about the technical competence and skill of those caring for them but instead place much greater emphasis on the interpersonal aspects of care (Ng, 2020; Atree, 2001). In relation to physiotherapy more specifically, patients have cited having a compassionate professional as a key characteristic of high-quality care (Bastemeijer et al., 2020; Bastemeijer et al., 2017). The need for these soft skills as a key aspect of clinical practice formed the basis of the ongoing descriptions throughout this theme about the need to engage with the patient, to build a relationship with them and to understand the patient perspective. For my participants these soft skills underpinned their assessment and management and enabled them to better manage the patients from a broader physical, social, and emotional perspective.

Boltz et al. (2010) explored the experiences of older adults during hospitalisation and found that a key expectation was of being able to go home better rather than worse, and being able to get back to doing what was normal for them once discharged from hospital was an important indicator of successful rehabilitation. My participants' discussions around finding out more about their patients, including their 'normal', in order to maximise function and address the broader health picture, reflect an appreciation of the broader aims of rehabilitation beyond addressing the immediate deterioration in physical and functional abilities. Getting the best out of their patients required time and understanding and discharge itself became a process of enabling social interaction and engagement as well as a return to independent function. For therapists working with older adults a narrative around enabling patients to 'do real things and be real people' has been closely linked to satisfaction in being able to get the patient home, and returning someone to their former level of function has been perceived to be getting them back to 'the good life' (Hasselkus et al.,1997). Much of the focus of the discussions within the approach to practice subtheme related to gaining the knowledge and understanding required to effect successful rehabilitation and discharge home. However, an expectation of successful discharge may not reflect the realities of an ageing process where at some point in the older adult's life functional decline or challenging circumstances may preclude discharge home, and some participants did specifically discuss the need to ensure that discharge was safe and feasible. P12 recognised the potential mismatch between patient expectations of discharge home and therapist anticipation of home discharge failure and described how it was sometimes necessary to allow some patients to go home for them to be able to realise that they could no longer cope. In addition, whilst previous participants had discussed recurrent admissions in terms of the need to identify the underlying problem rather than the immediate reason for admission, P12 was the first to see the recurrent admission process as having a positive purpose in enabling the patient to come to terms with their situation – this experiential learning being much more meaningful to the patient in terms of understanding their functional limitations than having a decision imposed upon them. Previous research has suggested that physiotherapists working in geriatric inpatient rehabilitation focus on bodily impairments and functional limitations rather than considering those impairments in relation to their patients' social and environmental contexts and constraints (Wallin et al., 2008). In contrast, my participants largely articulated a broader approach to the management of their older patients which included emotional, social, and environmental contexts, suggesting a synergy between participants' approach to practice and the evidence around older adults' expectations of good-quality rehabilitation.

Patient or person-centeredness is an important consideration in healthcare and the Picker Institute (2023) defines this as "an approach where users are recognised as individuals, encouraged to play an active role in their care, and where their needs and preferences are understood and respected". When discussing their approach to managing their older patients several participants discussed aspects of practice that were coded as person-centred. For some this reflected core aspects of person-centred care as described in the literature such as individualised care, responsiveness to the challenges faced by patients, understanding the needs and preferences of the individual, and autonomy (Picker Institute, 2023; Batemeijer et al., 2020; Batemeijer et al., 2017). Two participants, P2 and P3, evidenced specific instances in either their own practice or the practice of others where that patient-centred approach had been missing, whilst P3 and P10 described the need to pay attention to the various dimensions of a patient's identity (uniqueness) and not just their presenting condition, therefore helping build a stronger bond with the patient (Batemeijer et al., 2017). For some participants this uniqueness was more about how the patient's individual factors such as age, rehabilitation requirements and social circumstances influenced their physiotherapy input – arguably perhaps less person-centredness and more therapy-centredness. In fact, the patient-centred practice descriptor 'encouraged to play an active role in their care' (Picker Institute, 2023) was not evidenced at this point in most participants' descriptions of their practice. Batemeijer et al. (2020) categorise patient values as being values of oneself (the patient), values of the professional (the physiotherapist) and values of the interaction. The participant narratives here around approach to practice seem to largely fall within the 'values of the professional' category labelled by Batemeijer et al. (2020) as the 'conscientious professional', 'the compassionate professional' and 'the responsive professional'. Indeed, within some of the examples given by participants around person-centred practice the underlying message still seems to be more therapist centric. For example, P2's description of her change in practice post-research to one of giving the patient more autonomy is still described as a therapist-led compromise rather than a process of negotiation and dialogue with the patient, which suggests an unequal power relationship, although one more focused on the patients' needs rather than the therapist-driven goals. However, this participant does later query whether physiotherapists do really give patients enough autonomy to be able to come up with their own solutions, suggesting some self-awareness. That P2's query around the degree of patient autonomy offered to older adults was linked by her to a desire when older to be fully consulted in her care perhaps reflects the differentiation between personal experience and the more abstract general older adult perceptions articulated in the first theme - perceiving the general older population as different from those adults with whom participants had a personal relationship.

Several participants explicitly articulated an approach that encompassed equity of care for their older patient population alongside other age groups. Defined as being about fairness and with an implication of having equal opportunity to achieve full potential (Raine et al., 2016), this discussion around equity centred either on the individual patient or on the overall management of older adults within acute healthcare. For some participants equity was about seeing an individual regardless of age, whether it be understanding and accepting that the focus should be on ability rather than age and acknowledging that older adult patients come with a range of abilities (P4) or recognising that being older does not mean patients do not have goals (P9). However, these discussions continued to reflect some of the mixed messages about ageing discussed in the first theme with P4's *"Sometimes you think 'gosh you don't look as old as you say you are"* (I:134) reflecting Gendron et al.'s (2016) uncharacteristic characteristics in appearing to express surprise at a physical age presentation different from that of other older patients. The use of words such as "*they're terrified"* and *"they need nurturing"* (P9, I: 582-583) echoes the Fiske et al. (2002) vulnerable stereotype. However, P1 appeared more overtly aware of some of the challenges around ageism within acute care when describing the need to avoid treating older patients as children, reflecting an understanding of the potential for infantisation and elderspeak – treating and talking to older adults as if they were children – which has been shown to be a feature of ageist behaviour within the NHS and other organisations (Swift et al., 2016). Based on negative stereotyping of older adults as less competent communicators and resulting in oversimplification of communication by healthcare providers, elderspeak alone can lead to more negative patient outcomes (Williams, 2011: p2) and P1's articulation of the desire by older patients to not be treated as this way suggests that he may have witnessed elderspeak and/or infantisation during his clinical practice.

Equity within the overall management of older adults within acute healthcare was linked by participants to their own experiences and the perceived impact on approach to care of this population more generally. For some the cohorting of older adults within frail elderly wards was seen as a positive mechanism for promoting equity, reflecting the argument that this often-complex population is best managed in a specially designed unit where a multidisciplinary approach can best meet their needs. Indeed, there has been significant evidence around improvement in care, better outcomes and patient and provider satisfaction where older patients were managed together (Hickman et al., 2007). However, older adults as a population are one of the largest users of acute care services. – nearly two thirds of hospital admissions are in those aged 65+ (Shepperd et al., 2021) – and their clinical presentations may require a range of medical, surgical, and emergency services (Hickman et al., 2007). As such, many will be admitted to a variety of wards within secondary care. Whilst P4 recognised the benefits of cohorting frail elderly patients on specialist wards she also considered that those older adults on other wards did not have the same benefits in being managed by a specialist team, leading to potential inequity in the care provided to this broader older adult population. Given that frailer older adults are at significant risk of deterioration after even a short hospital stay (Keeble et al., 2019), the admission to wards less equipped to manage their complex needs could be argued to put these older adults at increased risk of deterioration and potential recurrent admissions as a result. For P4 the perception of inequity in the management of older adults across the hospital seemed to be reinforced by the very existence of the frail elderly wards.

Several participants discussed their professional role and/or identity as older-adult practitioners. Identity construction is an ongoing process that occurs through everyday professional encounters (Chambers, 2012). The concept of professional identity in physiotherapy is not only fluid in how it develops over time and with experience for individual practitioners but is also co-constructed between themselves and those around them (Hammond et al., 2016). For some of my participants their professional identity appeared closely linked to the value placed on them and recognition of their skills by other members of the multidisciplinary team, with a perception of being respected and listened to reinforcing their value as an older adult practitioner. Rasmussen et al. (2021) found that teamworking was considered a positive influence on professional identity within nursing, with being recognised as a valuable team member specifically cited as an influential factor. Given the earlier narratives around ensuring a return to “a good life” once discharged, P3’s description of how no patient was sent home without her agreement could be argued to reflect the close relationship between self-concept and sense of self as a practitioner, whose purpose is to return the patient to best possible health and social functioning, and the augmentation of professional identity by her position in the society of healthcare - in this instance with the power to influence discharge. However, Mackey (2007), in reflecting on the Foucauldian concept of dominant discourses, identifies that power relationships can directly influence professional identity. Professional roles within healthcare have long been perceived as hierarchical and healthcare professions and the individual practitioners within them need to negotiate their professional identity within this context (Best and Williams., 2019). In addition, less positive perceptions of a profession by other healthcare professionals can also have a negative impact on an individual's professional identity (Rasmussen et al., 2021). Some participants described how other healthcare professionals perceived their role differently to how these participants did themselves, with evidence of a potential devaluing of professional expertise and identity in the example of the tick box approach to discharge taken by doctors (P11), who are traditionally seen as being at the apex of the healthcare hierarchy. This challenge to professional status and identity as a healthcare professional was also perceived as extending to older patients who may query competence in junior physiotherapists and physiotherapy students and P14 described the need for less experienced staff to recognise they have professional legitimacy, a characteristic linked closely to self-concept (Johnson et al., 2012).

Professional identities are constantly developed and re developed (MacIntosh, 2003) and this constant reshaping has been shown to include the impact of role changes (Johnson et al., 2012). For some participants their changing role as practitioners brought both benefits and challenges. Teams can develop closer working relationships when role blurring – individuals taking on elements of another healthcare professional's role – is introduced (Ellis and Sevdalis, 2019), and this role blurring, leading to interdisciplinary working, was described in varying ways by some participants. Whether it be the process of taking on dual physiotherapy and occupational therapy competencies (P1) or a role with a significant non-traditional physiotherapy remit (P11), the taking on of additional skills in this way was perceived as enhancing management of their older adult patients. However, alongside this description of enhanced practice there was a concurrent dialogue around a perceived loss of physiotherapy-specific identity. Physiotherapy, as with any other healthcare profession, has a profession-specific identity, which begins to form from the moment of entry into training and includes not only the acquisition of knowledge and skills but also has been described as a transition into a new way of life (Duchscher, 2009). This application of profession-specific knowledge and skills in clinical practice has been shown to enhance professional identify. Thus, in these participants there appears to be simultaneously a tension between the construction of a new more interdisciplinary identity facilitated by organisational practices *and* a perceived lessening in value/loss of their more traditional physiotherapy-specific identity, focused predominantly on systems and practices that left them unable to utilise their physiotherapy-specific rehabilitation skills effectively.

6.3.2.2 Subtheme: The broader picture

In relation to working with the multidisciplinary team (MDT), four participants emphasised the value of a close working relationship in maximising the potential for effective patient care. P7 felt that the range of MDT professionals working with older adults in acute care helped meet all the patient needs. P13 echoed this but expanded upon it to describe how this effective team working was at least partially due to the team appreciating the role of other members and considering their opinions:

> really good at listening to physios as well, I think, and taking what we say on board so you feel appreciated I think more, you feel like you can do a better job (I: 390-392).

P12 reflected on how physiotherapists offered a different perspective from the other team members and how this team approach – different professions, different perspectives – provided the reassurance inherent in all professions saying the same thing in terms of patient care and decision-making. P3 specifically highlighted the value of the discharge coordinator in helping facilitate patient discharge when physiotherapists do not have the time to commit to liaising with others, such as the patient's family, due to workload.

Nine participants described the importance of a holistic approach in ensuring effective patient management, although their definitions of 'holistic management' varied. For some participants, such as P11, taking a holistic approach meant looking at all of a patient's health aspects and incorporating these into assessments, goal setting and treatment planning, such as recognising the impact of pressure sores on mobility and the need for patients with Parkinson's disease with swallowing problems to be assisted with feeding – considerations that she felt were not "*completely out of the realm of a therapist"* (I: 155-156). For P13 holistic management was about looking at both physical and psychological needs to ensure that the patient was in the right frame of mind to want to mobilise. For other participants this description of holistic management extended further. P15 described how:

> we're no longer just focusing on the mobility aspect or functional aspect we're looking at emotional support social support /.../ It's looking at nutrition, assessing nutrition, elimination, mobility, emotional status, social interaction (I: 566-567; 573-574)

For both P6 and P9 the result of a holistic approach was not only on getting someone home but in returning them to what was normal for each patient pre-admission:

> [not only] as someone we can get home but as someone who we can get home and they can enjoy home (P6: I: 769).

Several participants described the need to see the bigger picture in terms of patient management. P1 highlighted the need to consider all of a patient's current and previous health problems: "*incorporate everything into one as opposed to looking at conditions separately*" (I: 344), whilst P4 expanded on this theme and also discussed the importance of addressing issues that may not be directly related to an admission, such as checking a splint for a stroke patient's hand when they have been admitted following a fall – i.e. making the most of all contacts (Public Health England, 2016). P13 depicted the bigger picture within the context of the multidisciplinary management of the patient, understanding what the other team members were doing and how their input can impact on the patient, as well as having a more comprehensive understanding of home circumstances and the organisations (such as AgeUK or befriending services) that could enhance the patient experience once discharged. P10 summed up the purpose of seeing the broader picture as:

> giving some control back in your life maybe and choices…that seems a little bit too… so I suppose in terms of responsibility and duty it is a duty of care but its care of people as a whole it's kind of a social responsibility, moral I think (I: 276-279)

The broader picture – Exploring the findings.

A number of participants described the importance of a close working relationship with the other members of the multidisciplinary team (MDT) in maximising the potential for effective patient care. It is well known that comprehensive management of patients requires multiple healthcare professionals (Körner, 2010) and that the MDT is central to best serving older patients within acute care as this enables a coordinated and comprehensive approach to care where all domains (medical, functional, cognitive/psychological, and social) can be covered (Ellis and Sevdalis, 2019). Respect for colleagues is one of the core principles of effective MDT working (Ellis and Sevdalis, 2019) and this was reflected by my participants in their descriptions of how they were listened to by colleagues and in their appreciation of the role of others – for example, P3’s appreciation of the value of the discharge coordinator. For some the MDT not only enabled better patient care but served as a mechanism to support their clinical decision-making via providing the reassurance inherent in all the team saying the same thing. However, in comparing multi- and interdisciplinary approaches to team working, Körner (2010) identifies that teams work most effectively where staff are on the same hierarchical level and where there is a high degree of cooperation and communication amongst team members. Whilst participants did describe aspects of these characteristics there were also indications of a less effective MDT process - for example, the tick box approach to referral described by P11. However, it should be acknowledged that much of the literature around team working reflects research in a rehabilitation context. The specific challenges in acute care around high patient turnover and pressure to discharge (of more later) may limit the cohesiveness of the MDT, especially where there may be a tension between the desire to return a patient home to “a good life”, as described by my participants, and the need to meet the demands inherent in the high patient turnover in secondary care.

Nine of my participants described the importance of taking a holistic approach to the management of their older patients. Holistic care requires consideration of an individuals’ physical, social, emotional, economic, and spiritual needs, as well as their response to illness and the resultant impact on their ability to self-care (Ventegodt et al., 2016: p1935). This holistic approach should put the patient at the centre of care to ensure that all aspects of patient needs, goals, expectations, and preferences are met (CSP, 2019). Some of my participants described holistic management within this broader context. However, for others the definition of holistic appeared to focus much more physical than biopsychosocial, albeit involving consideration of the wider physical factors that might impact on a patient’s rehabilitation, such as pressure sores and impaired swallowing. This would seem to reflect the findings from Wallin et al. (2008) where their physiotherapy participants’ accounts of their clients in geriatric inpatient rehabilitation appeared to focus more on bodily impairment and limitations in physical function. However, a review of the transcripts suggests that for some of my participants the response when asked to define holistic linked very much to the discussion immediately prior to this and where this discussion was around physical factors their definition of ‘holistic’ mirrored this. As such, this contextualisation may well explain the apparent contradiction between this focus on physical factors and the broader narrative around consideration of the wide range of factors (emotional, social, and environmental) identified by most participants when describing their overall approach to practice.

The broader definition of holistic as defined by Ventegodt et al. (2016) was, however, reflected in participants’ descriptions of the need to see the bigger picture in terms of patient management. Whilst this bigger picture encompassed the wide range of factors described by participants as needing to be factored into patient management, the overarching message from this bigger picture perspective was how all these disparate factors needed to be brought together to provide a comprehensive understanding of the patients’ needs and the ways in which the MDT could address these to effect best management and discharge. Thus, this bigger picture perspective provided an effective summary of how all the factors identified as being influential in their approach to practice came together to summarise participants’ overall accountability and agency in relation to their older adult patients.

6.3.3 Theme: The older patient and family

This theme explores participants' perceptions of their older patients and the involvement of patients' families in their care.

6.3.3.1. Subtheme. The older adult.

Participants described a range of both physical and behavioural/emotional perceptions of their older patients. From a physical perspective, participants described their older patients as sicker, with many more comorbidities and much more complex than other patients they worked with in acute care:

> I think the older they get the more frail they're getting…and becoming more dependant as well...and they come with a lot of co-morbidities as well (P13, l: 705-706).

This physical presentation impacted in a number of ways both on the patients themselves and on the physiotherapy management. P9 identified that one of the consequences of being older was that an infection that can result in a significant physical decline that would be unlikely in a younger person: "*can just take them off their legs completely whereas another person that might not happen*" (l: 204-305). P7 described how the health status of frailer older adults can change from one day to the next, meaning that older adults could go very quickly from being independent and well to very dependent and unwell. The degree of dependence exhibited by some of their very unwell patients was described as having a significant impact on the rehabilitation. Both P4 and P9 explained how their frailer older patients took longer to recover, needed more time to regain their function and took longer to get back to their baseline in comparison to younger patients.

> a lot of older patients get deconditioned a lot quicker than a younger person. It doesn't take much for them to actually really lose their mobility in hospital (P9, l: 238-239).

This population were also more likely to have cognitive challenges and to experience a level of fatigue during rehabilitation that would not be expected in a younger patient population.

P9 described how she had different expectations of older patients compared to younger patients with the same conditions.

> you do have a slightly different approach…you know you don't walk as big a distances, you don't expect as much of them depending on the individual but I don't think…as you would for example somebody who was 30 and had a neck of femur fracture as opposed to someone who is 94, it's very different expectations physically (l: 221-225).

P11 identified the significant number of members of the multidisciplinary team that were required to be involved in the management of these frailer older patients, and this was reflected in P8's description of how patients' complex clinical presentations alongside hospital-acquired deconditioning meant that discharge from hospital became a more complex process:

> older adults are obviously more complex discharges because a lot of them either live on their own or with an elderly partner/…/ and obviously if they've been poorly and they've deconditioned a lot in hospital then I don't think its straightforward discharge home with care support or with equipment (l: 447-478; 486-488)

However, there was some, limited, recognition that not all older adults might present this way:

> not all older adults though I think it's only some. I think some older people can be just as bright and spritely as me or even brighter (P9, l: 249-250).

In terms of their behavioural and emotional perceptions of their older patients the participants' responses were more mixed. A number of participants described a range of negative perceptions of their older patients including them being: vulnerable (P1, P9 & P12); isolated and lonely (P9 & P10); stubborn and unwilling or too proud to admit they needed help (P6 & P8); and short fused (P12). P7 felt that some of his patients had unrealistic expectations of physiotherapy:

> patients do sometimes think that we're going to come in and can waive this magic wand when they have been as they have /…/ after so many years (I: 823-824).

P15 reported that many of her older (85+) patients were more likely to take to their beds and show less motivation to engage in physiotherapy. P10 described how she felt that some patients were reluctant to go home as they were alone, lonely, unable to cope at home and liked the company in hospital:

> they get to the point where they're not coping anymore or actually yes they might not be coping because they're isolated and they're lonely I think sometimes, I suppose the admission is for the company actually and they are reluctant to go home for the company and the confidence I think, because actually going to a house on your own is quite scary where there is going to be nobody to call (I: 152-157).

However, P13 stated the view that most patients wanted to stay at home and P11 felt that many patients, particularly the oldest old, did not want to be in hospital but were simply unable to cope in their home environment:

> they know they don't want to be in the hospital, not at all would they want to be in the hospital but they've got all these issues going on and they don't know how to manage and they keep falling or they keep forgetting to take this bit of medication and yeah it's because they're probably living much longer that they're just not managing (I: 823-827).

P5 felt that his older patients took a positive approach to rehabilitation. P4 reflected this when she described how her older patients want to "*try and make the best of what they've got*" (I: 231) to enable them to improve and achieve a better quality of life and gave an example of the patient who had a very positive attitude towards their rehabilitation and who understood what was required to get them home. Positive perceptions of older adults described by participants included: being motivated and wanting to get better as quickly as possible (P1); really keen (P12); having morals, values and beliefs which meant that they listened to healthcare professionals and were easier to work with (P14); and being more interesting, funny and with life stories (P8). P5 described how some older adults were very active and able, whilst P9 felt that some more challenging behaviours demonstrated by her older patients were simply an attempt to take some control back and gain some recognition for who they were as people rather than patients.

Finally, P13 identified a gender-based discrimination between her older patients, with older women being described as more independent and determined to keep and regain this independence than their male counterparts and a perception that in the acute care setting her older male patients were more poorly than her older female patients.

Ten participants discussed perceived differences between their older and younger patients. A number of these related to the issues around complexity and perceived vulnerability of the older patient population as discussed earlier. P4 and P9 cited a longer recovery time in their older patients, P7 referenced comorbidities in these older patients that he would not anticipate finding in his younger patients, and P5 felt that those comorbidities impacted on rehabilitation and that his older patients required more support and could not be treated as intensively as he would treat a younger patient. Both P4 and P8 identified that discharge planning was easier for younger patients as the process was less complex, with P4 stating that it was harder to get some older patients home as they have less support available than their younger counterparts who have a better social network. P9 described not only a perception that there was a physical and mental difference between older and younger patients but that differences in expectations and lifestyles needed to be considered when working with an older patient population:

> Older bodies are different and older minds are different…and older people's perceptions are different, and routines are different (I: 854-859).

Conversely, when discussing more personality-related characteristics, participants largely described their older patients more positively than their younger patients. Older patients were perceived as: having a more positive attitude and wanting to get better in comparison to younger patients (P1 & P12); an easier population to negotiate with because they do what they're told to do (P14); easier to build rapport with in comparison to younger patients who are less willing to chat and may be attached to their phones (P14 & P3) and more independent than a younger population (P7). P4 felt that life experience facilitated a degree of resilience that was not present in younger patients:

> people are more accepting when you get into that bracket and they've got more age and life experience and they just go 'well I need to do it' or if it's what they've been through in the past. I don't know…they do generally seem tougher than getting a youngster up or if they are just, I don't know…first time they've been through something quite traumatic when you're in that younger age bracket and it just affects you a little bit more whereas when you've got that life experience you just cope with it a bit more (I:181-187).

P5 described how some of his older patients were actually more physically able than the younger patients he worked with and described how he would sometimes get an older member of the orthopaedic ward up in front of younger members as an example of what could be achieved in rehabilitation. P14 took a more nuanced approach and recognised that whilst older patients may have multiple comorbidities and may also be trying to cope with being carers themselves, younger people may have other social pressures that they are dealing with.

P8 expressed the strongest views and described how many of her younger patients were less compliant and, due to a range of what she perceived as more negative behaviours, were described as less deserving of physiotherapy time and input than her older patients:

> they treat the hospitals more as a hotel. They like being waited on hand and foot, they press the bell, someone comes and makes them a cup of tea even though they could get up and do it themselves (I: 268-270)
>
> I've had a man in his 30's, 40's who has made himself…well…he's an IV drug user and actually I think he can walk but he refuses to walk /…/ I'd be more forceful getting him up and mobile compared to a little old lady who's not got any sleep, who's in a lot of pain with a fractured hip, than a man who's receiving IV antibiotics who could walk if he could be bothered (I: 288-294)

Finally, reflecting P13's perceptions of gender differences, P7 described a perception that older adults had not been raised with the same support systems as those now available to a young population and were therefore more independent. Older men in particular were described as strong, independent, and not going to the doctor until absolutely necessary.

The older adult – Exploring the Findings.

Participants described a range of physical characteristics of their older patients which very much reflected characteristics of frailty. Xue (2011: p1) defines frailty as "a clinically recognizable state of increased vulnerability, resulting from aging associated declining reserves and function across multiple physiologic systems such that the ability to cope with everyday or acute stressors is compromised”. This loss of physiologic reserve and the resultant challenges in coping with acute stressors reflects participants descriptions of patients who can go from being well to being dependent very quickly and in whom stressors such as infections can have significantly more adverse effects than in most other populations. Although the mean prevalence of frailty increases with age, Kojima et al. (2019) stress that frailty is different and distinguishable from advanced age, disability, and comorbidity. However, these authors identify that frail older adults with comorbidities are more likely to require hospitalisation due to an increased risk of various negative health outcomes including falls, fractures, and acute illness. Not only does frailty result in a greater likelihood of serious decline with acute illness but it is also characterised by slower (and sometimes incomplete) recovery to baseline (Mudge & Hubbard, 2019). This is reflected in P4’s and P9’s descriptions of how their frailer older patients took longer to recover, needed more time to regain their function and took longer to get back to their baseline in comparison to younger patients. In addition, given that frailty is also characterised by muscle weakness and a low exercise tolerance (Xue, 2011), it is also to be anticipated that frailer older patients would be more likely to become further deconditioned during hospital stays and tire more quickly during their rehabilitation sessions. Given that frailty is overrepresented amongst acute hospital admissions of older adults (Mudge & Hubbard, 2019) it is therefore perhaps understandable that participants descriptions of the physical characteristics of their older patients reflect those described in the frailty literature.

However, whilst frailty maybe overrepresented amongst acute hospital admissions, frail older adults reflect one subsection of a general older adult population - many of whom may also be admitted to secondary care for a wide variety of reasons, both surgical and medical. Therefore, it is interesting that when describing their older patients my participants very much presented a picture that reflected this frail subgroup. During the interviews discussions about the older adults encountered in acute care were deliberately kept broad to try to ensure that participants were not led into discussing particular subgroups or presentations. However, it may well be that my participants experienced much more contact with frailer older patients due to their higher prevalence within acute care and that due to their frailty presentation, they required more physiotherapy input than their non-frail counterparts. As such, participants' descriptions may simply have reflected the bulk of their everyday contact and input with an older, more dependent patient population. The characteristics of the frailer older patients encountered by participants can also be linked back to the discussion in the first theme around the contrast between participants more personal experiences with healthy older adults and their clinical experiences with unwell older adults, with these frail older adults perhaps serving as that stark contrast to most of the older adults described by participants in their more personal relationships.

The more mixed behavioural and emotional perceptions of older patients described by participants can appear on initial review to reflect the ageist stereotypes and categorisation of older adults described by authors such as Widrick and Raskin (2010), Fiske et al. (2002) and Hummert et al. (1994). For example, the use again of the Widrick and Raskin negative descriptor 'vulnerable'. Negative descriptions articulated by participants such as stubborn, unwilling, too proud, and short-fused also fit within the 'disagreeable' stereotype highlighted by Widrick and Raskin (2010) as a characteristic of the stigma attached to older adults. In contrast, participants' descriptions of older adults being gorgeous and lovely (P11), funny (P8) and having morals, values, and beliefs (P14) could be argued to reflect the more benevolent stereotypical perceptions of an older population.

However, these descriptions of both positive and negative attributes overall reflect a mixed picture of participants' perceptions of their older patients. Some individual participants used a mix of both positive and negative descriptors at differing points in their discussions, suggesting a range of experiences in working with this population. These participants were also some of those who described a more mixed personal and pre-training experience of older adults in terms of health and ability – such as P1 who described grandparents with chronic illnesses but who were resilient and P12 who had worked with both largely independent and long-term care older adults. This perhaps suggests a potential increased awareness of a more mixed behavioural and emotional presentation based upon both pre-clinical and clinical experiences. In addition, many of the characteristics identified by my participants appear to be personality-related, including (lack of) motivation, stubbornness, positive attitudes to rehabilitation and engagement. Whilst it could be anticipated that patients of all ages would present with differing personalities which might in turn influence their engagement with rehabilitation there is specific evidence around factors influencing the health behaviours of older adults. Duberstein et al. (2003) found that the association between personality and subjective health was related to age. Neuroticism, the trait disposition to experience negative affects, was significantly associated with poor perceived health in those aged 75 or older and the authors suggest that greater age-related physical vulnerability may intensify maladaptive health behaviours – such as P15's description of many of her older (85+) patients being more likely to take to their beds and showing less motivation to engage in physiotherapy. However, extraversion was shown to have a significant positive affect on the self-perceived health of this older old age group. Etxeberria et al. (2019) in exploring the evidence around the role of personality traits in the subjective well-being of the oldest old concluded that whilst neuroticism and extraversion were key influences there were ultimately complex causal relationships between multiple indicators of personality and subjective well-being. Given that the older adults described by participants largely fitted within the frailer, more dependent older adult subgroup it is perhaps to be anticipated that for some their physical vulnerability may intensify maladaptive health behaviours whilst for others with a more extraversive personality their response to rehabilitation might be the trying to make the best of things approach described by P4. The combination of multiple comorbidities, frailty, impaired function, and social losses in the older old population are likely to present a significant challenge in which adaptive fitness and resilience are key to maintaining positive well-being (Etxeberria et al., 2019). Some participants do appear to recognise links between behaviours and individual situations - such as reduced motivation due to being overwhelmed (P1) and patients exhibiting challenging behaviours as a means of taking back control (P9). However, others appeared to have a less nuanced, arguably more stereotypical perceptions, such as the older generation per se taking to their beds when unwell (P15).

French (1990) in describing what she called the seven deadly myths of old age, highlighted that isolation and loneliness - two more descriptors cited by some participants - are perceived as typical characteristics of old age. However, frailty is not just physical in nature and the concept of social frailty can be described as insufficient participation in social networks and a perceived lack of contacts and support which can render someone socially vulnerable (Bunt et al., 2017). Social criteria such as living alone, lack of social support, reduced social network and limited social activities can be both predictive of, and criteria of, frailty (Bessa et al., 2021). The lack of contact with others in these circumstances is termed social isolation and there is evidence that this social isolation can result in sleep disturbance, depression, and fatigue (Choi et al., 2015) and has been identified as contributing to more adverse outcomes in a range of physical clinical disorders, including asthma, hypertension, heart disease and stroke (Tomaka et al., 2006). Social networks are crucial for the well-being of older adults, providing support to maintain independent living and to cope with life events. In a longitudinal study investigating the effects of frailty on social functioning in older adults pre-frail and frail older adults were found to have smaller social networks and higher levels of loneliness compared to their non-frail peers, with frailty being associated with an increase in loneliness over three years of follow-up (Hoogendijk et al., 2016). It is important to distinguish social isolation, the objective separation from others, from loneliness, a subjective feeling of being alone with or without others around (Tomaka et al., 2006), but Hoogendijk et al. (2016) highlight a link between the two. It may be that those of my participants who described their older patients as isolated and lonely recognise this link and may not simply be articulating a stereotypical older adult perception, as defined by French (1990), but may in fact be describing characteristics that they have recognised in their older patients where social frailty has formed part of the overall frailty presentation.

Finally, to the perception of older female patients as being more independent and more determined to regain independence than older male patients. There is statistical evidence around gendered differences in life expectancy (female: 82.9 years; male: 79.2 years) and disability-free life expectancy (female: 9.8 years; male 8.9 years), with older women expected to spend longer in poor health (11.3 years compared to 8.9 years for men) (Office for National Statistics, 2018). In addition, Consedine et al. (2005), when exploring sex and age cohort differences in socioemotional functioning and physical resilience in older adults, did report that there may be gender differences in ADL limitations and health, which they linked to differing clinical presentations – with older men being more likely to present with acute, life-threatening illness whilst older women are more likely to present with chronic conditions. Whilst the above may link to P13's perception that in the acute care setting her older male patients were more poorly than her older female patients it is difficult to find literature to support the gendered health behaviours she describes. However, it may at least partially reflect her personal experience of a grandfather who became quite isolated and less motivated following her grandmother's death.

Ultimately, participants demonstrated mixed perceptions of their older patients, which are likely to be a mix of some stereotypical perceptions and some perceptions formed from their ongoing daily interactions with a frailer patient population.

When exploring perceived differences between participants' older and younger patient populations much of the discussion centred around the complexity and perceived vulnerability of their older patients when compared to those who were younger, and the resultant impact on rehabilitation and discharge. As such, this very much reflected the issues around frailty discussed above. However, in contrast to this frailer older and less complex younger patient discussion where younger adults were less challenging to physically manage, there appeared to be a reversal of perception of challenges when it came to personality and behavioural characteristics. Several participants described characteristics such as older patients being more positive and more motivated, more compliant, more independent, easier to build a rapport with and more resilient than their younger patients. There is some evidence for resilience being higher in advanced age, perhaps due to life experience which can play a major part in resilience outcomes (Hayman et al., 2017; MacLeod et al., 2016); this would reflect P4's discussion around life experience and her perceptions about older patients' ability to cope "*a bit more*". In addition, when correlating stereotypes with personality, Chan et al. (2012) found that in adults in general (including those of similar ages to my participants) older adults were considered more agreeable in comparison to a younger population. Compliance was also rated as highest in an older adult population. Thus, at least some of age-related behavioural traits described by my participants would appear to reflect aspects of personality stereotypes of ageing. Even P5's description of his use of older patients as exemplars for rehabilitation, whilst at first glance appearing to be emphasising their abilities and recovery, could be argued to be an example of uncharacteristic characteristics (Gendron et al., 2016) in suggesting that if older adults are capable of that level of recovery, then younger patients should be able to achieve at least broadly similar outcomes.

Some descriptions did, however, seem to move beyond a potential generalised stereotyping. Both P1 and P8 when comparing and contrasting younger and older patients, articulated perceptions that seemed to imply some younger patients were less deserving of, or did not value, physiotherapy input. P1's story of his younger patient who did not listen to him or engage with his rehabilitation and P8's descriptions of challenging behaviours in some younger patients attest to the likely impact of individual significant patient-experience events in forming more generalised perceptions, whilst P3's suggestion that those under 40 are less willing to engage in conversation may suggest that she in turn engages with patients in a different way depending on their age – with an advance expectation that older adults will be more responsive.

6.3.3.2 Subtheme: The family.

Six participants discussed family involvement in the care of their patients. P13 explained the value of getting the family involved and having the family on board with the decisions made during discharge planning so that she could reinforce the need for support post discharge where the patient may be reluctant to accept help. P10 described how some families are more supportive than others and how where the family may be keen to get involved in care the physiotherapist needs to engage with them and often educate them as much as they educate the patient so that the best support can be provided.

However, participants described a number of challenges when family support may be required. P13, P10, P9 and P7 recognised the challenges that families themselves may face in trying to care for a more dependent older relative. P10 acknowledged that some families are unable to support their relatives as much as they might wish to, perhaps due to other family and work commitments, whilst both P13 and P7 recognised that some families might be getting tired or at breaking point and that families themselves may need support as well as the patient:

> I think families are having to do more for them…families, you know, a lot more are working now so families can’t always support them as much like they might have used to and families are getting tired (P13, I: 707-709)

P7 reflected on the sometimes-differing perceptions of patient and carers:

> I do have sympathy and empathy for relatives when you do speak to them ‘cos you do let a different picture. You might get a patient who comes in and says ‘oh I’m fine, yeah my daughter’s fine, blah blah’, but then you come to speak to the daughter [and] she’s absolutely drained, an emotional wreak and just ready to burst out into tears (I: 347-351).

Three participants discussed the challenges to discharge where the families lived a distance away. They recognise the difficulties faced by these family members in trying to engage with those looking after their older relative within acute care, but P6 also described the challenges that staff faced in trying to get in touch with distant relatives and get them on board with the decisions being made. He perceived relatives who lived further away as a barrier to discharge and who would challenge discharge decisions, due possibly to a lack of experiential understanding of their relative’s abilities or concerns about their own ability to offer support:

> it's just my experience is the further away they are the less involved they are, the more unrealistic they are with what they would have expected to happen from their relative coming to hospital because they don't know necessarily what they're doing day to day (I: 704-707).

His experience was that those relatives living nearer to the patient had a much greater understanding of what their relative could do and a more realistic expectation of hospital admission outcome.

Some participants articulated a recognition of the conflicting demands many families faced. P9 felt that for many families it was more a case that competing demands and busy modern family life made it more difficult for families to provide the support required post discharge, with the impact being that the patient cannot be discharged without other solutions being in place. She acknowledged an additional societal challenge where female members of families, traditionally those more likely to take on caring responsibilities, were faced with the competing demands of work, childcare and caring responsibilities.

P13 articulated a different slant to the patient-family dynamic in describing how some patients are themselves carers for others and how the role of the physiotherapist will involve getting support for patients themselves upon discharge so that they can better meet their caring demands and also have their own health challenges better supported:

> I think that's where we can help in getting carers involved, getting more support when the patient goes home, knowing that they're not on their own knowing that there is help out there…there's a carers support group as well, just letting them know they're not on their own (I: 721-722).

However, P7, whilst acknowledging that most families wanted their older relative to go home and some families may have reached breaking point, felt that some families needed to take more responsibility in relation to supporting their older relatives:

> families need to take more responsibility in certain aspects of a patient's life, 'cos again it's their relative at the end of the day (I: 331-332).

The family – Exploring the findings.

Six participants discussed the involvement of families in the care of their patients. As previously identified, teamwork is a fundamental factor in rehabilitation (Körner, 2010) and the involvement of both patient and family is crucial to effective MDT working in gerontology in order to establish the patient's wishes, feedback on progress and manage expectations (Ellis and Sevdalis, 2019). Indeed, involvement of families in transitional care/discharge planning has been shown to provide better health outcomes for both patients and families and reduce readmission rates (Thiengtham et al., 2022). These authors also highlight evidence that failure to address family caregivers needs during discharge planning can result in increased caregiver burden and stress as well as clinical deterioration of the patient and early readmission to acute health services. Where families are involved in care decisions the impact includes being able to provide them with a wealth of information which in turn can positively influence patient care (Hickman et al., 2007). For some participants this direct impact on patient care was a reason cited for gaining family involvement, such as P13's description of using the family to reinforce discharge planning decisions in order to gain patient compliance with these decisions and P10's discussion around the importance of engaging with family and educating them as well as the patient so that the best support could be provided. The concept of patient-centred care ensures that the planning and delivery of care is designed to meet the needs of both the patient and their family (Hickman et al., 2007). However, the focus of the discussion for these two participants seems to be centred more on using the family to help the participants deliver the rehabilitation and discharge planning they wanted to provide rather than taking a truly family-centric approach.

Upon discharge from acute care, older adults have reported being more dependent upon family members to help them perform their activities of daily living (Atwal et al., 2007). Family involvement in tasks tends to accumulate over time as older adults become less independent due to cumulative episodes of illness, frailty, and deconditioning: thus, the transition of older adults across different settings of care can also have significant implications for their family members who are the ones typically managing biopsychosocial and environmental risks (Gitlin and Wolff, 2011). The impact of care transitions on the health and well-being of families is closely tied to family structure with factors such as the density of family network, the characteristics of family members (spouse etc), competing roles and availability directly influencing the care that can be provided: families caring for older adults with long-term conditions, including dementia, are more likely to have poor health themselves, have depression, report substantial burden, be less likely to engage in healthy behaviours and be at higher risk for mortality (Gitlin and Wolff, 2011). Healthcare professionals need to be responsive to the priorities, needs and dynamics of all those involved when families provide care (Hickman et al., 2007). At a family level competing commitments both workwise and familywise, lack of time, and a sense of guilt or depression can all make rehabilitation and the successful transition from acute care to home or other discharge destinations more challenging not only for the family and patient but also for the healthcare professionals involved (Gitlin and Wolff, 2011). In addition, families may be reticent about being involved in the care of their relatives for many reasons, including there being disparate or mismatched needs, goals and perceptions between them and the healthcare professionals managing their relatives (Haesler et al., 2007). For those participants who discussed family involvement there were some apparent differences in the way challenges were described which may have been based at least partially on length of clinical experience. Arbon (2004: p1) argues that becoming an experienced healthcare practitioner is a progressive and ongoing interaction between “experience, meaning and lived world” that results in a more personal understanding of practice. It is likely, therefore, that for my more experienced participants (such as P9 and P10) greater life experience and increased clinical experience may have enabled them to develop a more nuanced understanding of the challenges faced by families than some of those articulated by less experienced participants. Indeed, some of my more experienced participants, such as P9, described challenging care-related personal experiences with older relatives, which may have provided additional context alongside their more extensive clinical experiences.

6.3.4 Theme: Challenges of and change in practice.

This theme explores the perceived challenges to participants' management of older adults within acute care and their experiences of change within this clinical environment and its impact on their practice.

6.3.4.1 Subtheme: Practice challenges

When asked what they thought the greatest challenges today were for physiotherapists managing older adults in acute care participants identified four issues: time, pressure on resources/beds, changed priorities and challenges with community resources.

Seven participants explicitly identified time constraints that negatively impacted on their ability to rehabilitate their patients effectively. These time pressures manifested in distinct ways. For P1, P11, P6, P7 and P9 these time challenges limited the amount of time they could spend with their patients and how effective they felt they could be in successfully rehabilitating those patients. P1 summed up the general consensus when he stated:

> We don't have enough time to rehab those long-term patients that could benefit from say twice a day input /…/ we're lucky if we see them 3 times a week…because our priorities have obviously changed. Our priorities are not to *rehab* those patients…our priorities are to get those patients who are medically fit out of hospital, so we have to work on them first and we have to make sure that all our discharges are seen prior to us being able to give those who need that specialist rehab input...the time that they deserve and that they need (l: 615-622).

P9 felt that this lack of time to spend with patients had a significant overall impact on the older adults she was working with:

> I think the biggest issue for them is that a day sitting in a chair without being mobilised will have massive consequences to their final outcome, confidence you know, fear, all

> the rest of it and I think then you are dealing with a bigger problem that you could have solved if you got more time and resources to put into those people (l: 744-748).

Furthermore, both P11 and P15 highlighted their perception that these time pressures and the limited time to work with their frail elderly patients simply resulted in repeat admissions and no time to address the underlying problems which were bringing the patients into acute care.

P15 described how these challenges were magnified by blanket referrals of older patients by other staff in the hospital who rather than checking themselves to see if there were any problems with mobility were instead referring *all* patients for mobility assessment prior to discharge, many of whom were mobile independently. Because these patients needed assessing prior to discharge they had to be prioritised by the physiotherapy staff, which again took them away from those patients requiring rehabilitation.

This negative impact on rehabilitation was at least partially perceived to be due to changed priorities within acute care. P6 reported that the focus was now very much on ensuring safe discharge rather than getting patients back to pre-admission baseline, whilst P11 described her role as "*literally treat and transfer*" (l: 711) and spoke about how her colleague perceived her role to be simply assessing and discharging patients home: *[she] "calls us discharge monkeys in the fact that we are there to discharge the patient, we are assessors at the end of the day nowadays"* (l: 715-717).

Both she and P14 described the rehabilitation that they had been able to provide for frail older patients earlier in their careers, their frustration that this could no longer be provided, the resultant negative impact on their patients and how they felt that the physiotherapy profession was now shifting out into the community, with P14 saying *"I know my patients progressed more if they were with me longer"* (I: 690).

P2 described how the prioritising of safe discharge often meant patients were being discharged home with maximal support rather than being given a rehabilitation bed, the result being a limiting of the potential for those patients to reach their full rehabilitation potential and an increased need for support. P4 reflected this when she described the impact of this earlier discharge in terms of trying to ensure patient safety:

> you'd have to send them home with more equipment and more dependent on others than you would have done a few years ago even (I: 607-608).

However, P3 acknowledged that due to discharge pressures physiotherapists had got better at steering patient discharge.

Ten participants cited pressure on resources and beds and described working in a very pressured environment. P1 highlighted that pressures on acute care services were consistent throughout the year:

> Winter pressures, so I don't think anyone has ever not had winter pressures. I don't think it's ever stopped during the summer (I: 634-636) /…/ that's not sustainable because if that that many people are coming in the front door, we certainly don't have that many people going out the back door (I: 639-640).

This "*sheer number of patients*" (P9, I: 751) results in pressure to get people out of hospital as quickly as possible, and the resultant focus on discharge planning rather than rehabilitation:

> that then flows through their patient's stay from a physio point of view and how much work you have to put in, because if you know everything you need to know about them

> and what there is to do…then you can put in an action plan and you can turn them round much quicker and that sounds awful but that is the way of the NHS. It's discharge mad (P3, I:186-189).

To compound the challenges in being able to rehabilitate their frail older adults due to the focus on discharge planning the majority of my participants (13 of the 15) highlighted problems with the community resources available to support their patients upon discharge. These were a combination of a loss of community rehabilitation beds to transfer patients into post-acute care, a lack of community physiotherapy provision, a lack of social care and a lack of family/support networks (as discussed earlier). P9 and P15 described how the challenges around social care, such as delays in the provision of care packages or lack of availability of assessment beds meant that patients were staying in acute care for longer, with resultant further deconditioning. The limited number of community rehabilitation beds rather than the patient's rehabilitation needs was seen as dictating the route of discharge:

> when community beds are at their capacity and there are no more community beds, but the acute trust needs them out you know that a patient's long term prognosis is dictated by availability of beds…you know...it's the luck of the draw whether you're the lucky one to get a bed or whether you're the one who gets sent home with 4 double up calls a day and that's how it will be (P2, I: 671-676).

Whilst the resources required to manage the more dependent patients in the community were identified as being so much greater (P11) and the lack of community rehabilitation beds meant patients were being discharged home, several participants identified a lack of community physiotherapy provision to rehabilitate these frail older adults effectively in the home environment. P4 described an expectation within acute care services that community services would pick patients up despite evidence that they did not have the resources to do this: *"we all know the community services aren't there in the capacity that we would like them to be"* (I: 666-667).

In addition, even where community services were able to support patients upon discharge there were delays to this support starting which meant that patients were not getting back to their baseline. These challenges to community rehabilitation were compounded by difficulties in communication with community therapists:

> I think this is a big thing for this hospital is that we don't have the communication with the community therapists like we should do. We don't…they never come in /…/ we don't have any communication, we don't know what services are available out in the community, whether they're changing, whether there's anything's developing, it's just all on the grapevine (P11, I: 376-380).

These time, pressure and resources challenges were concisely summarised by P2:

> Failing provision of community care… coupled with huge pressures on the acute trust, that then can very often lead to patients going home…without any expectation that…they will get any better than they are at that point of discharge (I: 635-637).

Participants managed these challenges in different ways. Some navigated the system to try to maximise opportunities to utilise other staff to help them manage discharge more effectively. The challenges in communicating with community physiotherapy services had led P11 to rely heavily on the intermediate care team as she felt more confident about their availability and the service they could provide. For P3, who felt some days she could spend most of her working hours trying to sort out discharge arrangements for one patient, the ability where possible to hand over this task to a discharge coordinator freed her up to work with other patients.

For many participants their primary coping strategy was to focus on the patients they were treating rather than engage any more than necessary with the pressures from above. P3 described how she focused on trying to achieve quality in her assessment and management as the more she knew about her patient, the more effective her action plan could be to enable her to tick "*every box*" (I:147) before the patient went home. P6 identified the need to ensure "*we do the best every time*" (I: 845) and how he tried to focus on "*enhancement*" (I: 846) and ensuring a broader approach to discharge planning that encompassed factors such as social interaction/support rather than just physical management. P15 described how she told her staff to focus on the quality of their assessment and treatment rather than the quantity of patients treated, as she felt that while some patients may not be seen every day the input they received would be more meaningful. For P14 this patient-centric approach extended to discharge planning and actively pushing for quicker community input. P2 summed up this patient focused strategy when she said, "*your allegiance is to your group of patients*" (I: 705-706), whilst P9 stated "*I would fight my corner for a patient and not think twice about it*" (I: 789) when describing her approach in response to the pressure to discharge patients.

Some participants described a change in the way they used their skills. P10 described an adaptation of her problem-solving skills to work within the constraints of these pressures, whilst P11 described a more gradual process of gaining information over time to try to identify underlying issues in response to the more limited time each day she could spend with each patient. For P12 a more extensive clinical experience enabled her to simultaneously prepare for two discharge options – home or rehabilitation.

Finally, a few participants were more sanguine (or resigned?) and appeared to accept the limitations imposed on them.

> "I suppose I can only do what I can do and I can only express my concerns" (P7, I: 421).
>
> "I can't do any more so you learn to live with it really" (P9, I: 805).

In contrast, P3, despite describing some coping strategies, reflected on her approach to discharges she did not agree with which involved making sure she had expressed her views and clearly documented her concerns to cover her liability in case of an unsafe discharge:

> So that's kind of how I get out of it because I just palm it off as it's not my problem. I'm giving you my professional opinion, this is what it is, I've documented it clearly because I always think 'well I'm not taking responsibility for this if something goes wrong it's not on my neck' (I: 696-699).

Another significant challenge when working with older adults in acute care was the complexity in clinical presentation, a challenge explicitly identified by 11 participants. Several participants articulated a perception that the patients being admitted into acute care were much sicker than they had been in the past, with some (P2, P10 and P13) ascribing this to patients being managed at home for longer and so being more poorly when finally admitted. The aspects of complexity described included older adults having several comorbidities, complex social histories, an increase in the number of patients with mental decline/mental health conditions that further complicated management and support and the impact of all those comorbidities on their frail older patients.

> the complexity of their conditions and how that might impact on them and, and the way in which they're presenting at that time and how…co-morbidities can have such a profound effect on somebody's sort of presentation in older life (P2, I; 347-349).

This led to a number of challenges in managing this patient group. P4 described how this management required physiotherapists to deal not only with the cause of the current admission but also to recognise the impact of the other problems the patient might have and to do whatever is needed to improve the patient's overall situation:

> just because you're on an orthopaedic ward doesn't mean that a person isn't going to turn up because they've fallen, because they've had a stroke and…kind of tunnel vision

> of not looking outside the box and not using that opportunity to try and improve somebody's life even if it isn't particularly related to what they're in hospital for that particular time. It's exploring and making that situation better for somebody overall (I; 504-509).

Some of the considerations around dealing with this complexity very much reflected those discussions around thinking outside the box and holistic management described by several of my participants when discussing their approach to practice (as discussed previously in the second theme). Managing this complexity was perceived as requiring an extensive skill set. P1 identified that physiotherapists working with this population needed to be an expert in numerous fields of medicine and to be able to incorporate all aspects of their patients' clinical presentations into one comprehensive understanding in order to get a full picture of the issues that needed addressing. P5 described how if a patient came in with a particular acute illness such as a chest infection there needed to be a recognition that comorbidities would tend to have more of an impact on their immediate clinical presentation. In addition, P11 identified that these complex presentations often resulted in recurrent readmissions which needed significant input not only from the physiotherapists but from many other members of the multidisciplinary team. However, despite these challenges there was a recognition of the value of managing these complex patients in developing physiotherapy skills.

> with elderly care you can have a mixed picture of a lot of things…you can go from having fractures to neurological patients to…you can learn a lot of skills just from one ward and have different patients on one ward so yes they might all be elderly but they will be a mixed picture whereas sometimes in your orthopaedic wards you just see those presentations /…/ when you're there and you're exploring you do have a lot of different skills and different patients and different presentations /…/ that you can keep your skills diverse in (P12, I: 807-814)

Finally, when reflecting on the above practice challenges some participants described a tension between their role as physiotherapists and the demands of the organisation they worked for. P1 described how other staff can become frustrated about the bed situation due to the organisational pressure to discharge and can take this out on therapy staff:

> we get people shouting at <u>us</u> because we are not moving these patients off, but we can't safely discharge [them] 'cos there's nowhere for them to go (I: 626-627).

P3 expressed frustration when management and flow coordinators missed "*that clinical link*" (I: 719) and could not understand why patients who were undergoing physiotherapy could not be immediately discharged home. P7 described times when it felt that he was trying to carry out his role but organisational systems and demands impeded this, although he recognised that the pressure coming from his managers had in turn been cascaded down from those above them.

> Seniors /…/ and obviously managers, and obviously our managers for Therapies and so on. Obviously, they've dealt with the pressures, which gets brought down [onto us] (I: 383-385).

Finally, P2 articulated an understanding of the competing demands of the organisation per se and the staff on the ground, highlighting that the therapists have a sense of commitment to the patients in their current caseload and not to the patients waiting to be admitted for treatment:

> there is a dichotomy between your loyalty to the trust and to the service you are being expected to deliver and the service you would deem to be for the patient's best interests (line 685-687) /…/ There are pressures put upon you by the trust /…/ 'we've to get as many patients out of the system as fast as we possibly can so what are you going to do to make sure that happens'? /…/ You don't have the same overall picture and you don't necessarily… Your allegiance is to your group of patients isn't it /…/ and not to the next lot waiting to come in because they're not your responsibility… yet (I: 694-697 &705-707)

Practice challenges – exploring the findings.

Older age is characterised by increasing comorbidities and more complex health presentations meaning that with increasing age older adults are likely to require more significant input from health services (WHO, 2022). Thus, as the global and UK populations age in increasing numbers so they place greater demands on these healthcare services. This ageing population, plus the ongoing advances in healthcare, have meant that healthcare professionals around the world are experiencing increasing demands on both their time and their professional responsibilities due to an increased workload and changes to their role definitions. Reflecting the experiences of my participants, caseload quantity, constant excessive workloads, complexity of patients and underuse of skills were key workplace stressors also reported back in 2008 by Australian physiotherapists (Lindsay et al., 2008), suggesting that in terms of clinical challenges to practice these issues have been present for some time.

A number of my participants identified aspects of perceived underuse of their physiotherapy skills and subsequent loss of caseload quality due to the focus on discharge planning and limited opportunities to rehabilitate their patients. Elderly patients are regarded as particularly vulnerable to pressures on acute care capacity, causing discharge processes to be adversely affected and resulting in more frequent and earlier discharge from acute care (Nilsen et al., 2019). A study of the perceptions and experiences of patients, family and healthcare providers across several European countries, found that hospital staff across their sample described how the organisational pressure of being required to discharge older patients due to the lack of bed availability was more likely to result in avoidable readmissions as patients were often discharged despite not being ready to go home (Hesselink et al., 2012). Physiotherapists play an important role in the discharge process and there is evidence that where physiotherapy recommendations for discharge are not implemented patients are more likely to be readmitted within a short time period, leading to yet more stress on the healthcare system (Matmari et al., 2014), with evidence that with unmet discharge needs patients are 2.9 times more likely to be readmitted within thirty days post discharge (Smith et al., 2010). This evidence supports the experiences of my participants where they describe the primary focus on discharge planning within their organisation and the subsequent repeat admissions of their frail elderly patients. In addition, Griffin and McConnell (2001) found that the role of rehabilitation professionals in acute care was seen as being primarily to assess and plan for discharge, as reflected in P11's descriptions of her role.

P11's descriptions of the rehabilitation she used to be able to undertake with her acute care older patients in a previous role demonstrates a recognition of the longer-term value of being able to invest in the rehabilitation of these patients. Benefits of acute care rehabilitation include: improved recovery, a greater likelihood of returning to baseline function, a reduction in hospital readmissions and ultimately a reduction in hospital costs (Matmari et al., 2019). Early physiotherapy input to frail older adults in acute care in the UK has been associated with a shorter length of stay and less likelihood of needing care on discharge, due to the prevention of hospital -related deconditioning (Hartley et al., 2019). It was evident from my participants discussions that they recognised the beneficial role they could play in rehabilitating their older patients, and whilst clinical norms may have changed (as highlighted by P11) there remained a tension between the constraints of the system and their perceived role and responsibilities in relation to their frail older patients. As such, the frustrations expressed at the constraints on their ability to actively rehabilitate this patient group prior to discharge are therefore understandable.

To ensure safe discharge healthcare professionals within hospitals need to not only optimise patient function but also ensure that they are appropriately supported by community services upon discharge from acute care (Matmari et al., 2014). Lin et al.

(2022), in discussing the factors associated with hospital readmission in frail older patients in Taiwan, identified that patients who received rehabilitation and exercise programmes post-discharge from acute care were significantly less likely to be readmitted within the three-month period following discharge. They highlight the need for timely continuity of care and the requirement for high-value community rehabilitation services to manage an older frail population effectively. For my participants there was a dichotomy between the community-based services they knew their older patients needed and the reality of a loss of rehabilitation beds, limited community therapy input and delays in this input commencing. Frail older patients discharged with limited physical function and without subsequent appropriate community rehabilitation are not only more likely to be readmitted but their subsequent need for rehabilitation significantly increases (Lin et al., 2022). This would therefore be likely to result in the cyclic discharge and readmission situations described by my participants as their patients became progressively more deconditioned and less able to cope functionally at home, consequently becoming progressively more vulnerable to physiological stressors and loss of functional homeostasis (Mudge and Hubbard, 2019).

The challenge of increasing complexity in their older patients was a significant focus of discussion for many of my participants. Frailty, multi-morbidity and disability overlap substantially in a significant number of the older adults accessing healthcare services (Calderón- Larrañaga and Fratiglioni, 2019). As a result of these age-related, multiple, accumulated deficits, a decreased physiological reserve, and a compromised ability to maintain homeostasis these patients are extremely vulnerable to adverse health outcomes as a result of quite minor external or internal stressors (Kojima et al., 2019). A bidirectional association between multi-morbidity/frailty and function has been described and whilst the diseases common to multi-morbidity may interact and result in physical and cognitive decline, physical and cognitive impairments may themselves affect the severity and burden of multi-morbidity, frailty and function (Calderón-

Larrañaga and Fratiglioni, 2019). Thus, a vicious circle of decline results. This complex clinical presentation becomes more common with advancing age, with the result that frailer older people challenged by seemingly minor stressors such as infections or medication change may be admitted to hospital with falls, reduced mobility, or delirium (Mudge and Hubbard, 2019).

There is significant evidence to suggest that appropriate interventions have the potential to reverse frailty and the health and social consequences of frailty, thus allowing people to stay at home for longer, and since 2018 contractual changes to the General Medical Services contract require general practitioners (GPs) in the UK to identify and coordinate the management of frailty within their patient caseload – with the aim of avoiding unplanned admissions to acute care (Alharbi et al., 2021). Thus, older adults living longer, gradually succumbing to frailty, multi-morbidity and disability over time and being largely managed in primary care all help to explain the degree of complexity and severity of illness presentations described by my participants in relation to their frailer older patients. The challenges inherent in managing such a complex patient population were summarised in P4's description, quoted earlier, of the range of comorbidities and problems an older patient may present with, and this highlights the need to deal not only with the immediate clinical presentation and problems, but also the impact of the more comprehensive multi-morbidity/frailty and function challenges the patient might have.

Evidence suggests that interventions focused on the management of frailty in these hospitalised frail complex older patients are effective, with multi-dimensional interventions covering physical, psychological, and social functioning demonstrating the greatest efficacy (Rezaei-Shahsavarloo et al., 2020). However, high-frequency physiotherapy (defined as an average of >0.5 contacts/day) for hospitalised frail older adults in the UK has been suggested to be an independent predictor of functional improvement, shorter length of stay and being discharged without a formal care package (Hartley et al., 2016). This evidence of the ability of physiotherapy input to effect significant change in hospitalised frail older adults serves to reinforce my participants' descriptions of the tension between the reality of a time-limited, discharge focused service provision and their desire for a rehabilitation-focused role that could make a longer-term more positive difference to their patients. This was compounded by organisational pressures and competing (and potentially conflicting) patient management aims, – summarised by P3 when describing management and flow coordinators who could not understand why patients who were undergoing physiotherapy could not be immediately discharged home. Current models of care for frailer older adults do not reflect the complex challenges of multimorbidity (Calderón-Larrañaga and Fratiglioni, 2019), and this would appear to be reflected in all the challenges identified by my participants.

Challenges such as time and resource limitations, workload, organisational and discharge pressures, and patient complexity are all potential workplace stressors. Indeed, workload is one of the most critical stressors within hospitals (Ahmadi et al., 2022). Moreover, a range of pressures within the workplace can result in role stress and ultimately role overload: role overload only results where individuals perceive they do not have the capabilities to cope with the collective set of demands being placed upon them (Stevenson and Duxbury, 2018). Similar to my participants, women healthcare workers in Canada identified a range of pressure factors influencing their roles including time pressures, volume of demand, familiarity (i.e., situations well known to the workers), duration of sustained pressures, regularly of occurrence and complexity; and the women working in clinical roles identified higher stress levels than those working in administrative roles (Stevenson and Duxbury, 2018).

Coping resources can mediate the relationship between the pressures of clinical practice and role overload (Stevenson and Duxbury, 2018), and my participants described several coping strategies. For some their primary coping strategy was to focus on their patients and disengage, where possible, from organisational pressures. Al-Hakim et al. (2022) discuss the concept of psychological meaningfulness, defined as perceiving a job in a meaningful way – being about helping the patient rather than delivering procedural tasks. They argue that psychological meaningfulness is about a positive feeling that work is worthwhile and meaningful and that it has been found to have a positive relationship to work engagement and commitment. In their study exploring the effects of psychological meaningfulness on workload and job satisfaction within nursing they found that, overall, their participants were satisfied with their jobs despite pressures such as heavy workloads and they propose that this was due to their participants' ability to focus on the 'caring' purpose of their role. It is possible that the patient-orientated coping strategies described by some of my participants are evidence of psychological meaningfulness and that, in concentrating more on the patient rather than the organisational pressures, this enables them to focus on the more meaningful and worthwhile aspects of their clinical role. This approach is perhaps encapsulated by P2's statement "*your allegiance is to your group of patients*" (I: 705-706).

Belgian nurses' experiencing time pressures in caring for hospitalised frail older adults, cited two main coping strategies: proactive strategies in which they dealt with pressures by proactively planning and adapting to meet the changing demands of their role, which perhaps reflects the approach of those of my participants who described changing or developing the way they utilised their skills – such as P10's adaption of her problem-solving skills to meet the pressured acute care demands and P11's more gradual information-gaining process to mitigate for time pressures; and a more survival-focused strategy where their focus was on survival in the face of work pressures rather than actively trying to find ways to change the situation (Dierckx de

Casterle et al., (2020). There appeared to be aspects of this survival strategy in the responses of a few of the participants, for example P9's statement "*I can't do any more so you learn to live with it really*" (I: 805). In addition, P3's refusal to take responsibility when faced with a situation where her recommendations have been ignored or rejected could also be seen as a survival strategy in the face of organisational pressures.

6.3.4.2 Subtheme: Othering and ageism

Several participants described aspects of perceived ageism within acute care, some more to do with labelling and some reflecting a perception of segregation of older adults within the hospital.

In terms of segregation, P11 articulated an observation that frail older adults were all "*bundled*" into one building that was external to the main hospital building and she characterised this building as "*an old building that epitomises older adults which I don't think is ideal*" (I: 829-830), and which had no rehabilitation facilities. As such, she felt there was a perception that the building was miles away and a completely different entity from the main hospital. While she described the nurses and staff on the wards as wonderful and the building having a massive community feeling she felt this had a negative impact on perceptions of the patients in that building, saying "*being put over there is an element of segregation*" (I: 899). In addition, because the patients who were most dependent and awaiting assessment beds were placed in two of the wards, she felt that this generated a perception that there were no discharges from the building as a whole, that everyone was stuck there.

Several participants discussed how labelling these older patients as frail and elderly had a negative impact on how staff perceived these patients. Whilst those working within the service called it the older adult service P11 felt that culturally within the organisation it was still labelled as frail elderly and that this was a disrespectful term to use:

> it's ingrained that it's the Frail Elderly therapy team, so I think there's still a perception of kind of dependency in a sense like 'older adults' doesn't suggest to me that they're that frail whereas frail elderly is kind of well derogatory isn't it really (I: 850-852)

P5 echoed this sentiment when he discussed how the physiotherapy rotation onto the older adult service was called 'frail and elderly' which he felt already labelled the rotation as frail and dependent in nature and as such facilitated a negative perception, sending a message that the rotation was slow and heavy in terms of workload. He felt that the term geriatrics itself had a stigma attached to it (dementia and frailty) and that calling the rotation 'care of older adults' would be a much more positive label.

Following on from the discussion in the first theme about chronology and ageing several participants discussed how using the age of 65 as an arbitrary definition of elderly worked to the detriment of more active and physically fit older adults who found themselves admitted to hospital wards via a process predicated solely on their age.

> The fact that people do seem to be living so much longer and leading so much more active lives etc doesn't seem to have caught up with the [national health service] /…/ There is still a perception that if you are at a certain age…you therefore fit into this frail elderly definition…and there is nowhere else for you to go in the hospital. You will end up on a ward that is a frail and elderly ward…that yes may be full of people who…are frail and dependent…but there is also a danger in that that you get lumped into the same way so everybody then gets treated in exactly the same way and you get treated by that label of frail and elderly (P2, I: 602; & 617-622).

P4 did acknowledge that there were pros and cons to cohorting all older adults together. There were benefits to having wards where the turnover was likely to be slower and separate wards for younger patients who would be more likely to have a quicker turnover and who might not feel comfortable being placed next to a confused older patient. Conversely, she felt it important to recognise that not all older adults (65+) are cognitively impaired or will rehabilitate slowly.

Finally, P5 identified additional challenges in areas such as orthopaedics where clinical practice and surgical protocols were very number-and age driven and, given that older adults were more likely to present with many of these pathologies, this could further reinforce a negative perception of those older patients.

Four participants discussed examples of perceived mismanagement of older adults within acute care which they felt were directly related to patient age. P8 described wards in the hospital where she felt the older patients with dementia were not managed effectively and where staff became angry with them when they got aggressive; P11 described her perception that *“culturally in the hospital patients are still dragged and mishandled”* (I: 644) and P3 felt that that other wards in the hospital did not manage older patients who were deteriorating effectively and would not necessarily escalate care if they felt that ultimately there would not be good outcome for the patient. However, she then described the frail elderly wards as being “*the worst for inappropriate management of unwell patients*” (I: 349) and felt that where other wards might step in and discontinue care the elderly care wards would often inappropriately steer clear of withdrawal of interventions. When discussing early clinical experiences with stroke patients on a general medical ward, P2 described how medical practitioners would sometimes withdraw medical input based on the perception that the patient no longer had any quality of life, a perception that she felt was based largely on the medical practitioners’ own personal opinions. When asked if she felt this still occurred today her perception was that the opposite occurred and that medical practitioners at times continued with active input when palliative care would be more appropriate, echoing P3’s comments.

Virtually all participants (13 of the15) discussed the negative attitudes held by others towards working with older adults. Working with this population was described as being perceived as: unfashionable and not glamorous; boring; slow-paced and unstimulating; not sexy; unrewarding; not well liked; dreaded; simply dementia patients and not a popular rotation.

Some participants described how physiotherapy staff did not want to get involved in working with older adults because they did not feel they could learn anything from this rotation. Most participants felt this was an erroneous assumption and participants such as P5 and P10 felt that it was up to senior staff to change these perceptions and to enable more junior staff to understand how rewarding it was to work with this population.

> *we* need to look at how *we're* supporting them in terms of their training and how they are engaging with older patients with complex needs and maybe some of it is they don't know what their options are and actually they do have quite a big list…patients take [longer to recover]…you don't always see the rewards the same as you might with someone who has been in an RTA and suddenly they're up and they're mobile and they're recovered and…yeah…you gotta look for different kind of rewards (P10, I: 696-702).

Several participants did recognise that physiotherapists may choose to work in other clinical areas for a variety of reasons and in their discussions, this was very much linked to the perceptions of the various clinical specialties and how they compared to working with frail older adults. P5's comparison of frail elderly to respiratory, musculoskeletal and neurology specialities cited earlier was an example of these different perceptions across the varied clinical areas.

P4 felt that the reluctance of staff to go onto the frail elderly rotation was less about the patients and more about wards and staffing levels. She did however acknowledge that working on a ward with just frail older adults was somewhat arduous:

> it's difficult to deal with those patients on a ward in a quite intense situation /…/ rather than on more of a sort of general ward where you've got a mix of ages (l: 240-243).

Overall, there was a perception that many physiotherapists, especially younger staff, preferred to work in fast-paced areas such as critical care or musculoskeletal outpatients. However, several participants did point out that the majority of staff would be exposed to older adults in other clinical areas and not just the frail elderly rotation, suggesting that the negative perceptions of working with older adults on this rotation may be due, at least partially, to labelling and stereotyping as well as the actual clinical presentations of those frailer older adults. P6 felt that there was a perception that on the frail elderly wards all the patients would have dementia, whilst other participants felt that staff came to those wards with preconceived ideas about patients' abilities and that physiotherapy input to patients on these wards was not very proactive:

> with the perception I think as well that would potentially…you know if it's a frail 90 year old…I think they do probably come out with a perception of what the person would be able to do (P9, l: 341-343)
>
> Still a perception /…/ we're still granny-dragging, so it's considered a sort of get up out of bed, move them along till they're ready to go to the next place. It's not seen as a particularly proactive area (P5, l :573 & 577-579).

Whilst most participants articulated these perceptions in relation to others P8 cited these perceptions as her own views and experiences of working in frail elderly, stating that the work was not rewarding or interesting, but somewhat tedious:

> people think it's…to be honest I agree I think it's…in terms of physiotherapy I think it's not much job satisfaction in terms of challenging your knowledge and your thoughts because every day you are just basically walking patients, and especially on some wards you're not even discharge planning because they've all come from nursing homes so you just need to maintain their mobility, and I think I agree I do think that is boring (I: 429-434).

She articulated a view that physiotherapists were not required to manage these patients and that technicians could achieve the same results, and that physiotherapists would either really enjoy working with this population or strongly dislike it, with nothing in between. However, this participant did explicitly discriminate between liking older adults and liking to work with them and described the work as boring but not the patients themselves.

Othering and ageism – exploring the findings.

Whilst the issue of cohorting frail older adults within acute care has been discussed previously in terms of the benefits of more coordinated management and better outcomes (second theme), the nature of this cohorting, in a separate old building away from the main more modern hospital building, did generate in some participants a perception of segregation. In addition, within both the organisation and the physiotherapy service, participants described a cultural labelling of the older patients within this service as "frail and elderly". Nye et al. (2022) discuss the concept of othering as a process by which people are excluded based on their perceived limited degree of adherence to the real or perceived norms of those groups. Within this process of othering, individuals or groups are labelled according to perceived differences from what is considered the societal norm: as such, these individuals or groups are categorised based upon these differences and in turn these differences are used to define them (Canales, 2000). Structural othering is where macro-level conditions, including institutional policies and practices, organisational culture and work environments may lead to exclusionary practices when patients do not easily fit into standardised clinical pathways or are perceived as difficult to deal with (Jacob et al., 2021). Frail older adults are complex to manage both physically and in terms of their wider health and social needs, and the acute care environment is one where there is significant pressure on beds and a high turnover of patients. Thus, there may be a disparity between the rehabilitation needs of many of these frail older patients and an organisational culture focused on quick discharge and turnover. Placing this frail older population in a separate building with limited rehabilitation resources and cohorting the most dependent patients and those awaiting assessment beds within this building may therefore suggest not only a physical segregation but also an othering of this population where they are perceived differently by the organisation in comparison to the majority of their patients who either recover and go home or have very clearly defined pathways of care.

Othering may be unintentionally exacerbated by identifying groups using terminology such as “vulnerable” (Browne and Reimer-Kirkham, 2014: p27), a term used both in the ageing literature and by my participants to describe the frail older patient population. In discussing their conceptual framework for ageism, São-José et al. (2019) describe how a cognitive component, i.e., “what we think about”, accounts for our stereotypical perceptions of older adults. With a general societal perception of old age as a time of dependency and ill health (van Dyke, 2016) and the use within healthcare of labels such as “frail” and “vulnerable” it is perhaps not surprising that many of my participants discussed the negative impact of this labelling on staff perceptions of this patient group (of more later).

Negative and potentially devaluing terminology can itself result in othering (Akbulut and Razum, 2022). The term “elderly” has long been considered ageist in itself and has been argued to be a form of prejudice or pre-judgement that shapes perceptions

(Avers, 2014), with *older adults* being the preferred and arguably more value-free term. This differentiation in value-based terminology was reflected in the dichotomy between institutional nomenclature and cultural practice described by P11 in her identification of how, whilst those working within the service called it the older adult service, culturally within the organisation it was still labelled as frail elderly. Interestingly, in exploring the views of older adults in terms of perceived ageism, Minichiello et al. (2000) found that older adults themselves preferred the use of the terms older or ageing as opposed to elderly or old as the former were seen as more positive terms.

This institutional and organisational labelling of older adults was reflected in the use of age (65+) as a determinant of ‘elderly’, with a perception by participants that older adults who did not reflect the physical and social challenges of the frail older patient were still categorised in this way by organisational practices that resulted in them being admitted to the frail older adult wards. The use of age 65 as a determinant of old is arguably a social construct based upon the now outdated traditional pension age in the UK (Abrams et al., 2015) and thus arbitrarily defines an extremely varied older population (Adhiyaman, 2017). Since the majority of those over 65 remain healthy and active, chronological old age should perhaps be redefined as 75+ and consideration given as to whether chronological age as a cut off for admission to frailty units is now an obsolete criterion without scientific basis (Adhiyaman, 2017). This suggests that the perceived labelling and bracketing of all those aged over 65 as frail and elderly, as described by my participants, reflects not only institutional ageism but a broader cultural misunderstanding of the variation in the older adult population within healthcare more generally.

Tadd et al. (2011) found evidence that healthcare staff almost unanimously felt that the acute ward environment was not the ‘right place’ for older people and cited challenges around competing motivations, such as the organisational priorities around high turnover versus the physiotherapy aim to rehabilitate. In addition, they identified that factors such as increased specialisation and a lack of knowledge about how best to manage complex older adults such as those suffering from dementia were significant barriers to effective and dignified care. Older patients may be perceived as different and that *different* ends up being translated into more *difficult* (Rybarczyk et al., 2001). This may be further compounded by a focus on terminology around diseases, deficits and decline that has been argued to present a reductive biomedical view of ageing which can result in a pessimistic view of the older adult patient population (Crutzen et al., 2022). Podhorecka et al. (2022) describe how numerous studies have demonstrated the existence of both under and over treatment of older adults due to clinicians confusing acute disease with physiological ageing processes. Whilst the instances of perceived mismanagement described by participants are a small number of personal accounts of experiences within one organisation, they would appear to reflect aspects of the differing management of an older patient population described in the literature above, such as P3's description of both a perceived under and over treatment of very unwell older patients. In addition, her comments suggest an element of contradiction in the premise that the cohorting of frail older patients ensures improvement in care and better outcomes (Hickman et al., 2007) given that the frail elderly wards were described by her as being the most likely to manage older adults inappropriately.

Within physiotherapy practice specifically, almost all my participants described how physiotherapy colleagues held a range of negative perceptions of working with frail older patients. Terms such as boring, slow-paced, and unstimulating, unrewarding, dreaded and not glamorous painted a picture of an unpopular rotation. There is significant evidence within the ageing literature that geriatrics/older adult focused professional practice has long been a less popular choice than many other clinical areas, both within healthcare more broadly and within physiotherapy (e.g., Waiserberg et al., 2023; Kydd et al., 2014; Dunkle and Hyde, 1995; Coren et al., 1987). There was also a perception by my participants that some staff felt that they would not learn anything meaningful from the rotation in terms of physiotherapy practice. This was explicitly articulated by P8, who felt the rotation did not challenge either her knowledge or skills and did not require a qualified physiotherapist to work with this group of patients. There may be several reasons for these more negative viewpoints. The nature of clinical experience in working with older adults whilst a student may positively or negatively influence the choice to work with this population once qualified and this may mean that some staff come into practice after having a more negative clinical education experience (Waiserberg et al., 2023). The use within healthcare of labels such as “frail” and “vulnerable” and the often -reductive biomedical view of ageing may perpetuate a pessimistic view of older adults’ capabilities in terms of rehabilitation. In addition, the organisational constraints noted previously in terms of a discharge focused service may result in inaccurate perceptions of the actual skills required in the management of frailer older patients in more newly qualified staff – complexity and a theoretical skill set versus the actual day job of mobilisation and discharge planning.

However, the picture may be more nuanced. Physiotherapy students have been found to have a preferred population or area of future practice, the choice of which was based on numerous factors which included personal experience, clinical experience, and educational components of their programme of study (Waiserberg et al., 2023). The choice of whether or not to work with older adults has been shown in some studies to be independent of attitudes towards older adults (e.g. Morris and Minichiello, 1992), perhaps reflecting P8’s differentiation between liking older adults and liking working with older adults, and factors such as ward environment and staffing (both identified as challenges by several of my participants) have been shown to adversely affect the choice to work with an older adult population (Herdman, 2002).

Participants highlighted that the majority of staff would be exposed to older adults in other clinical areas, and they perceived part of their role to be in changing and challenging negative perceptions and enabling staff to understand the rewards of working with an older population. Given the evidence around gerontological education and clinical experience (Blackwood and Sweet, 2017; Watkins and Waterfield, 2010), reflective practice (Flores-Sandoval and Kinsella, 2020) and experiential learning alongside experienced staff (Kydd et al, 2014) in changing attitudes, together with the narratives from my participants themselves in relation to their career development, this perceived role responsibility may well have some success. As Herdman (2002: p112) states, more newly qualified staff “will aim for areas in which they can consolidate and extend their skills, but their stated career aspirations offer few insights into their long-term career goals”.

6.3.4.3 Subtheme: Positive Change.

Despite the challenges articulated above some participants were able to identify some beneficial changes in practice both at an institutional level and within physiotherapy practice within acute care.

P5 described how he felt the organisation had significantly evolved in terms of its management of those with dementia and cited strategies such as dementia coordinators, redesigning wards so that they were more dementia-friendly and having a lead dementia nurse on each ward. His perception was that this increasing awareness around dementia meant that wards had developed new strategies to help manage those patients, with better integration of dementia management into both nursing management and therapy treatments, although he felt that within the organisation there was more proactivity in dealing with dementia from a nursing point of view than from a physiotherapy perspective.

P15 discussed several initiatives on the frail elderly wards. These included information leaflets given to patients on admission that were designed to challenge any perception of being unwell as “taking to our bed” and to reduce deconditioning by encouraging activity, both physical and cognitive, and regular team meetings to encourage physiotherapy staff (and students) to share ideas about service change and to then explore with them how those ideas could be implemented. This focus on service development also benefitted from cross pollination:

> staff who have rotated to us recently have started projects in other areas that actually translate nicely across to what we are doing so they’re able to carry on with their projects as well (P15, I: 340-342).

Finally, P6 reflected on how increasing understanding of complexity and long-term conditions and their resultant impact on older adults has benefitted physiotherapy as a profession.

> as the knowledge of the conditions gets better our interactions are going to get better and our therapy approach is going to get better. I still think we're doing the same manual techniques. we’re still doing the same approaches, we’re still mobilising people, we’re still providing equipment, we’re still managing any injuries they have, but it's working around the conditions…which is going only to get better with more evidence, more science, more scientific approaches (I: 657-663).

Positive change – exploring the findings.

Given that effective dementia management was mentioned by several participants in terms of the need to adapt management to get the best possible engagement from patients and the need to see the person behind the condition (see second theme), P5’s description of an evolution in organisational practice in managing this patient group suggests a move towards synergy in organisational and individual practitioner ideals. Admission to specialist geriatric wards within acute care in itself has not been shown to be sufficient to ensure positive outcomes for those with dementia, but strategies such as use of the Comprehensive Geriatric Assessment, environmental modification (such as colour coded bays as described by P5), minimisation of unnecessary disruption (such as those strategies described by P6 in the approach to practice theme) and staff training and increasing awareness around dementia management (mentioned by both P5 and P6) have all resulted in more positive outcomes (Hermann et al., 2015). In addition, geriatric wards perform consistently better than medical wards in all aspects of clinical care, including multidisciplinary management, with physiotherapy specifically cited as being of valuable input to this patient group (Ho and Nicholl, 2013). This differentiation between geriatric wards and general medical wards may also explain P8’s description of other wards in the hospital where she felt the older dementia patients were not managed effectively. However, it is interesting to note that P5 was in fact describing his experience on more modern orthopaedic wards. Whilst there *was* a differentiation in participants’ discussions about dementia management between frail elderly and general medical wards, the adaptations to the clinical environment described by P5, such as colour coded bays, had not been applied to the frail elderly wards, perhaps reinforcing this population being perceived differently by the organisation in comparison to orthopaedic patients with very clearly defined pathways of care. P5’s description of physiotherapy “*catching up with some of the awareness around dementia*” (I: 598) and following the lead of nursing in terms of improved care for dementia patients is evidence of a cascading of strategies beyond one profession in developing clinical practice.

This cascading of clinical practice development and enhancement was also evident in P15’s description of her facilitation of service change via regular team meetings to facilitate sharing of ideas and cross pollination as staff rotated onto the frail elderly wards and brought their projects with them. Reid et al. (2023) describe innovation in healthcare as being composed of *what* and *why* categories and in P15’s case the *what* seems to fit with the Reid et al. category of innovation in practice and process and the *why* around several Reid et al. categories, including improving people's (patient's) experiences and changing behaviours. The challenge of minimising further physical deterioration and rehabilitating those with deconditioning has been identified by my participants in most, if not all, themes thus far and P15's description of strategies to keep older patients active reflects campaigns to end 'pyjama paralysis' – the process whereby older patients in acute care have been found to spend more time in bed when wearing nightclothes compared to their day clothes, with resultant significant deterioration in mobility and increased falls risk (Fitzpatrick and Gallagher, 2019). Whilst the strategy of keeping patients active is evidence-based, the underpinning reason why older patients are less active when wearing nightclothes is less well explored and it is interesting that whilst there may be several reasons for this behaviour (including nightclothes being perceived by patients as denoting illness), P15 ascribes this more sedentary behaviour to older adults culturally taking to their beds until they feel better, an arguably ageist perception.

Whilst complexity was perceived as a challenge by many participants, P6 saw this complexity as facilitating an expansion in physiotherapy knowledge and skills. For him, whilst the fundamental practice of physiotherapy was seen as remaining the same, the understanding of the underpinning concepts (dementia, long term conditions) was evolving. Thus, the experiential learning resulting from practice challenges was less impactful on fundamental physiotherapy techniques and skills and instead seen as impacting more on the application of new knowledge and understanding to physiotherapy practice. This reflexive monitoring or evaluation of how new knowledge and understanding impacts on current work may lead to critical questioning of current taken-for-granted (situated) aspects of patient care (Sanders et al., 2014) and, in P6's view, result in progressive learning and enhanced practice.

Overall, whilst there were some very strong messages around the challenges of working in acute care there was evidence of more positive changes in practice to, in at least part, mitigate some of these challenges.

6.3.5 Theme: Communication and engagement

There was a small but distinct theme around communication and the ability to engage with others as key skills for practitioners, students and patients and this theme explores the different aspects of communication and engagement identified and discussed by participants.

6.3.5.1 Subtheme: Impactful skills

Communication skills and the ability to engage with older patients effectively were perceived as having a significant impact on the potential for successful patient management. For P3, P12, P14 and P15 building a good rapport with the patient and putting the patient at ease meant that they were better able to find out more about that patient and what they wanted from physiotherapy:

> if you're not really engaging with them then I don't think you're going to get the best results (P12, I: 271-272).

Both P3 and P13 also perceived this ability to connect with patients and their families as engendering, and enabling them to build on, trust.

P1 and P11 discussed the need to engage with families straightaway so that they could address any specific concerns families might have. P11 described how in her experience family members were often very cautious and risk averse to having older adults home and how engaging with those family members as soon as possible meant that she could show them what her patients were capable of doing and could explore the support families could offer so that discharge was not delayed.

The importance of effective communication with multidisciplinary team was identified:

> you're much more heavily reliant on your MDT for the older adults and they regularly have board grounds which is ideal as you get that communication initially so you're working on it as a team (P11, l: 907-909)

P11 described the need for open and assertive communication with members of the MDT and felt that she could always approach staff with concerns or raise issues and that she was listened to and could normally get the result she wanted, as well as being able to hand over situations or issues she was not equipped to deal with herself.

P15 discussed the challenges where nursing staff were reluctant to mobilise any patients, regardless of mobility status, until they had been assessed by a physiotherapist. In terms of individual patients her communication centred on identifying a goal, reporting this to the nursing staff and giving them the confidence that they could manage the patient without further physiotherapy input. In terms of changing staff perceptions more broadly she described various educational strategies she had employed with some success, including leaflets, presentations, posters on the ward and information on the trust intranet.

Impactful skills – exploring the findings.

Therapeutic communication is a process of using both verbal and non-verbal communication to connect with patients (Rosenberg and Gallo-Silver, 2011), and the quality of communication between healthcare providers and patients has been shown to have an important influence on patient outcomes (O'Hagan et al., 2013). Effective communication has been linked to improved adherence to therapeutic interventions, increased psychological well-being and better biomedical outcomes (Ambady et al., 2002). Within a study exploring effective communication within nursing O'Hagan et al. (2013) found that empathy and rapport were identified as key to patient-centred practice. It was evident that my participants recognised and valued the need to build a good rapport with their patients in order to achieve a better outcome, highlighting the importance of effective communication in enabling them to establish this closer relationship.

This appreciation of the value of effective communication extended to the families of their older patients. Communication issues have been highlighted as extremely important to the families of hospitalised older adults (Gitlin and Wolff, 2011) and, as identified earlier, there is substantial evidence that family involvement provides better health outcomes for both patient and family (Thiengtham et al, 2022). Both P1 and P11 highlighted the need to engage with families to address concerns, and P11 described utilising that engagement to enable families to more fully appreciate their older relative’s potential for rehabilitation, recovery and discharge. Exploring the evidence around hospital discharge for older adults with dementia, Stockwell-Smith et al (2018) found that families often feel excluded from decision-making processes and that family carers had limited confidence in their ability to support their older relatives post discharge; and it would appear that these two participants had not only experienced this but recognised the value of effective communication to mitigate these issues.

Frail elderly is an area where multidisciplinary (MD) or interdisciplinary (ID) teams are essential to best manage the complex needs of an older adult population within healthcare, and quality of communication between team members has been identified as one of the top three factors crucial for effective collaboration and decision making, alongside respect for other team members and having similar perceptions (Abramson and Mizrahi, 1996). Ellingson (2002) highlights the value to effective patient care of both formal meetings, such as the board rounds mentioned by P11, and more informal communication channels such as conversations between individual team members. For P11 not only did the formal board rounds ensure a coordinated approach to care but she felt able to approach individual team members for both information and support in decision-making in relation to patient care – indicative of effective team working. P15 also described the value of team working but when discussing communication highlighted differing role expectations between herself (and her team) and the medical practitioners and nursing staff. These differing role expectations reflect the challenge of multidisciplinary teams where professional autonomy is high and the focus on individual professional responsibilities can override cohesive team working (Körner, 2010; Ellingson, 2002). P15's utilisation of a range of educational strategies to overcome this mismatch in role expectations was an example of how a range of non-verbal communication strategies can also be utilised to reframe understanding within a team.

6.3.5.2 Subtheme: Being an effective communicator.

Thirteen of my 15 participants described communication as being a fundamental skill for physiotherapy, with some examples below:

> part of the art of learning to be a physio is learning to talk to someone and just engage in conversation (P14 I: 457-458)
>
> communication… That's your gateway to understanding the patient (P5, I: 500-501)
>
> a lot of the job is being able to understand people, having their best interests at heart and having the confidence to be able to start conversations with anyone and everyone (P8 I: 580-582)

Several participants described how this ability to hold a general conversation was a precursor to most other aspects of their role as physiotherapists. Being comfortable with how to start a conversation and make small talk was perceived as making it easier to start a professional dialogue and made it easier to ask questions in a more natural way, which often resulted in patients providing the therapist with more information than direct questioning would achieve, could yield information that the therapist could use to motivate the patient, and help prepare more effectively for discharge. P10 described the need to use conversation to find out more about the patient as a person so that a stronger therapist: patient relationship could be developed, and the need to find "*an aspect of who they are that you can talk to them about and build that rapport*" (I: 436-437).

Several participants discussed intergenerational communication with a focus on the differences of approach between students and/or younger healthcare professionals and more experienced staff and described factors that were perceived as resulting in less effective communication strategies in this younger population. P1 felt that younger professionals and support staff tended to be too formal and didactic with older adults, rather than building a partnership: "*it's more kind of ordering rather than actually working in collaboration*" (I: 229).

He went on to describe how he took a different, more friendly and engaging approach, using humour and persuasion, to connect with them as adults in order to work collaboratively:

> you have to charm the old ladies… You had to have a little bit of a laugh and joke with the old men because that's what they used… That's what they want (P1, I: 234-235)

P15 also perceived challenges in the generation gap and described how she felt that it was difficult for the younger generation to start a conversation with someone from an older generation because they were unsure what they had in common or where to start the conversation. P11 felt that many younger people were scared of talking to older adults because they had little or no experience doing this and were unsure how to start and maintain a conversation with someone from this generation. For P3 this struggle to relate to much older adults was seen as potentially relating to personal relationships where even students' grandparents were likely to be younger than the older adults in acute care. For these participants their initial strategy with students and younger staff was simply to get them to sit down and chat to patients and find out more about them.

P7 felt that that this ability to be able to converse with patients would then translate into more effective communication with other healthcare professionals. P3 highlighted that clinical skills could be taught whereas appropriate non-verbal communication to perhaps offer reassurance or respond appropriately to emotional distress was more difficult to teach:

> it's much harder to teach someone to smile at an appropriate moment or you know the patients crying what do you do, kind of, if you just freeze (P3, I: 497-499)

P9 highlighted communication as a fundamental skill for physiotherapists, and how the use of voice can enhance the varying roles and tasks that a physiotherapist has to achieve:

> it has to be one of the essential skills really because if you can't communicate then you can't… You use your voice for everything… Treatment, assessment, consent, reassurance, motivation, enthusiasm (I: 452-454)

In terms of the dos and don'ts in communicating with older patients, participants talked about the need to spend time talking to patients and using a conversational style rather than more direct questioning (P6, P12 and P14), and exploring patient responses rather than just accepting an initial response (P14). P6 described finding out the story of a patient's daily routine rather than using specific questioning, recognising that being able to guide this story was itself a skill. P1 identified another perceived value of effective communication in his practice when he described it as empowering patients *"to be actually making decisions the themselves rather than telling them what to do*" (I: 218), whilst P14 recognised that although therapists could tell a patient what to do, the patient may not choose to do this and it was the therapist's role to use communication to find "*that middle ground of concordance*" (I: 281-282)

Being an effective communicator – exploring the findings

Skilled and appropriate communication is a key tenet of effective practice and professional competence within physiotherapy (Parry and Brown, 2009); this is reflected in its inclusion as a standalone standard within the Health and Care Professions Council (HCPC) Standards of Proficiency for Physiotherapists (HCPC, 2023) and the Chartered Society of Physiotherapy (CSP) Code of Members' Professional Values and Behaviour (CSP, 2019). Within both documents there is a strong focus on the ability to utilise and adapt both verbal and non-verbal communication within all relevant aspects of clinical practice, and P9's description of the essential value of verbal communication – "*you use your voice for everything*" (I: 453) highlights this clinical importance.

Whilst communication between physiotherapists and their patients is often task centred (i.e., content-focused) considerable relational or affective components such as empathy, tone of voice and sensitivity to patient needs are required to ensure these interactions are effective (Roberts and Bucksey, 2007). For my participants building a therapeutic relationship with their patients required them to gain a more holistic understanding of that person and establish a rapport and the ability to engage in general conversation was seen as key to this process. The Cambridge Dictionary (n.d.) defines conversation as a "talk between two or more people in which thoughts, feelings, and ideas are expressed, questions are asked and answered, or news and information is exchanged" and this definition effectively summarises not only the content and affective components of communication required for successful therapist–patient interaction but also a more informal interaction style which enables effective engagement and is perceived as being key to achieving best patient outcomes. Conversational interviewing is an approach recognised more in the field of business and can be described as a two-way conversation with a free exchanging of questions and information to enable employers to gain a better overall perspective of candidates.

The conversational style advocated by my participants reflected a similar two-way exchange which they felt enabled them to not only more fully explore and contextualise patient responses but also helped empower patients and achieve concordance in a way that a more formal communication approach would not.

Generational challenges in communication were discussed by some participants, with a perception that younger staff and students were less able to achieve an effective communication style with older patients compared to more experienced staff. P1's description of the strategies he utilised – charming the old ladies and having a laugh and joke with the old men – appears on initial review to be rather stereotypical in terms of anticipating the communication needs of an older population. However, McCabe (2004) in exploring nurse-patient interactions found that friendliness and humour were highly valued by patients and in themselves helped establish rapport and trust. Effective person-centred communication is closely linked to experience (of which more later) and this participant, with several years of varied clinical experience, evidenced an understanding of this, perhaps reinforcing his perception of the directing or *'ordering'* approach of younger staff being a less successful communication strategy. In addition, the perceived generational challenges in communication described by P15 and P3 would seem to reflect earlier discussions around previous experiences with older adults and it perhaps would be anticipated that those with limited prior contact with an older population would struggle more to find a common ground in general conversation. Given that those coming into acute care are most frequently the very old it is also highly likely that even those with older relatives might find this general communication challenging given that their older relatives, such as grandparents, may still be significantly younger than the very old population they encounter in clinical practice.

6.3.5.3 Subtheme: The novice communicator.

When asked specifically about the communication skills of physiotherapy students most participants described a range of challenges in terms of student communication. Some reiterated the perception of generational challenges. P14 observed that younger students found speaking to people in general quite challenging, whilst P4 observed that students seem to be able to make connections with younger patients more successfully than older patients and postulated that this may simply be that they felt they had more in common with this younger patient population. P3 and P10 suggested that differences in language and terminology between younger students and older adults (societal, cultural or area-specific) might potentially adversely affect intergenerational communication, whilst P15 felt that students might not want to ask the patient about family in case the patient did not have much family and she felt that communication preparation was important in enabling students to understand how to approach family-focused conversations with patients.

There was some recognition that personality also played a part in students communication abilities with older patients, with P13 identifying that shyer students were less likely to have conversations with patients without facilitation by, and encouragement from, their clinical educators. P4 described many students as being a bit timid when talking to patients and demonstrating closed body language when placed in those situations. She felt that her students often were so focused on the patient’s clinical presentation at that moment in time that they could not see beyond this to a person who had lived a long life or use these life experiences as a basis for communication and building a relationship with the patients:

> [they are] stuck in that one moment, in that point in time, rather than knowing that the patient has had this whole life before that they could talk to them about or their own interests that they could talk to them about (I:432-434)

However, some participants demonstrated what appeared to be stronger negative perceptions about students’ communication skills. P1 highlighted his perception that there may be a mismatch in communication styles between the generations, causing a barrier to effective interaction:

> [the] *the youth of today has changed and the way they interact with people is not necessarily the way the elderly people expected to be interacted /…/ with* (I: 212-214)

He had observed younger students struggling because they tried to be really strict with older patients and felt that mature students were overly mothering and caring when patients wanted to be spoken to as adults. He also identified how he felt students lacked the ability to relate with patients’ families and as a result found those interactions quite difficult, but observed that this was a communication skill that came with experience. P10 felt that some students could be a little more patronising when it came to communicating with older adults, whilst P9 described how some older people did not like being told what to do by younger people, and felt that students needed to learn that there were different ways to get the best out of a person without simply being directive or “*telling them what to do*” (I: 538).

Several participants did discuss the specific communication challenges faced by students working with older adults within acute care. P11 described instances where there was a barrier to communication, such as hearing impairment, and the student had withdrawn from the communication situation and needed help in exploring how communication could be made more effective. P4, P7and P8 discussed the specific challenges of communicating with someone who was cognitively impaired or confused. Both P4 and P8 accepted that students might be scared to engage those types of patients in conversation or struggle with how to cope with what those patients might be telling them, and both participants recognised the degree of support some students might require in these situations. For P7 and P12 one of the biggest challenges facing students was the ability to adapt their communication and develop a repertoire of communication strategies for the wide range of older patients and complexities they would encounter:

> I've had some others who I think may struggle communicating anyway so communicating with a complex patient for them, someone who is hard of hearing, someone with dementia, somebody who is just demoralised generally by being in hospital, all those things /.../ I think make communication a lot harder in elderly care (P12, I: 508-512)

Less information was offered by participants when asked about students' communication strengths, although there were some positives described. P2 felt that what students actually did really well was empathise and communicate effectively with older adults and that they related well to this population. For her, unless she had a particularly poor student who could not relate to older patients, this empathy and communication was the starting point for the clinical education experience. P12 when asked what students did well in clinical practice cited most of them as being strong in terms of communication skills, with a perception that mature students were much better in this respect. P10 felt that some students were much better at building rapport and breaking the age barrier than others, whilst P14 described some students as very good, and very fluid, at adapting and amending communication.

Participants described a number of strategies that they used to facilitate development of students' communication skills. For some, such as P4, P11 and P15 this was very much about encouraging their students to simply have those general conversations with older patients in order to build students' confidence as well as encouraging them to give patients time to respond. When using this strategy P4 distinguished between students who were in their first year of training, where she used this strategy often, and those in their second year onward who she felt could already hold a conversation with the patient and were not perceived as needing this general conversational practice. However, she reflected that her strategy of encouraging general communication with older patients may actually be relevant for most students regardless of stage of training. She also felt that evidencing these communication skills in her own practice was in itself a learning tool for students. P5 described an approach where he encouraged the students to use and adapt the skills they had learnt through university and previous placements, whilst P8 focused on developing communication skills via various aspects of clinical practice, including taking a social history and contacting the next of kin of those patients with dementia to find out relevant information. P1’s overall approach was to put physiotherapy students into uncomfortable situation where they had to work hard communication-wise to develop the skills they will need once qualified.

The novice communicator – exploring the findings.

Reflecting the generational challenges discussed in relation to the second subtheme, some participants described similar challenges in relation to physiotherapy students specifically. Health care students have been shown to express significant concerns about their communication skills (Corless et al., 2009), and apprehension about communicating with patients and a self-perceived low communication competence can act as barriers to communication and interaction efforts (Morris, 2021). Thus, additional challenges such as perceived intergenerational differences in terminology and language or a lack of a similar frame of reference may further hinder effective communication. Students can be concerned about saying the right or, in particular, the wrong, things to their patients (Kotecki, 2002, cited in Corless et al., 2009), reflecting P15’s observation about students being reluctant to ask about family circumstances. Some of the common challenges of working with older adults, such as hearing impairments, poor eyesight and memory loss, can be additional barriers to effective healthcare-patient interactions (Park and Song, 2005), and several of my participants reflected this in their discussions. Developing communication skills is an ongoing process as students integrate prior learning (university-based) and clinical experiences, and novice students on older adults placements faced with the challenge of a fast paced environment and the communication challenges often evident in the management of this patient population – and in particular those students who are apprehensive about communicating - may avoid contact with patients and require additional support to engage, as identified by P4 and P8.

The Dreyfus model of skill acquisition (Dreyfus and Dreyfus, 1980) explains how novices (those with no situational experience) tend to be inflexible and struggle to link didactic teaching and clinical context. Advanced beginners begin to recognise situational patterns and can start to problem solve whilst competent students, those with extensive experience, possess more strategies and demonstrate flexibility in adapting to communication challenges (Morris, 2021). This model helps support my participants' observations that, in general, mature students have better communication skills (greater life experience) and that students further into their training were more able to hold a conversation with patients (greater clinical experience). Communication skill acquisition continues post-registration as healthcare professionals become proficient and finally expert – able to act intuitively and respond flexibly and situationally (Morris, 2021). An understanding of this developmental process was evidenced in several of the strategies described by participants to facilitate communication skills, including role modelling as an expert practitioner. P1's perception of the way both younger and more mature students struggled to communicate with older adults is likely derived from his expert skill perspective. However, his generalised comments appear ageist, and his description of putting students into uncomfortable communication situations may suggest more limited understanding of the support requirements for the acquisition of communication skills and progression from novice to advanced beginner to competent communicator, and/or perhaps unrealistic expectations of students' communication abilities.

However, evidence suggests that communication skills within the clinical setting are not dependent on experience alone (Moore et al., 2010). Both emotional intelligence and emotional regulation have been shown to directly influence the efficacy of healthcare professionals' communication. Emotional intelligence (EI) is the ability to monitor both one's own and others' emotions and use this information to guide thinking and actions; effective patient-centred practice requires staff to be able to identify and respond appropriately to emotive discourses with patients (Cherry et al., 2013). Emotional regulation (ER) refers to an individual's ability to respond to and manage emotional experience and expression effectively (Eweida et al., 2022). EI and ER have both been shown to influence healthcare professionals' (HCP's) communication skills. EI is considered a significant predictor of healthcare students' self-perceived communication competence (Morris, 2021) whilst higher EI results in HCP's being better able to respond to and communicate patients' needs, leading to better patient care (Cherry et al., 2013). Effective ER is important for managing challenging clinical communication situations (Eweida et al., 2022). Whilst EI and ER may be higher in some individuals than others there is significant evidence that both can be learned or enhanced via a combination of motivation, experience, extensive practice, feedback, and reinforcement of this new learning (Eweida et al., 2022; Serat, 2017: p336).

A variation in students' EI and ER may help explain the differing perceptions of students' communication challenges and strengths amongst my participants – variations that would be further influenced by factors such as students' previous life experiences, clinical experiences and/or previous experiences with older adults. Reassuringly, the majority of the strategies used by my participants to develop students’ communication skills reflected the extensive practice, feedback, and reinforcement of a new learning approach as advocated by Serat (2017: p336).

6.3.6 Theme: The clinical education experience

This theme explores those aspects of the clinical education experience that my participants perceived as important to their education of physiotherapy students.

6.3.6.1 Subtheme: The clinical education environment

Participants felt that there were experiences and skills that could only be learnt and refined in the clinical environment. Following on from the fifth theme and the discussions around the importance of communication and the challenges faced by the novice communicator, nine participants discussed how effective communication with older adults could only be learnt by interacting with this older patient population in clinical practice, as summarised by P12:

> I don't think you can teach someone how to communicate with an elderly person without communicating with an elderly person so you can't do that at University, that has to come from here/…/That's the reason they're here isn't it (I: 670-672).

A number of my participants highlighted a need for a translation from theoretical learning to clinical application to ensure students achieved authentic learning and were able to manage older patients effectively. P2 and P6 felt that learning about patient management within the university setting could not prepare students to manage successfully either a confused patient or a patient who refused treatment, whilst P10 highlighted the importance of understanding real-world presentations that are complex, which cannot be experienced in a university setting: *"never going to encounter the complexities that patients come in with in a lecture theatre"* (I: 548-550).

For P10 and P11 the reality of clinical exposure enabled students to successfully apply assessment skills and develop their clinical decision-making. P12 and P13 discussed how it was only by applying practical skills learnt in university to the older patient population that students could understand the particular challenges faced by this population, and that students need to appreciate that working with them is not easy:

> sometimes when you go to stand a patient who is like max assistance of two I don't think they realise how much effort you have to put in to do something like that, so I hope when they're finished their placement they do realise how difficult…because when you're in your classroom it's quite easy to stand somebody who can stand up anyway…so hopefully they have more understanding on how difficult it is and how much effort is needed (P13, I: 523-528).

For P5 it was about students seeing the difference between theory and the reality of practice i.e., *"what the book says compared to what we see clinically"* (I:424).

Several participants felt that working with older adults in acute care offered learning opportunities and experiences that students would not gain in many other placements. For P1 this was around understanding and managing the complexity of long-term conditions whilst for P4 it was the opportunity to gain experience in holistic management. P7 and P13 described the benefits of working with a broader multidisciplinary team and how students could gain leadership and managerial experience as part of this involvement (e.g., speaking on board rounds). P7, P12 and P13 reflected upon the variety of conditions encountered:

> you might do a bit of respiratory; you might do a bit of neuro, you might do a bit of msk so it covers all areas as well (P13, I: 833-834).

Furthermore, P13 reflected on how students working with older adults have the opportunity to gain some of the less familiar skills such as discharge planning.

P9 described how those clinical experiences working with older adults helped students understand the factors that might mean older patients needed to be treated differently from similar younger patients, for example, when they had more extensive social support needs. P15 stressed the importance of clinical practice in engaging students more fully in the reality of older adult practice, which helps them to gain more appreciation of the older adult. "It's just *having the exposure and the experience/…/ that changes your perception* [of older adults]" (I: 713-714).

P7 described working with frail elderly as "*a massive confidence booster*" (I: 591) in terms of learning to manage a range of problems and abilities and P5 suggested that all students should have a frail elderly placement as part of their core learning to develop their practical experience and communication skills with this population.

These clinical placements were perceived as helping students to gain an authentic experience, but not with the expectation that the student had gained all requisite knowledge prior to the placement:

> I don't know that there is an expectation that were gonna get students coming out [onto placement] having been taught everything, that's not the point. The point is they have these placements in order to be able to learn from real life (P2, I: 469-472).

The clinical education environment – exploring the findings.

Authentic learning refers to educational strategies that enable students to connect what they are taught in an educational setting to real-world issues, problems, and applications (Glossary of Educational Reform, 2013). Experiential learning can be defined as 'learning from experience or learning from doing' (Lewis and Williams, 1994: p1) and in allowing students to practice skills learnt in the classroom in a real-world setting, authentic learning through those real-world experiences gained on clinical placements is central to physiotherapy education (Smith and Crocker, 2017). The clinical education environment enables students to engage in learning by facilitating translation of course work and theoretical learning into clinical practice (Strohschein et al., 2002) and as such is usually viewed as the most rewarding and enjoyable part of pre-registration training (Neville and French, 1991). This clinical exposure to medical conditions, usually in an active patient setting, results in a high probability of learning clinical information (Jarski et al., 1990) and skills, behaviours and attitudes acquired clinically are frequently more meaningful and lasting than those gained in the university setting (Neville and French, 1991).

In their discussions, my participants echoed the literature on the importance of experiential learning when they highlighted the unique value of clinical education, in relation to both the translation of theory into real-world practice and the meaningfulness of the learning. The older adult acute clinical environment presents students with many challenges, as reflected in earlier themes, such as communication with those with hearing or cognitive impairment (Park and Song, 2005) and complex clinical presentations requiring a wide range of assessment and management strategies and skills (Gorman et al., 2010). Many of my participants articulated a perception that it was only by being immersed in this clinical environment that students could gain a true appreciation of both the older adult experience and the physiotherapeutic and broader skills required to manage this population successfully. Jette et al. (2009) cite the broad range of skills and clinical knowledge required for physiotherapy practice within the older adult acute care setting, including musculoskeletal, neuromuscular, cardiovascular-respiratory, and functional assessment and management – very much reflecting the variety of conditions cited by P7, P12 and P13. Gorman et al. (2010) not only enumerate this diversity of physiotherapy practice within this environment but in addition highlight the broader skills required for effective practice including: proficiency in communicating with patients, family, and colleagues; having an appreciation of differences in illness presentation across the life span; and understanding the complex medical system and holistic management that constitutes older adult acute care. These were all aspects of practice cited by my participants as key learning opportunities for their students. Tying in with discussions around learning about less familiar skills such as discharge planning, Masley et al. (2011) emphasise the challenges inherent in rapid patient turnover and the important role of physiotherapists in this discharge planning process (again reflecting earlier themes) and these authors argue that the knowledge, clinical reasoning, decision-making skills and professional responsibility required of physiotherapists in the acute care setting goes beyond those required in most other clinical areas (of more later). In relation to my participants, the learning opportunities and experiences offered by the older adult acute care environment not only reflects their discussions around being older-adult practitioners within a challenging clinical environment but also, for many, appears to link to their own learning experiences either as students or less experienced practitioners, including: the reframing of understanding about and management of those with dementia detailed by P4 and P6, the 'seeing the person' seminal experiences described by P14 and P15, and the appreciation of the value of multidisciplinary working and holistic management engendered by P11's Early Discharge role.

Finally, clinical education has been demonstrated to increase students' confidence in their knowledge base and their ability to interact with patients (Hakim et al., 2014). Given the particular challenges of working with an older and acutely unwell population and the potential demands these place upon student learning, a successful application and development of their skills in this environment would indeed be likely to provide the "*massive confidence booster*" described by P7 (I: 591).

6.3.6.2 Subtheme: The clinical educator role

When asked about their general approach to student education some participants described how they focused on student needs. P7 always asked students what they wanted to get from placement so that the resultant educational experience was student centred, and he identified the importance of knowing about any prior relevant experience with frail older adults so that he understood the student's baseline knowledge and skills. P1 described the need to tailor learning to the individual student and preferred to focus on a student's specific weaknesses rather than setting generic goals. He also spoke about engaging students and forcing them to learn so that they felt they were getting something meaningful from placement. P15 felt that, whilst it was up to students to maximise their learning, her role as an educator was to identify ways for them to do this.

Three participants described how they tried to ease students into the placement. This included starting with students shadowing them for a few days, to "*give them a reference point*" (P12, I: 493), or initially selecting patients who would respond well to students to minimise any barriers to them settling in - *"break down the boundaries between the student and the patient"* (P3, I. 528).

Some participants highlighted how they used themselves as role models and/or examples both in general patient interactions and in assessment and treatment of patients. Both P4 and P11 described the importance of students observing them communicating with patients, with P4 identifying how she used her verbal communication skills as an example to facilitate student communication, whilst P11 described a range of non-verbal communication strategies when persuading older patients to engage in treatment that she hoped would "*brush off*" (I: 508) on students so that they could understand how best to engage with these patients. P5 tended to initially lead treatments so that students could see what was required, and P12 explained that her role modelling strategies were intentional to help develop future practitioners:

> If I can get them to see what I do/../ then that's what I'm trying/…/ to achieve because we're trying to make another practitioner aren't we (I: 482-484).

When participants were asked about their general approach to student learning within a more clinical context there were various areas of importance identified: getting them thinking about the whole person rather than the specific problem necessitating that admission (P1); focusing on communication, physical assessment and physical handling with the student gradually taking on a more active and independent role (P12); and taking them through complex patient scenarios to help with clinical reasoning and discharge planning, building upon the skills the students had already learnt from their university-based teaching (P10):

> giving them a good clinical experience and teaching them as we go and building on/…/from what they're learning in lectures and trying to pull all of that together to create the picture for them (P10, I: 538-540).

Participants articulated a range of knowledge and skills they wanted their students to learn. Some, reflecting previously discussed themes, related to communication, engagement with patients, and the development of people skills in order to build trusting relationships and facilitate personal development.

Alongside these affective skills participants identified a number of different cognitive and practical skills they wanted their students to gain from placement including: being able to complete an assessment (P8, P9, P10, P11, P14); a basic level of competence in practical skills, including mobilising patients (P6, P7, P8, P10, P11, P14); clinical reasoning (P1); note writing (P6); holistic management (P10, P11, P14); discharge planning (P8, P10, P12); and an understanding of the pathologies commonly encountered in older adults (P7, P11, P14). In contrast to several participants who articulated a view that a range of practical skills could be gained when working with older adults in acute care, P8 perceived the speciality to be primarily about mobilising patients, the value being in enabling students to practise assessing gait, but that the nature of chronic gait patterns in a frail older population meant that rehabilitation beyond mobilisation was not a skill students could practise.

Three participants (P2, P9, P12) discussed the need for students not to bring preconceived expectations to their clinical practice with older adults and to recognise the need to tailor or adapt assessment and treatment based upon the additional challenges of comorbidities and frailty – the thinking outside the box approach discussed in the second theme:

> the thing with elderly care is that none of the assessment and treatment techniques are different /…/ [from] assessing another person of another age group but you'd maybe just have to tailor them /…/ It's not teaching a new skill, it's challenging [them on] how it can be done differently if things are complicated by the patient being impaired for any reason due to old age (P12, l: 723-732).

Finally, the participants described the key messages they wanted to get across to their students. For some, such as P5 and P14, it was about recognising that older adults have a range of abilities and not all are dependent and requiring significant input. The need to see the individual, look beyond the condition and consider the patient as a whole, and be open-minded about patient's abilities, were recurrent themes, as was understanding the importance of communication in the patient–therapist interaction.

Participants identified several perceived challenges to educating physiotherapy students, some directly related to students themselves, whilst others related more to the learning environment within acute care. P1 described his frustration as an educator with students who were not willing to work hard either because they were not prepared to engage with reading outside of placement or they did not seem to value the experience and learning opportunities in working with older adults: *"it's like beating your head against a brick wall for five weeks"* (I: 398-399).

P3 had experienced students who did not take responsibility for their learning and who blamed her as the educator when there were problems, whilst P4 related experiences where she had felt under pressure by students arriving on placement with high expectations of what they wanted to achieve.

In relation to environmental challenges to student learning, the combined challenges of working with a very frail older population and the time and workload pressures, identified in the fourth theme, were perceived as impacting on student learning. This was effectively summarised by P11 who linked caseload and time pressures to educators' changing expectations of students to have a level of proficiency on arrival on placement, and to be independent and active learners who seek knowledge and answers to their questions rather than simply being receivers of knowledge:

> I think we expect them to run before they can walk/…we potentially don't have the time to offer up that training, so we expect that they have it beforehand/…/I think we do set the post quite high. [*They need to be*] much more autonomous in their learning, much more proactive and driven towards questioning/…/it's kind of expectation now that if you have a problem you will ask or if you don't know something you ask because your mind as an educator is having to deal with everything else as well so it's very much time constraint/…/ back in the day we'd have allocated time to do teaching/…/we don't get that at all now because of the caseloads on the ward (I: 587-607).

Some participants did also highlight the challenges faced by the university in covering everything required and identified what they felt was taught well in the university setting. P9 felt that students came out with a good understanding of individual pathologies and holistic management and P13 felt the topic of falls was taught in some detail. Two participants (P11, P14) identified that students had to take responsibility and be autonomous learners because of the packed curriculum, with P11 stating "*if time is restricted at the uni then you can only teach what you can teach*" (I: 634-635). P9 felt that some information, such as discharge planning, would be picked up on placement anyway and P13 considered that students generally well prepared for placement when she identified they were "*quite well equipped to be honest with you*" (I: 624).

When asked what they would like students to be taught within the university setting to better prepare students for clinical practice and thus aid themselves as educators my participants identified several topics which largely tied in with previous discussions around the requirements and challenges of working in acute care. Table 7 summarises these identified topics and related knowledge and skills.

Table 7: Summary of topics participants proposed be taught in university setting.

Topic areas	Knowledge and skills	Participants who identified these topics
Communication	Communication barriers with older adults and communication with families/carers	P8, P9, P13
Organisational practices	MDT working, particularly in relation to older adults	P8, P10
	Discharge planning, including services available to refer patients to post-discharge	P8, P10
	How hospitals work and the different pathways for the patient journey through hospital	P8
Clinical knowledge and skills	Dementia, including the different types, early signs, engaging and working with dementia patients, understanding delirium	P4, P5, P10, P12
	Effective management of the older patient, including adaptation of management strategies, understanding the skills required in acute care to get these patients back to normal function and the ability to manage complex presentations rather than just individual pathologies	P2, P8, P9, P13, P14
Broader patient-centric management	Seeing the individual rather than the condition/presentation	P9, P10
	Looking at clinical presentation rather than age	P3
	Understanding that everyone can’t be cured or returned to previous levels of function	P1
Study skills and contextualised learning	Background reading/self-directed study in relation to key conditions	P14
	Awareness of guidelines and evidence-based practice	P10, P14

Three participants identified the importance of students being encouraged to get any experience working with older adults in some way, either clinical or voluntary, (P6, P11, P14), whilst P5 felt that the university should ensure that frail elderly was a core placement so that students could gain insights into the possibilities and potential to develop a rewarding career path in that clinical area, saying "*there's a lot of scope to specialise and progress in care of the elderly*" (I:530).

Finally, four participants discussed the transition from student to qualified physiotherapist and reflected on their role in preparing students for this transition. P9 expressed a view that students had rose tinted glasses and needed to be prepared for the reality of clinical practice. P1 and P4 described how students were generally protected from the time and workload pressures of clinical practice despite students finding it challenging; but P1 felt that it was important for students to be challenged in order to prepare them for the reality of clinical practice: "*trying to get them ready for the real world when they do qualify*" (I:671-672).

P7 wanted to expose students to the broader aspects of clinical practice with older adults to prepare them for qualification and described his intention to alter students' focus from what they had to do to get through placement to how to manage the patient effectively from admission to discharge.

The clinical educator role – exploring the findings.

In investigating the clinical educator role within physiotherapy education several authors emphasise the importance of good communication and interpersonal skills as key to a successful educator-student relationship. Educators' and students' highly value the ability to communicate effectively and focus on the students' needs (Kelly, 2007), as well as being approachable and having good communication skills (Neville and French, 1991; Jarski et al., 1990). Onuoha (1994) examined clinical teaching behaviours from the perspective of students, clinical educators and tutors, and their findings identified that clinical educators rated requiring students to identify their own learning objectives as one of the most important aspects of their role, whilst the students valued a facilitatory and supportive approach to clinical education. The above evidence supports the general approach to student education described by so many of my participants either via being explicitly articulated – such as the student-centred learning approach described by P7 and P1 – or implicitly implied in the discussions around finding the best ways to facilitate student learning (P15) or the strategies used to ease students into placement.

Several participants described how they acted as role models both in relation to general patient interactions and in patient assessment and management. This aim reflects the findings of Ruczynski et al. (2022) where medical students considered that their learning occurred predominantly through role modelling and feedback, with strong role models making significant positive impact on this learning. Three aspects to role modelling have been proposed: behavioural models who show learners how to perform a skill and achieve a goal; representational models who act as motivators to learners that a goal is attainable; and inspirational models who make someone aspire to be more like them (Morgenroth et al., 2015). Behavioural role models are closely linked to professional practice (Ibarra and Petriglieri, 2008, cited in Morgenroth et al., 2015) and this aspect of role modelling certainly fits well with participant descriptions of using self as an exemplar for communication and patient management. Some of these role modelling activities were explicitly described as such, as evidenced by P4's use of her verbal communication skills to facilitate student communication with patients. Others by contrast appear more tacit, such as P11 describing a hope that her non-verbal communication strategies would *"brush off"* (I: 508) on students. However, whilst most of the discussions reflect a behavioural model, P12's description of her aim of "*trying to make another practitioner*" (I: 484) can be argued to also reflect a representational role model where, in a complex clinical environment, students can be encouraged to see that the effective management of acutely unwell older adults is an attainable goal for them.

In relation to approaches to student learning, some participants again reflected earlier themes around communication, complexity, seeing the whole person, and discharge planning, advocating approaches that were focused on providing opportunities for students to practice skills, extend prior knowledge and create new knowledge (Higgs, 1993), a process reflected in other studies of clinical educators (Bennett, 2003). Students enjoy and appreciate student-centred teaching (Neville and French, 1991); and the andragogic (adult learner) behaviours most valued by students are those pertaining to discussion and feedback (Jarski et al., 1990) – key components of strategies identified by some of my participants such as taking students through complex clinical reasoning scenarios to help with clinical reasoning and helping students better understand the holistic patient picture.

When asked what they wanted their students to learn from their clinical placements several of my participants reiterated the range of affective skills discussed in previous themes relating to both communication and their approach to practice. In addition, eight participants identified what, from earlier themes, could be described as perceived core competencies for physiotherapeutic clinical practice in older adult acute care. A proposed model of clinical competence identified that surface level aspects of knowledge, skills and attitudes relate to observable activities such as techniques and procedures, demonstration of knowledge and professional relationships and communication with patients and others (Stengelhofen,1993, cited in Cross and Hicks, 1997). This reflects the clinical competence in practical skills identified by several of my participants, alongside note writing and carrying out assessments. Complex clinical reasoning, holistic management, the ability to think outside the box and discharge planning are professional competence characteristic which sit at deeper levels of learning and require knowledge awareness – the ability to reflect on knowledge and its appropriateness to the individual personal practice experience - which is a higher level cognitive and affective skill (Cross and Hicks, 1997). Cross et al. (2001), in exploring what clinical educators viewed as important in students on placement across different specialities (including gerontology, neurology and orthopaedics) found that educators cited aspects such as safe practice, competence, the ability to apply theory to practice, some level of critical thinking, being a good communicator, and good practical skills. They found in comparison that their sample were less focused on higher levels of critical thinking, and that this was largely consistent across all specialities. It is possible that the elderly care physiotherapists within their study were not working in an acute care environment, with the specific challenges this entails. The demands of an acute care environment may well reflect some of the more complex clinical reasoning aspects of care such as discharge planning where the pressures, immediacy of discharge and acute nature of the patients require not only complex clinical reasoning but also a speed of decision-making. However, this does not account for the complex nature of clinical presentation that could be anticipated for many older patients beyond acute care. Thus, it would seem that, in comparison to the Cross et al. (2001) participants, at least some of my participants differed in their aims for their students by focusing beyond the clinical competency in practical skills and focusing more on developing these higher-level cognitive skills. Whether the students are able to step up and achieve is a different matter (to be explored further below). The one discordant voice was that of P8 who felt that working with an older acutely unwell population had little to offer students beyond practising gait assessment and mobility skills. This was consistent with her own practice experiences where she described not liking working within frail elderly care and found the work to be less stimulating in comparison with other areas such as critical care, where it could be argued that the requirement for higher level critical thinking skills might be more obvious. The nature of clinical education exposure to older adults is highly influential in students' learning outcomes (Reicherter and McCombe Waller, 2014), and P8's limited perception of both the learning experience itself and the skills that can be achieved suggests her students may be much less likely to develop beyond surface level learning.

Overall, though, the key take-home messages to students around the individuality of older patients, seeing the person and understanding the importance of communication, very much reflected earlier discussions, including participants' descriptions of their own approach to practice.

In relation to the challenges faced by participants in facilitating student learning there were two distinct aspects identified: the acute care environment, with its combined challenges of a complex patient population and time and workload pressures; and what were perceived as more negative characteristics of the students themselves. P11's summary of the impact of the demands of the acute care environment on educators' expectations of their students seems to shift the responsibility for learning much more onto the student and to require of them some competence in metacognition in directing and evidencing their learning (Cross et al., 2001), further increasing the deep learning requirements and demands on students.

Reviewing those factors directly relating to the students themselves there was a focus on a lack of interest or motivation and unprofessional behaviours which mirrors the broader evidence around clinical educators' perceptions of negative behaviours. Both Onuoha (1994) and Neville and French (1991) identified that a perceived lack of enthusiasm, motivation and interest was considered to be evidence of poor student behaviour, and not being questioning and receptive and evidencing a lack of commitment were characteristics perceived negatively by educators (Neville and French, 1991). In addition, demonstrating a poor work ethic, not taking responsibility for learning and not being respectful, perhaps a feature of P4’s description of students who she felt hounded her until they got what they wanted, were all explicitly identified as student characteristics that led to educators having a negative experience with their students (Neville and French, 1991).

Participants were asked what the physiotherapy programme could do differently or better to help prepare students for clinical practice on acute older adult placements. As might be expected, a number of the suggestions very much tied in with previous discussions and themes and were discussed very much with an older adult focus. There was, however, some recognition of the limited availability within a packed curriculum to fully cover all aspects of practice and in contrast to some other participants P9 felt that skills such as discharge planning could be learned specifically on placement, perhaps recognising the difficulties inherent in trying to teach the complexity of discharge planning in this older adult population without the real-world context. In addition, some participants perceived part of their role as clinical educators to be preparing their students for the realities of the qualified physiotherapist role. Stoikov et al. (2022) in exploring the challenges new graduates faced in transitioning into clinical practice found that their participants identified a number of clinical tasks for which they felt unprepared as newly qualified physiotherapists. These included managing complex patients including those with complex psychosocial factors, interaction with the multidisciplinary team and a limited understanding of interprofessional practice, engagement with families, and caseload management – all areas that require both a theoretical understanding and an ability to translate this knowledge into real world practice via experiential learning. Duchscher (2009) refers to transition shock, where new graduates experience a range of negative emotions as they struggle to adapt to the demands of clinical practice: some of my participants appear to recognise the challenges faced by physiotherapy graduates and felt that they had a role in preparation of students for this transition, alongside any enhancement or adaptation of university teaching.

Within the Chartered Society of Physiotherapy Learning and Development Principles for Qualifying Programmes (CSP, 2020) Principle 1 states that “qualifying programmes should aim to develop the knowledge, skills, behaviour and values required to practice physiotherapy at newly qualified level” whilst Principle 3 focuses on learning principles which should prepare students well for clinical practice. Masley et al. (2011) explored the requirements for physiotherapy practice in acute care. They identified the need for complex clinical reasoning within the context of integration of medical information with specialist physiotherapy knowledge and ongoing dynamic assessment of patients, a process that was identified as taking place within a complex and fast-paced environment that requires rapid decision-making. Effective communication with numerous people was identified as essential to this process. In terms of clinical reasoning, effective communication is needed at both micro (minute to minute and day to day) and macro (big picture e.g., discharge planning) level (Masley et al., (2011). This evidence, the discussions with my participants and the themes resulting from these discussions suggest that acute care older adult placements have the potential to offer students a range of enhanced knowledge, skills, and experiences that might prepare them for clinical practice once qualified in a way that many other placements may not. However, my participants’ identification of the ways in which the physiotherapy curriculum could better prepare students for placements within older adult acute care suggests a requirement for improved synergy of teaching and learning to maximise the student clinical experience, with a clear awareness of what the university and clinical placement individually offer in terms of student learning and how best they can complement each other.

6.3.6.3 Subtheme: The student learner

Having explored the perceived challenges of the older adult acute care placement and environment itself, and the educator perspectives in relation to student clinical education, my participants discussed their perceptions of the student learners themselves.

In relation to the challenges faced by students coming to acute care older adult placements they identified four key areas: poor understanding of patient complexity and its management; lack of awareness of discharge planning processes; a struggle with converting theory into clinical reality; and challenges in relation to interpersonal skills and approach to learning.

Several participants felt that students were significantly challenged by a lack of understanding of the complexity of clinical presentation in a sicker, frailer older population and how to manage the overall patient presentation. P1 described challenges in integration of information, saying he felt that whilst students had medical knowledge in relation to individual pathologies, such as diabetes or chronic obstructive pulmonary disease, they seemed not to understand the concept of comorbidity:

> they struggle with/…/being able to incorporate everything into one as opposed to looking at conditions separately (I: 343-344).

P9 described an inability to be holistic or “*see the whole picture*” (I: 391), which meant that students were unable to address all the factors that needed to be considered to enable the patient to return to their previous level of function. P10 acknowledged the potentially overwhelming challenge of managing an acutely unwell older population effectively when she articulated a perception that this patient complexity caused some anxiety for students: “*scares them a little*” (I: 531), - reflecting in addition that the complexity of the frail older adult patient was often challenging for qualified staff to prepare for. This inability to coalesce a number of separate problems into a whole picture resulted in students not only struggling with treatment options but also how to adapt them appropriately, a situation further compounded by any less common conditions that the patient might have, and which were not in the student's library of medical knowledge (P7). P1 highlighted the degree of challenge faced by students on placement early in the course where they have had no prior experience of any health or social care or real-world experience of managing patients, and the significant learning facing students:

> [you] don't know how to get people in and out of bed. You never had your hands on a patient so you have to learn all that too /…/ you've got no real ideal about medicine so you don't really know what's going on there and then you got the social aspect which again you don't know about /…/ the growth you have in [those early placements] can be massive and you can just struggle because you won't be safe /…/ you won't have the medical knowledge to be able to make safe decisions (I:352-359)

In addition, students were not aware of the different discharge planning options (P13) and all the factors that went into the decision-making process, both physiotherapy specific (P8) and in relation to the broader MDT (P4).

Seven participants discussed the challenges students faced in translating their university-based knowledge and skills into the reality of clinical practice. This included an over-reliance on crib sheets and an inability to adapt general assessment skills to be able to assess a frail older adult successfully. Successful assessment requires students to understand the need for thorough assessment, which takes time, in order to gain deeper understanding of the problems presented, and to observe the patient in functional activity in order to more readily identify problems that require further investigation:

> I think sometimes students come with "I need to do these assessments" /…/ but there's no way you could go to an elderly person and assess everything in a formal quick way. Often you have to do it in a more functional observational manner /…/ if you see an issue or something you are unsure about then homing in on that problem (P12, I: 495-503)

P9 articulated a perception that students came out with unrealistic expectations that they were "*going to cure everyone*" (I: 649), rather than recognising that physiotherapy input was more about getting someone back to their normal, whatever that might be; whilst P10 felt that whilst students came to placement with a lot of empathy and understanding they still failed to grasp the reality of the patient experience.

In relation to interpersonal skills and approach to learning, several participants felt that students lacked the interpersonal skills and confidence to be able to engage with the older patient population effectively, echoing earlier discussions. In addition, P10 said that students often seemed terrified of getting their hands on patients and P11 considered that many of them had a fear of pushing their patients too hard and hurting them. Those students who did not engage in independent learning were seen as limiting their own ability to learn effectively from placement (P8), whilst some were perceived as only focusing on the physiotherapy specific aspects of management (i.e., those they would be marked on) or made it clear that they would prefer other placements (P12, P13).

However, a number of participants also highlighted what they perceived to be the strengths in the students they had supervised. Some described students as having a good underlying knowledge base, evidencing understanding of university teaching and demonstrating that they had completed preparatory reading prior to and during placement (P5, P8, P11, P12), with evidence of transfer of skills from both university teaching and previous placements (P6, P12). In addition, P11 considered that her students generally worked very well with teams and within teams.

Key strengths present in many students in terms of interpersonal skills and approach to learning were identified as: demonstrating general empathy and understanding (with the caveat identified above) (P10); generally being proactive and conscientious (P4, P11); giving patients time (P9, P14); being keen to please (P14); demonstrating a caring personality (P9); having an awareness of patient needs, particularly maintaining patient dignity (P15); and seeing the relevance and value of an older adults placement (P4, P9). P1 described a ‘good’ student as being one who is hard-working, accommodating, and refreshing:

> If they put the work in they <u>are</u> very good and they <u>can</u> become very helpful and they can bring almost a breath of fresh air to a team (I: 395-396).

Finally, there were a few specific observations made about international students, particularly where students with English as a second language might struggle in some more challenging communication situations (P8, P9, P12) and P12 identified instances where, in particular, older male patients had asked to be treated instead by someone who could communicate with them more clearly.

The student learner – exploring the findings.

The challenges my participants described as being faced by students are arguably all facets of CDM. Communication, education, experience, and the physiotherapists’ individualism all influence clinical reasoning for physiotherapists working in acute care (Holdar et al., 2013). Both conceptual knowledge and experiential knowledge are necessary for effective decision making and because novice practitioners have limited knowledge in both areas, they are much more challenged when trying to make effective clinical decisions (Wainwright et al., 2011). Factors involved in CDM are those influencing CDM *abilities* (informative factors - such as professional and personal experience and reflection-on-specific-action) and those influencing CDM *processes* (directive factors – such as observation, patient-therapist interactions and reflection-in-action) (Wainwright et al., 2011). Novice practitioners rely heavily on informative factors and external sources of information and, because of this and their limited experiential and conceptual knowledge, they find effective CDM challenging, particularly in relation to atypical or complex cases: in contrast experienced practitioners are able to use directive factors to synthesise and evaluate in relation to multiple impairments, using forward reasoning processes, and are able to be selective about data collection and hypothesis generation to enable them to manage atypical and complex cases effectively (Wainwright et al., 2011). The student learner challenges that my participants identified could be argued to require use of directive factors unavailable to the novice learner and are examples of the high-level clinical decision-making processes required to not only manage complex and atypical presentations effectively but to also be able to consider the wide range of factors influencing discharge planning and to make safe and appropriate decisions based on these. The Wainwright et al. (2011) participants were novice qualified physiotherapists, suggesting that student physiotherapists will have even more difficulty with CDM, and that these challenges are likely to be closely aligned to their progression through their programme of study (stage of education) and their previous experiences (including number and characteristics of previous placements). This is perhaps encapsulated by P1’s discussion about the clinical challenges faced by students early in the course and the student ‘growth’ as they progress through their early placements. Educators, as experts, tend to skip some of the steps in the problem-solving process and may fail to make this explicit to their students as novices and there is a risk that this failure to share may further inhibit knowledge restructuring and encapsulation (Ruczynski et al., 2022).

Clinical educators’ perceptions of the behaviours required for a physiotherapy student to enter the profession have included: theoretical and clinical knowledge; knowledge of research; technically correct clinical skills; safe practice; interpersonal communication skills; effective clinical decision-making; and self-directed learning (Jette et al., 2007) – all identified by my participants as aspects of practice that students may struggle with. Kelly (2007) found in relation to learning that educators are looking for an adult learner who is eager to learn and willing (and able) to self-assess their learning needs and direct the learning experience accordingly as well as take responsibility for this learning. This expectation is reflected in P8's perception of students limiting their ability to learn effectively from placement by not engaging in independent learning, and the frustration described by P12 and P13 at students who were reluctant to learn the broader context of patient management beyond the physiotherapeutic, or whose negative attitudes towards the placement adversely impacted on engagement with learning. In order to integrate effectively and appropriately apply learning, students need to establish a connection between different information, concepts and experiences, apply ideas or skills learned in one context to a different context (transfer of learning), and combine the knowledge gained to enhance their understanding and gain new insights (Barber, 2012). There is a continuum of supervision of learning and at the early stage when the student has little competence, they may take on a more passive learner role as the educator actively teaches and guides them; during the transitional stage the responsibility for learning becomes gradually more collaborative as the student takes on an active learner role until finally, in the self-supervision stage the student becomes largely self-sufficient in their learning (Strohschein et al., 2002). Ultimately, this independent and self-directed learning moved students towards metacognition and metacritique (Cross et al., 2001) – high level cognitive skills that students may not possess even by the end of their training.

Earlier I discussed the challenges students face in being able to achieve the complex clinical reasoning required in managing older adults in acute care. Add to this an inability of many students to demonstrate high level decision-making (due to limited knowledge and experience) and the difficulties of achieving self-sufficiency in learning for many students, particularly those at an early stage of their programme, and it perhaps becomes impressive that many students do well on these placements. In their discussions my participants showed understanding of the challenges faced by students with such considerations as the level of their knowledge and skills dictated by their point in their training programme, the reality of patient contact versus the conceptualisation of patient care within higher education, and the impact of more limited life experience on interpersonal skills. However, there was a dichotomy to their discussions: when asked what they wanted from their students, many of the skills they cited were around this complex clinical integration and clinical reasoning, including an ability to ‘think outside the box’, prioritise effectively where there were several comorbidities, and to understand all aspects of broader holistic management. Ultimately, whilst my participants appreciated the constraints on student knowledge and skills many of them articulated expectations that would be challenging for many students to achieve.

It is perhaps not surprising given the above discussions that participants valued students who had a good underlying knowledge base, arrived prepared for placements and were able to transfer their learning into the clinical environment. However, much of the focus on the attributes of the ‘good’ student was around interpersonal skills and a caring approach to patient care. This reflects studies such as those of Jette et al. (2007) and Cross and Hicks (1997) where, despite identifying an extensive range of skills perceived as being required for entry into the profession, their participants rated appropriate communication and interprofessional skills as the fundamental requirements for practice.

Of interest, Watkins and Waterfield (2010) found that physiotherapy students recognised some of the challenges described by my participants, such as institutional and staff ageism and othering, communication challenges when working with older adults, seeing the patient, holistic management, the role of the family in older-adult rehabilitation and the value of the MDT. In their study the students perceived their university-based teaching had prepared them for working with older adults in clinical practice effectively. This suggests that whilst students seem to understand some of the challenges of working in acute care with older adults, there is a potential mismatch in educator: student perceptions about the skills and knowledge required for working with these patients effectively.

Finally, a few participants specifically mentioned experiences with international students. The additional challenges experienced on clinical placements by physiotherapy students who have English as a second language has been well documented (e.g., Mikkonen et al., 2016; Jenkins and Bell, 1997). In their systematic review Mikkonen et al. (2016) found that cultural and linguistic diversity resulted in a slower process of adaptation to the clinical education environment and that culturally diverse students perceived language difficulties as a disadvantage that limited their learning opportunities. Jenkins and Bell (1997) identified that culturally and linguistically diverse (international) students struggled with patient interactions – tending to have more clipped conversations and struggling to understand idiomatic speech. Mikkonen et al. (2016) did find evidence that a positive clinical learning environment helped to minimise language barriers and, given the range of communication strategies used by my participants to facilitate students' communication skills (described in both this theme and the fifth theme), this may help explain why my participants described the students as potentially struggling in more challenging communication situations rather than with communication per se.

Chapter 7: Summary discussion and implications for educational practice

This chapter will discuss the key findings from this research and will explore their implications for the education of physiotherapy students.

Several key findings emerged from the research: evidence of clear links between participants' previous experiences with older adults (both personal and professional) and their current practice and approach to the education of physiotherapy students; the challenges of working within acute care and the demands this environment places upon both staff and students; the complex presentation of older patients within the acute care environment and the resultant complex clinical reasoning and problem-solving required to successfully manage this population; and the evidence of both explicit and implicit ageism and othering in clinical practice.

7.1 The value of experiences with 'healthy' older adults

Meaning and understanding are the central feature of our behaviours and actions and begin in our social interactions (Lock and Strong, 2010, p6-7). Because meaning-making is embedded in sociocultural processes, it will be specific to particular places and times and, as such, the meanings we place on particular experiences and the ways in which we understand them will vary for each individual, depending on the situations in which they find themselves. Thus, knowledge and understanding are created within both historic and cultural contexts that help people make sense of their world (Phelan, 2011), with personal and demographic differences resulting in different vantage points and experiences that will influence normative expectations about ageing (Abrams et al., 2015). For most of my participants, their pre-training experiences with an older population were predominantly with healthy older adults and, as such, there was a marked contrast between their personal experiences and their clinical experiences with an acutely unwell and more dependent clinical population. Personal experiences were described largely in terms of positive experiences of ageing and physical and cognitive functioning. Even where there were early experiences with unwell older family or friends, or discussions around a gradual deterioration in health status or negative health behaviours demonstrated by family members, this was largely framed within a positive narrative of independence and retained function or contrasted with experiences of active and healthy ageing. Hay et al. (2016) argue that there are different perspectives that physiotherapists can take, as practitioners, on ageing and ageing bodies, describing both the traditional biomedical approach with its focus on function and dysfunction and the social constructionist perspective, which recognises that this function and dysfunction is interpreted by older adults within social, cultural, and historical contexts. They argue that physiotherapists need to take an embodied perspective where the physical aspects of ageing (function/dysfunction) are considered as inseparable from the lived experiences of their older patients; that is, an incorporation of both the biomedical and social constructionist perspectives. This linking of the social, physical, and lived (social, cultural, and historical) context of patients' lives has been posited as enabling more effective and individualised patient-centred care and facilitating more empathic practice, as well as providing an alternative perspective to ageist and healthist stereotypes, therefore avoiding reductionist narratives around physical decline in old age (Hay et al., 2016). My participants' early more personal experiences with older adults were largely discussed within this broader social, physical and individual lived context. Thus, their viewing of these early experiences with older adults within a more embodied perspective may well go some way towards explaining the narratives around patient-centred care, seeing the person and holistic management described by so many of my participants as being central to the management of their older patients and as being key messages to be shared with their physiotherapy students. In addition, whilst their experiences of active and healthy ageing of relatives may have served to form a background to contrast with their unwell clinical populations, these broader social, physical and lived experiences may also have enabled a recognition of what could be achieved in rehabilitation, with the right resources – a message that is perhaps more difficult to appreciate, for both staff and students, where experiences are only within the context of an acutely unwell older adult population.

There is substantial literature advocating healthcare students having contact with healthy older adults as an educational strategy to reduce ageism via facilitating a more balanced perspective on ageing (e.g., Crutzen et al., 2022; Heise et al., 2012; Holroyd et al., 2009). In addition, some of my participants also suggested that physiotherapy students be given early contact with a more healthy older population to aid the development of interpersonal skills and effective communication strategies, particularly where there may be challenges such as hearing impairments and poor eyesight in this older population – the aim being to facilitate an earlier transition from novice to advanced practitioner communication skills (Morris, 2021) and earlier development of effective emotional intelligence and regulation (Cherry et al., 2013). As with my participants, student experiences with a healthier older population may also expedite an understanding and appreciation of the broader embodied perspective of ageing and older adults.

Many physiotherapy students may not have much experience with healthy older adults prior to beginning their training, Therefore, the challenge within healthcare education is to avoid focusing on a reductive biomedical perspective that reduces ageing to a story of linear medical and functional decline (Crutzen et al., 2022). This can be difficult within a packed curriculum that needs to prepare students for successful management of an older population, the largest single users of healthcare services (Shepperd et al., 2021), who are predominantly accessing physiotherapy due to clinical and/or functional deterioration and may well present with complex problems. Within the physiotherapy curricula at Keele University there is currently very limited teaching on healthy ageing and most, if not all, clinical placements where students are likely to encounter older adults with some form of physical, functional and/or cognitive dysfunction. Thus, the programmes themselves are likely to foster a pessimistic view of ageing. Evidence suggests that facilitation of both voluntary work with healthy older adults and clinical experiences or placements involving healthy older adults can positively influence students' integration of gerontological knowledge, reinforce the concept of healthy ageing, and facilitate understanding and encourage more positive attitudes towards this population (Heise et al., 2012; Beling, 2004). However, whilst much of the literature around healthcare education and ageism cites the value of students interacting with healthy older adults there is an argument that the concept of "healthy" within this context is in itself reductionist; this term not only implies an absence of physical, functional and/or cognitive dysfunction but also fails to acknowledge that whilst many older adults present with health challenges they are able to live a "successful" life, i.e., one where an older adult is still able to lead what they themselves consider to be a fulfilling life regardless of some dysfunction – be it physical, psychological or social in nature (Bülow and Söderqvist, 2014). This concept of successful ageing seems to better reflect the personal experiences described by many of my participants, particularly where deteriorations in health status or negative health behaviours demonstrated by their family members were still largely framed within a positive narrative of independence and retained function. As such, the emphasis in terms of educational strategies, both within university teaching about "healthy" ageing and within the context of voluntary or clinical experiences with "healthy" older adults, needs to focus more on the concept of successful ageing and experiences with older adults who are ageing successfully. This would hopefully enable students to better appreciate the range of factors beyond the physical that can influence an older adult's ability to lead a (self-perceived) fulfilling life. Blackwood and Sweet (2017) found that interactions with older adults were highly valued by first-year physiotherapy students and were shown to positively inform both their future practice and their attitudes and beliefs about older adults. However, they cite evidence that the quality of the relationship a student has with an older adult (either personal or professional) needs to be perceived by the students as meaningful. There is therefore a need to explore and present physiotherapy students with opportunities to engage effectively with a successfully ageing older population, particularly where social interaction enables students to hone interpersonal skills and in doing so gain a broader understanding not only of the physical and cognitive abilities of healthy older adults but also of their lived experiences.

7.2 Reflective practice

The acute care clinical environment was described by participants as a challenging one in which to work, with significant time and workload pressures and a focus on discharge planning rather than rehabilitation. Some participants expressed frustration at not having time to rehabilitate their patients effectively, compounded by problems with accessing community rehabilitation resources. The result was that patients were often readmitted due to a failure to rehabilitate them sufficiently or to address the underlying factors that were underpinning these readmissions. These time and workload pressures were identified by some participants as also impacting adversely on their education of physiotherapy students and meant that they required their students to be more autonomous self-directed learners who could ‘hit the ground running’.

Clinical placements provide students with the opportunity to transfer skills and knowledge learnt within the University environment to a real-world setting (Smith and Crocker, 2017) and, as such, clinical education is a core element of professional training within physiotherapy (Chartered Society of Physiotherapy, n.d.). However, given the diversity of clinical practice within physiotherapy, older adult acute care forms only one small part of overall clinical education opportunities and environments in which physiotherapy students learn; it could be argued that within this broader context it becomes more difficult within the curriculum to prepare students to be able to meet the challenges of this specific placement area effectively. Yet some of these acute care challenges, such as time and workload pressures, are not to be found just within older adult care services. Evidence suggests that these can be problematic within many acute care environments (e.g., critical care; Bucknall and Thomas, 1997) and, indeed, they were highlighted by several of my participants who worked in acute care older adult related areas such as orthopaedics and neurology.

In addition, my participants identified broader issues that students face in this environment, such as a lack of awareness of discharge planning processes, a struggle with converting theory into clinical reality and challenges in relation to interpersonal and communication skills and approaches to learning. If these can be addressed effectively within the physiotherapy programme, this should benefit student learners within many areas of acute care (and beyond). Interestingly, whilst literature on the challenges of working within acute care often highlights workload and time pressures, the literature discussing the practice of physiotherapy within acute care focuses more on skills such as communication, problem solving, team working and clinical reasoning, despite evidence for the adverse impact of time and workload pressures on staff wellbeing and patient outcomes (Duffield et al., 2011). Yet, reflecting my participants' experiences, time and workload pressures have been shown to have a negative impact on both the clinical educator and student experience (Hägg-Martinell et al., 2014). It is therefore not surprising, perhaps, that clinical educators perceive the need for students to be more autonomous self-directed learners to help mitigate the time and workload constraints on their ability to supervise their students.

Understanding one’s learning needs requires self-awareness and the ability to be a reflective practitioner. Learning is a dynamic process where theories are continually challenged and new theories often emerge, and it is multifaceted, including gaining and developing knowledge, skills, competence, practice and behaviours (Fragkos, 2016). Fragkos (2016) argues that both self-consciousness (reflection) and ongoing self-critique (critical reflection) are essential for the development and continuation of competence and cites Schön’s reflection-in-action and reflection-on-action (Schön, 1987) as key to this process. However, students may fail to make connections between university teaching and clinical practice, between different areas of clinical practice, and between the differing nature of the knowledge used in academic and clinical practice; this failure to bring together differing knowledge and understanding may result from inadequate development of their reflective skills (Strohschein et al., 2002). In contrast, the effective development of those reflective skills should enable students to convert theory into clinical reality and also enable them to formulate learning objectives pertinent to each clinical placement and drive forward this learning. Reflection enables self-actualisation, which is required to fully reach intellectual, emotional, and psychological potential (Hakim et al., 2014). Within the physiotherapy programmes at Keele, the theory and models of reflection are taught and assessed early in students training and, while students are encouraged to write reflections during their clinical placements, reflection is not then formally assessed within the taught components of the programmes until students’ final year of training. As such, development of their reflective skills is largely dependent on their clinical educator’s engagement with this process. Norrie et al. (2012), citing a range of pedagogical approaches to develop reflective skills including the use of models and frameworks, emphasise the need for self-reflection to be guided by supervisors, mentors, or peer observation. Accordingly, there is a need within the physiotherapy programmes to introduce reflective practice more formally at various points in the programme, including more scrutiny of practice-based reflections to ensure that students are demonstrating self-learning and understanding, and to explore additional pedagogic strategies such as peer review and feedback on those reflections. Within acute care, time and workload challenges, and the way these may influence patient management, may be very pertinent topics upon which students should be encouraged to reflect and from which they could demonstrate learning. However, it should be recognised that clinical educators need to engage in this process and may require training to better enable students to reflect appropriately.

In addition, students' ability to manage time and workload challenges successfully is assessed in clinical modules in the final year of each programme. However, there needs to be further consideration of the feasibility of introducing aspects of time and workload management problem-solving into some clinical patient scenarios used in relevant academic modules and in preparation for practice teaching prior to clinical placements; this would better prepare students for the challenges not just in terms of patient management but also in negotiating their learning within these constraints.

7.3 Communication skills

Many of my participants described a range of both positive and more negative communication experiences which had directly influenced their own practice and highlighted for them the importance of effective communication as a fundamental skill when working with older adults. As such, they considered the ability of students to be able to effectively communicate with older patients as central to successful patient assessment and management and student difficulties with communication were particularly highlighted as another challenge when supervising their physiotherapy students. As discussed earlier, communication skills are an essential component of healthcare practice (Sheldon and Hilaire, 2015) and as such they already feature within the physiotherapy curricula at Keele. However, the teaching on communication occurs early within both programmes and, anecdotally, students often fail to appreciate its significance to clinical practice or the specific challenges regarding communication they may later experience in their clinical placements. Current teaching utilises a mix of didactic teaching on communication theory and workshop clinical role-play scenarios, and both have some evidence for efficacy (Lane and Rollnick, 2007). However, students need to actively engage in role-play activities to fully experience patient-practitioner interaction, and simulated patients might provide a more realistic ‘patient’ experience (Lane and Rollnick, 2007). Teaching approaches to explore in the future could include:

- Utilising ‘patient’ scripts for role-play communication activities to more accurately represent the patient experience.
- Reviewing role-play activities to see if the communication scenarios accurately reflect common communication challenges within older adults (such as sight, hearing loss or memory loss) and have a relevant clinical context (such as telephone communication with the relatives of a confused patient or liaison with the multidisciplinary team)
- Consideration of whether simulated patient activities could be feasible within the constraints of large cohort numbers.

Authenticity in terms of relevance to communication within the clinical environment is key (Smith and Crocker, 2017).

Sheldon and Hilaire (2015) advocate for communication content to be revisited as healthcare students progress through their programme, and whilst communication is an integral part of patient management it is currently largely implicit within much of the teaching across all years of the Keele programmes’ or is presented didactically where communication challenges link to clinical presentations (e.g., stroke). Making the communication elements more explicit within teaching and allowing students to role-play and problem solve over and over again as they progress through their programme would allow them to continually recontextualise their learning and skill acquisition, with the expectation that this would facilitate earlier demonstration of effective communication skills within their varied clinical placement environments. In addition, revisiting these skills would also allow for a broader appreciation of the value of the ‘soft’ skills such as empathy, compassion, rapport building and touch, all of which were explicitly identified by some participants as essential to more fully engaging with and managing older patients effectively.

However, a note of caution is warranted. Whilst it is important that students develop the communication and interpersonal skills required for effective engagement with and management of an older patient population, there is a risk that too much emphasis on communication challenges related more specifically to an older adult population could serve to reinforce student perceptions of the otherness of this patient group. Educational strategies that present these communication challenges within a broader patient perspective will not only facilitate communication and interpersonal skills that are transferable across different populations in terms of age, clinical presentation, function/dysfunction et cetera, but will also reduce this risk of othering.

7.4 Complex clinical reasoning and decision-making

Some skills that students need to learn and demonstrate may have to be taught within a more specific older adult context. Whilst many patients may present with some element of complexity, the frail older adult admitted into acute care services is likely to present with several comorbidities, frailty syndrome and the implications (physical, functional, social etc.,) of whatever illness or condition has resulted in their admission (Mudge and Hubbard, 2019). These physical and/or cognitive challenges may well exist alongside complex personal, family and social situations that may influence both inpatient rehabilitation and discharge planning (Lin et al., 2022). As identified earlier, these complex clinical presentations require complex clinical reasoning and problem-solving skills – which many students will find difficult to demonstrate, particularly in the early stages of their training – and yet were articulated as expectations of their students by many of my participants. The challenge then is how to facilitate in physiotherapy students the development of these complex reasoning skills whilst recognising the adverse impact of early stages of training, with learners possessing more limited knowledge and skills, and the often more conceptual and theoretical nature of university-based training.

Within the Keele physiotherapy programmes, and alongside theoretical underpinning and practical skill development, students are taught how to perform subjective and objective assessments, identify and prioritise problem lists, develop management plans, evaluate the success of their management strategies, and consider all relevant patient information and other factors that might impact on these processes. Initially, students work with more common and less complex clinical presentations, with a focus on increased complexity of presentation and the introduction of less common conditions and presentations as the course progress. Doody and McAteer (2002), in exploring clinical reasoning within physiotherapy, identify the importance of hypothetico-deductive reasoning processes where information is gathered from patient assessment and used to construct and evaluate a hypothesis which in turn determines the implementation of appropriate management strategies. This process involves cue acquisition, hypothesis generation, cue evaluation, hypothesis evaluation and treatment implementation (Doody and McAteer, 2002).

Clinical reasoning and decision-making abilities develop in stages via the experience of academic and clinical education and the development of clinical reasoning skills is influenced by a variety of factors, including the affective attributes of self-assessment and reflection as well as experience. As such, the attainment of knowledge and skills within the affective, cognitive, and psychomotor domains of learning is essential for effective clinical practice (Flannery et al., 2011). Whilst both novice and expert practitioners utilise a hypothetico-deductive approach, novice practitioners make many more errors during this process and have more limited knowledge whilst expert practitioners use pattern recognition/forward reasoning in their decision-making processes (Flannery et al., 2011; Doody and McAteer, 2002). Doody and McAteer (2002) argue that physiotherapy students should be introduced to the hypothetico-deductive process early in their training.

Al Rumayyan et al. (2018) explored the value of hypothetico-deductive reasoning processes in medical students who were presented with patient vignettes. In their self-explanation group students were presented with a full case and were able to provide a diagnosis and an appropriate pathophysiological explanation for the clinical findings. However, the students in the hypothetico-deductive group were provided with a staggered reveal of the case and had to provide tentative hypotheses that were subsequently tested as more information was made available. Al Rumayyan et al. (2018) found that the group using the hypothetico-deductive approach were able to generate more hypotheses in relation to signs and symptoms as they progressed through the case information, which resulted in more effective learning. Flannery et al. (2011) cite evidence that expert practitioners are more responsive to patient and environmental cues and better able to self-assess than novice practitioners and it may be that the staggered approach to case-based learning described by Al Rumayyan et al. (2018) provides a hypothetico-deductive structure that helps develop a process of self-assessment and responsiveness to cues, thus aiding the novice learner. Much of the case- and scenario-based learning within the physiotherapy programmes currently takes place in more of a whole case hypothetico-deductive format and it could be argued that, particularly within complex clinical presentations, a staggered approach would better enable students to process and manage more effectively the significant information they need to process as part of the clinical reasoning and decision-making process.

Ruczynski et al. (2022) highlight three aspects to clinical reasoning: clinical reasoning as a cognitive ability (i.e., a sequence of cognitive steps required to get to the right clinical decision); clinical reasoning as contextually situated (i.e., performed and contextualised in the real world); and clinical reasoning as socially mediated (i.e., integrated with professional identify and workplace communities). For our students, a staggered hypothetico-deductive approach could be a more effective way to facilitate the cognitive aspect of clinical reasoning and thus prepare students for the contextually situated and socially mediated aspects of clinical reasoning that they would encounter within their clinical placements.

The clinical reasoning learning process is a continuum and students need to be able to develop and transfer effectively the clinical reasoning skills learnt within university-based teaching to varying clinical environments so that they can grow their clinical reasoning expertise (Ruczynski et al., 2022). Indeed, several of my participants explicitly recognised the unique value of placement experiences for student learning. However, Ruczynski et al. (2022) point out that expert practitioners, being so far removed from student novices on the clinical reasoning and decision-making continuum, may struggle to understand the difficulties experienced by physiotherapy students in both demonstrating and adapting their clinical reasoning and decision-making skills. The Keele physiotherapy programmes produce a skills list for clinical educators that details the skills and knowledge students have been taught within the university setting at each point in their training. It may well be that this list needs to be revisited to explore how explicitly and/or implicitly any content around clinical reasoning and decision-making is presented in this document, as clarity in this information may help facilitate more realistic expectations of their students in these expert practitioners. In addition, discussing the differences in clinical reasoning processes between expert and novice practitioners during clinical educator training days may further facilitate clinical educators' understanding of the difficulties experienced by physiotherapy students.

Kolb's Experiential Learning Theory (Kolb, 1984 cited in Hovey et al., 2017) posits that learners must pass through different stages for effective learning to occur. There must first be a concrete learning experience upon which the learner then reflects. Learners then conceptualise this experience, and finally utilise their newly acquired knowledge to solve problems and make decisions. It may well be that, whilst learning within the current physiotherapy programmes focuses on the overall concrete learning experience, there need to be more opportunities to reflect on this learning (beyond just communication and interpersonal skills) to enable more effective conceptualisation and application beyond the immediate learning experience. For example, in relation to discharge planning (a process that participants identified as a specific student challenge in older adult acute care), where students work on case scenarios within the university setting, a more thorough interrogation of social history factors as part of the overall case (the concrete learning experience) and reflection on the significance of these factors for overall patient management may enable translation and application of this knowledge and understanding into future more complex case scenarios and into clinical practice. This process may be especially relevant in complex patient caseload modules where multidisciplinary team working is central to management of patient case scenarios (including older adult scenarios) and where a fuller understanding of social history factors and their implications on patient management and discharge (conceptualised and applied from earlier learning) will enable students to more effectively recognise the value and involvement of each member of the MDT and of a range of hospital and community services. This could also be linked to overall clinical presentation and rehabilitation needs post-discharge to help mitigate for the limited rehabilitation available within acute care services and enable students to determine post-discharge rehabilitation needs and options. Thus, whilst discharge processes vary across placements, students would have a deeper understanding of discharge planning considerations as a starting point for their experiential learning.

For my participants, their early clinical experiences with older adults, whether positive or more negative, were often framed very much as significant learning events that were often about gaining a deeper understanding about this unwell older population in some way, and which often appeared to have led to a reframing of their practice that seemed to have gone beyond the 'immediate' and led to a reconstructing of their theory of knowledge in relation to managing this population. In addition, those with more clinical experience often demonstrated a more nuanced approach to practice. If the aim is to enable physiotherapy students to gain a deeper understanding of the value of their experiences with older adults in their clinical practice, whilst accepting the limitations of the more limited clinical exposure due to short placements, we need to facilitate this via the pedagogic approaches to reflective practice, interpersonal skill development and complex clinical reasoning identified above to enable their conceptualisation and application of their learning beyond these immediate learning experiences.

7.5 Ageism

Another key finding within this study was the description by my participants of both explicit and implicit ageism and othering within the acute care services in which they worked. To some extent, this was not a huge surprise given the extensive evidence of both ageism within society as a whole and of ageism within healthcare and as demonstrated by healthcare professionals. However, what did become clear when exploring my findings was that the evidence of this ageism articulated by my participants in relation to their own experiences and perceptions of older adults was more nuanced than some of the literature on ageism might suggest.

As identified in the literature review, ageism is considered a societal construct (Widrick and Raskin, 2010) where older adults are discriminated against, setting them apart from others within that society (Minichiello et al., 2000). Given that healthcare practitioners are themselves part of this society and cannot be immune to prevailing social attitudes and behaviours, they are liable to demonstrate some element of ageism themselves (Herdman, 2002; Wade, 1999). Foucauldian theory defines the concept of discourse as 'a group of statements which provide a language for talking about…a particular topic at a particular historical moment' (Hall 1997: p44) and Phelan (2011) argues that dominant negative discourses about ageing within healthcare result in more ageist normalised subject positions in relation to older adults. Examples include the use of chronological age classification that label those of a certain age as "old" and biomedical discourses of age as a degenerative process where interventions are required to sustain the preservation of the body. With this medicalisation of age and medical discourses that present older adults as unwell and dependent in comparison to a younger, healthier population, Phelan (2011) argues that there is resultant medical discrimination against, and othering of, older adults. As identified in my participants' discussions, this appeared to result in not only a physical segregation of frail elderly patients within their organisation but also an othering of this population – a population who often recover more slowly and may have much more significant social needs than the majority of patients within acute care. That this segregation and labelling of 'elderly' was described by my participants as being largely chronologically based (i.e., 65+) reinforces Phelan's argument. Participants also described a range of negative discourses expressed by some physiotherapy colleagues in relation to working with frail patients, with the area being described as boring and unstimulating being cited as examples. In contrast to these more explicit descriptions of ageism, othering and labelling, my participants' discussions in relation to frail elderly and to managing their older patients often appeared more nuanced. Whilst there was some evidence of medicalisation of clinical management (e.g., P8's perception of the limited range of physiotherapy input appropriate for this population), most participants articulated a more biopsychosocial approach to managing these patients. There was evidence of ageism within some of their descriptions of their older relatives and patients such as in the use of both negative and positive stereotypes (such as vulnerable, experienced and knowledgeable, and good for their age). However, this ageism was more implicit in nature and their more conscious discussions in relation to their older patients generally articulated a positive approach to these patients, which was largely focused on holistic and individualised care to maximise patient potential within the constraints of the system. Several of them saw their role as being positive role models, not only in educating students but also in changing the perceptions of other staff in relation to working with older adults. Levy and Banaji (2002: p51) acknowledge the challenges inherent in implicit ageism, given that those demonstrating implicit ageism often remain unaware of this and so cannot amend behaviours.

This difference between what appears to be an explicitly articulated positive perception of older adults and older patients and evidence of ageism that was implicit, as evidenced by the words and phrases used by participants, highlights a challenge within physiotherapy education. Within higher education, academic staff have to accept that they cannot immediately influence the ageist organisational strictures of the acute healthcare organisations in which our students gain experiential learning, even though we can hope that with time our students may become agents of change as they qualify and move into clinical practice. However, we can influence our students' attitudes and perceptions. Flores-Sandoval and Kinsella (2020) contend that challenging taken-for-granted discourses around decline and dysfunction to mediate stereotypical and ageist attitudes is a role that healthcare education can play. They argue that critical reflexivity, the critical examination of how these taken-for-granted discourses are socially constructed, can help students gain a better understanding of how social structures and discourses influence the way they think about older adults. An example of this might be challenging student perceptions in terms of all older adults being frail and vulnerable and enabling recognition of the valued contributions older adults make to society, a strategy that may be facilitated in part by enabling contact with older adults who are ageing successfully and who can share their life experiences. In addition, given that frailty as a concept involves physical weakness and may be perceived by students as a collection of deficits and incapacities (Kane and Jacobs, 2018), another critical reflexive strategy might be to get students to reflect on the broader context of their experiences with older frailer patients beyond the physical or cognitive dysfunction on which they may be more likely to focus.

Evidence for the impact of educational strategies on the attitudes of healthcare students towards older adults is mixed. Intrieri et al. (1993) found a six-week gerontology and psychology module for medical students resulted in more positive attitudes towards older adults. However, Taylor and Tovin (2000) and Hobbs et al. (2006) both found that in their physiotherapy students gerontological teaching increased knowledge about older adults but only translated into wanting to work with this population if the students also had clinical experience with this patient group. This supports the importance of experiential learning within the older adult clinical environment to reinforce and contextualise university-based teaching. Hovey et al. (2017) posit that this is likely to be due to Experiential Learning Theory, where the concrete experiences gained as a result of gerontological teaching are built upon and contextualised as students move into the clinical environment and engage in observation and reflection, so that, ultimately, they can apply their newly acquired knowledge to new situations.

The overall messages within the literature are that: in order to positively influence attitudes towards older adults healthcare students benefit from experiences and interactions with healthy older adults; specific gerontological teaching needs to address not only content related to dysfunction (e.g., frailty) but also attitudes and perceptions; and gerontological teaching is in itself insufficient without the contextualisation provided by clinical experience (Hovey et al., 2017). The current predominant focus in the Keele physiotherapy programmes, largely due to the limited time in packed curricula, is frailty and dysfunction in an older population, with the aim of enabling students to manage the more common clinical presentations of older adults in practice, and as such there is limited focus on healthy (or successful) ageing. In addition, some of the suggestions from my participants for additional teaching to support clinical placement experiential learning are already implemented within the programmes (e.g., dementia). However, current teaching strategies may not enable students to either contextualise that learning or view it through a more positive lens of patient enablement, resulting in potential perpetuation of negative perceptions of older adults with these conditions. Reassuringly for the programmes, evidence suggests that physiotherapy students do demonstrate positive attitudes towards older adults (e.g., Duthie and Donaghy, 2009), supporting at least some of the experiences of my participants. In addition, Watkins and Waterfield (2010) found that where physiotherapy students had negative clinical experiences these made their student participants more determined to be proactive in older adult rehabilitation. However, as identified earlier, there is evidence to support the introduction of more positive dialogues of successful ageing and rehabilitation to counterbalance the educational focus on dysfunction.

For additional consideration, Castellano-Rioja et al. (2022) found that whilst gerontological teaching increased positive attitudes in nursing students, it did not reduce ageist attitudes, and both Blackwood and Sweet (2017) and Meiboom et al. (2015) describe what they term a ‘hidden agenda’ in healthcare education where the negative attitudes of those teaching students within both the educational and the clinical environment can engender ageist attitudes, norms and values in students. In the case of my participants their implicit (and in some cases more explicit) ageism has the potential to negate the conscious positive messages about working with older adults in acute care that they wish to pass on to students. This suggests that not only do curricula need to facilitate in students an understanding of their own and society's ageist attitudes and perceptions, but this education also needs to enable them to recognise and address any more implicit ageism within clinical practice both within their own practice and (if feasible) that of others. Furthermore, education of faculty staff and clinical educators (via current clinical educator training days) in recognising more implicit ageism and the risks inherent in perpetuating this may help mitigate the impact of this 'hidden curriculum'.

Ultimately, my research suggests that both explicit and implicit ageism exist within at least some acute care services. This societal ageism will be present within physiotherapy students as well. In relation to educational practice, students need to be made aware of their own ageist attitudes and perceptions and taught to recognise ageism in clinical practice so that whilst they may not be able to address the organisational level or perhaps even challenge this in the staff around them (due to power relationships), they can at least avoid perpetuating this ageism within their own practice.

7.6 Summary of key findings

Clinical exposure and opportunities offered by experiential learning in the clinical placement environment not only facilitate the acquisition, development and application of knowledge and skills but also promote modulation of feelings and expose students to the work, roles and identities they will encounter as qualified professionals (Hakim et al., 2014). Thus, the role of clinical education is central to physiotherapy training. However, students need to constantly adjust to new tutors and clinical situations, striking a balance between their student role and their therapist role and between being independent and being overdemanding (Neville and French, 1991). Educators, in turn, have multifaceted roles in often challenging clinical environments and need to strike a balance in the support they offer individual students; they need to be supportive and facilitatory whilst challenging student learning and whilst balancing the needs of patients and the demands of the clinical environment. In addition, students in clinical practice often face ill-defined problems, complex goal management and outcomes that are difficult for them to clearly predict (Higgs, 1993). My findings reflect a number of these challenges. The acute care environment was described as challenging to work in, with substantial pressures on physiotherapy staff, and my participants identified some of the challenges inherent in facilitating student learning whilst balancing the needs of their older patients and the demands of their working environment. It was also evident that the complexity of this acute care older adult population was challenging for many students to manage, given the complex clinical reasoning and problem-solving skills required for many of those patients. Indeed, even what might be perceived by students as less complex skills, such as communication, were described by my participants as challenging within this environment and with this older adult population.

Importantly, my research suggests that the clinical practice of educators themselves may be influenced by their past experiences, both personal and professional, and by aspects of implicit ageism. The largely positive framing of personal/pre training experiences with older adults within the interviews was mirrored in discussions around aspects of practice such as seeing the person, gaining understanding of a patient's broader life beyond their presenting condition(s) and maximising function and quality of life - reflecting a positive framing of physiotherapy practice within a broader biopsychosocial context. Even where those early experiences had been less positive, such as P12's job working with dependent older adults a long-term care, the impact seemed to be a desire to ensure within their practice, where possible, that their older patients did not have to experience similar situations.

Some participants described seminal experiences that had significant impact on their approach to practice and their education of physiotherapy students. For example, P2 was able to make explicit links between her profound change in her approach to rehabilitation as a result of her research, where patients described loss of dignity and control over their rehabilitation, and how she now educated her students. However, for other participants there seemed to be more limited awareness of the impact of previous personal and/or professional experiences on current practice. For instance, P7 did not seem aware of the potential link between his personal experiences of a close knit and supportive extended family and his later expressions of frustration at families who did not take responsibility for supporting their older relatives. In addition, previous experiences, such as P8's experience of frail elderly as an area where the impact of physiotherapy was limited and P1's more negative perception of musculoskeletal practice (an area identified as being preferred by many male students, who were described by P1 as often having more negative perceptions of older-adult acute care) could be posited as having the potential to subconsciously influence their education of physiotherapy students. Ultimately, this research has highlighted that in clinical practice there are a range of experiences, with the potential to influence practice, that will be unique to the individual practitioner, and which may be therefore more challenging for physiotherapy programmes to prepare for educationally as students move into the clinical education environment.

7.7 Implications of the findings in terms of curriculum development

The challenge within physiotherapy education is how to better prepare students for entering this challenging environment, particularly in light of both packed curricula and the extensive variety of clinical placements for which they need to be prepared, with older adult acute care placements being only one small component of the overall experiential learning experiences available to them. However, some of the strategies proposed earlier in this summary discussion not only are feasible to bring into the programme, requiring a rethink about how we teach such content rather than an introduction of new content, but should also enhance student learning, both within the university setting and the varied clinical placement environments in which they will be working during their training. These include: more formalised and ongoing development of reflective skills; revisiting and recontextualising of communication strategies; consideration of the ways in which case studies are presented and worked on throughout the programme so as to better develop hypothetico-deductive reasoning skills; and an increased focus on factors such as discharge planning. Academic staff also need to ensure that they provide sufficient information to practice educators to enable them to most effectively recognise and continue to develop the knowledge and skills students have gained within the university setting at each point in their training, with the aim of hopefully reducing the mismatch in expectations between student abilities and clinical educator expectations that were articulated by my participants.

There are, however, implications in terms of curriculum development for some of my findings. Given the evidence within this research around both institutional ageism and othering, and the implicit ageism articulated by my participants during their interviews, it is important to raise awareness in students of both societal ageism and their own potential societally medicated ageist perceptions of older patients, and to help them recognise this within clinical practice (both their own practice and that of others) and take steps to manage this where feasible. Thus, we should explore where and how this education can best be delivered at an early point their training. Furthermore, the introduction of more content around successful ageing, in addition to the necessary older adult content around dysfunction, such as frailty and falls, would aim to help balance their perceptions of older adults as a general population.

Finally, there is substantial evidence that specific modules focusing on gerontological knowledge, skills and experiences can have a positive impact on both student learning and student attitudes towards older adults more broadly, and older patients more specifically. As such, whilst current gerontological content is spread across several modules and levels of study, as the Keele pre-registration physiotherapy curricula develop it is important to explore the feasibility of introducing specific gerontological modules.

7.8 Transferability of findings

One of the key features of qualitative research is the assumption that every case is special and unique (Patton, 2002: p41). As such, the claims for the generalisability within qualitative research are not exceptionally strong (Firestone, 1993). Therefore, it is important to recognise that the findings from this research in relation to past experiences (personal, clinical and educational) appear closely linked to the unique life experiences of my participants and may have influenced their current practice in very different ways from those of other physiotherapy clinical educators working in acute care environments with an older adult patient population. However, Firestone (1993) argues that there are strategies qualitative researchers can utilise to increase the broader applicability of their findings and that providing rich descriptions, as my study has aimed to do, can aid case-to-case transfer and reasoning. The literature suggests that the demands on both physiotherapy staff and physiotherapy students of working in this older adult acute care environment are common not just across UK secondary care organisations but more globally. In addition, the skills identified as necessary for students to demonstrate within this environment, such as effective communication and complex clinical reasoning, are skills that physiotherapy students are required to develop as part of their training in general (Chartered Society of Physiotherapy, 2020) and in their management of an older adult population (International Association of

Physiotherapists Working with Older People (IPTOP), 2021). As such, the student challenges identified by my participants may well be reflected more broadly across the UK pre-registration student population and there is value in all pre-registration programmes reviewing their educational strategies to ensure students are being best prepared to be able to demonstrate these skills within the clinical environment.

In addition, my findings suggest that, whilst there is evidence of institutional ageism and othering, which is more commonly cited in literature and thus likely to be present (to a greater or lesser extent) within many acute care settings, the type of ageism implicitly expressed by participants - whose explicit descriptions of their older adult patients were largely positive - is less commonly recognised within physiotherapy-related ageism literature. Thus, not only do physiotherapy curricula need to educate students on ageism per se, including recognising their own attitudes towards and perceptions of older adults and older patients, but programmes also need to help them recognise that overly positive discourses around ageing and older adults may have hidden implicit negative attributes that may in turn influence student perceptions about this population. Only in this way can we hope to change these clinical narratives over time.

7.9 Study strengths and limitations

7.9.1 Sampling

A purposive sampling strategy was used to recruit participants for this study, where individuals are selected because their characteristics and experiences can purposefully inform an understanding of the phenomenon that forms the basis for the research study (Creswell, 2007: p81). This strategy aimed to recruit participants within a single acute (secondary care) organisation who worked in or across a number of clinical areas where older adults would form part of their clinical caseload and who were a mix of grades and experience. As can be seen in Table 4, my sample did reflect a mix of gender, band (grade) of practitioner, years of experience clinically, length of time supervising students (years) and those who had, or were currently, working in areas that were either older adult specific or older-adult related (i.e., clinical areas where older adults formed part of the overall clinical caseload). As the data collection process progressed, it became evident that a significant amount of the data being generated related specifically to the acute (secondary care) management of older adults and the education of our students within the acute care clinical environment; this further supported my sampling strategy.

However, there were significant challenges to recruiting participants for this research due to a lack of initial response to the recruitment emails and, as detailed earlier, this necessitated an additional recruitment strategy via an ongoing process of my handing out the Participant Information Sheet to staff when at the organisation and a more informal recruitment via snowballing. Whilst my final sample did reflect the range of attributes identified in my purposive sampling strategy, it has to be acknowledged that these additional recruitment strategies meant that I had less control over who was informed about the research. In addition, whilst all participants recruited were self-selected due to interest in the research, it is difficult to know if any additional information about the study, passed on by those who had already taken part via snowballing, may have influenced the findings in any way.

Of further consideration, whilst the choice of institution and sample should be in some way representative of a larger population of institutions/physiotherapists (Seawright and Gerring, 2008), a note of caution must be sounded with regard to any assumption of transferability. Although my findings may be placed in an historical or societal context, I needed to be very careful about the meaningfulness of generalising the findings to other institutional settings and instead only extrapolate insights for possible transferability into different settings (Patton 2002), with no assumption within my research of a level of transferability which may not exist.

7.9.2 Data analysis

Although from early on in the data collection process it became evident that different participants were identifying similar issues, such as the need to see the person or individual and the importance of holistic management, there was a danger of confirmation bias where I might have focused on finding further examples of these codes rather than allowing different codes and categories to emerge as data analysis progressed (Creswell, 2007 p185). As such I tried to ensure that I allowed the codes and themes to emerge from each individual data set. This was facilitated by the use of a Constant Comparative Analysis (CCA) method of analysis, aided by the use of NVivo – both of which enabled ongoing review and scrutiny by both myself and others as themes were identified through the process of analysis, enhancing credibility, dependability, and confirmability, and forming part of the audit trail (as described in Chapter 5).

7.9.3 Bias

It must be recognised that I was known to the participants in my role as a physiotherapy lecturer at Keele, and for some as a visiting tutor for clinical placements. As identified in Chapter 5, this may have resulted in a social desirability bias, and I utilised various strategies to try to minimise this risk. In fact, many participants seemed to use my role as a means of enabling them to express themselves during the interviews, using professional and clinical terminology with the knowledge that their meaning would be understood. This meant that the interviews flowed more freely than if participants had needed to 'translate' into layman's terminology. Darawsheh (2014) highlights that researchers can employ the knowledge inherent in their professional roles to seek in-depth rather than superficial information, and I found that I was able to probe during interviews in a way that would not have been possible had I not understood this ‘physio speak’. Indeed, Chew-Graham et al. (2002), in exploring the dual role of qualitative researcher and clinician, found that where participants recognised the researcher as a clinician the resultant interviews provided richer and more personal accounts. However, there was a risk that my unconscious understanding of this professional and clinical language might in turn lead me to make assumptions about what my participants were telling me, so I had to make a conscious effort to ask participants to define concepts and terms, such as ‘holistic’, to ensure that I did not impose my definition or understanding onto each participant. This process in turn may have further served to remind them of my role as researcher as opposed to my other roles. In addition, it has to be acknowledged that there were instances where it was difficult to determine whether participants evidenced social desirability bias, such as the discussions around differentiating between liking older adults and liking working with older adults which occurred as part of interviews 8 onwards. Chew-Grahm et al. (2002) cite a risk that interview participants may perceive the clinician researcher as making moral judgements, particularly when discussing what might be perceived as more sensitive information. As a result, they may be more cautious in the information they share, and the data obtained may also need to be treated with some caution. Whilst P8 articulated a very clear personal distinction between liking and liking working with older adults, all other participants, whilst acknowledging and describing this distinction in others, described themselves as both liking and liking working with this population and it is impossible to determine whether this was in actuality the case or whether they felt, as older-adult physiotherapy practitioners, that they should express themselves this way.

7.9.4 Pilot study and timings

A review of the pilot study did indicate a few areas for further consideration in progression onto the main study. There were elements of repetition present in the pilot study transcript where topics had been returned to. I had not recognised this repetition and therefore had not moved the interview on at these points as effectively as I could have done. I had also misjudged the timing somewhat, meaning that less time was spent on the later questions in comparison to the earlier questions. Moving into the main study interviews, I was therefore more attuned to elements of repetition, and, in recognising this, could move participants on or rephrase questions to see if different responses were elicited. The challenge of timing became less of a concern as the interviews progressed: all participants had allocated over an hour for the interview and for each interview the topic and questions were addressed and explored in-depth within less than one and a half hours. In some cases, this was because the interview had naturally ended, and in others because I was conscious that my participants had allocated a finite amount of time to my research and so I brought the interview to an end.

There was also a risk that I may have allowed the pilot study findings to influence my data coding by looking for confirmation of these findings rather than allowing findings to emerge from the main study data. In reality, the delay in being able to recruit for the main study meant that the findings from the pilot study were less prominent in my mind and, during both carrying out and completing the main study and writing up the findings, I intentionally chose not to revisit the pilot study findings in order to avoid making any assumptions in terms of the emerging findings being identified as the interviews progressed and their implications for practice etc. However, some of the general themes from the pilot study were reflected in the main study findings. These included: discussions around vulnerable and active older adults; the interrelationship between participant’s early experiences of older adults and a career choice of physiotherapy; a mix of both negative and positive discourses around ageing; identification of several perceived institutional constraints and strictures imposed on older adults particularly within acute healthcare settings; the need for physiotherapy students to understand and apply holistic management strategies when working with older adults and meeting the full needs of patients rather than just the immediate problems that had brought them into hospital. Given that the pilot study participant had worked at other acute care organisations from those of my participants (including here any past experiences some of them had in other organisations), this synergy between these pilot study general themes and the findings in the main study suggests some transferability of the findings.

7.9.5 Terminology used in literature

One of the specific challenges in relation to writing about a more positive ageing process lies in the terminology used within the literature. Bülow and Söderqvist (2014) highlight challenges with many of the terms used, with healthy ageing, active ageing, robust ageing, positive ageing, optimal ageing, effective ageing, successful ageing and harmonious ageing all being used within the literature. They argue that many of these terms are reductionist and either do not encompass all aspects of ageing or do not reflect those older adults who are still able to lead what they themselves consider to be a fulfilling life regardless of their physical, psychological, and social functioning. Within physiotherapy, terms such as healthy ageing, active ageing (both utilised in a range of literature and sources on the CSP website) and positive ageing (IPTOP, 2021) are commonly used, perhaps reflecting a more healthcare-orientated biopsychosocial approach. Given that different terms are used within different articles, I have tried in my discussions to reflect the terminology used within the studies cited and reflected this discrepancy in my summary discussion when exploring the implications of my findings for student education, whilst acknowledging here that the term successful ageing also has its critics.

7.10 Conclusion: educational applications and recommendations

The aim of this study was to explore physiotherapists' experiences with older adults, how these experiences may have informed their clinical practice, and how these experiences may in turn influence how they educate physiotherapy students. There was evidence that previous experiences with older adults influenced both current practice and my participants' education of their physiotherapy students. Participants not only evidenced some commonality of personal and clinical experiences but also described experiences with older adults which were unique to each participant, all of which had the potential to influence practice and their approach to clinical education either consciously or subconsciously. Whilst explicit discussions were largely positive in relation to participants perceptions of and management of older adults, there was evidence of implicit ageism in my participants' discussions about older adults/older patients and of organisational ageism and othering - both of which could have the potential to negatively influence student perceptions of this patient group. The challenges of working in acute care also mean that educators may have expectations that many students will struggle to meet. A range of educational strategies are required to avoid a mismatch between expectations and actual performance, which may negatively impact on both the student and educator experience. These could include:

- A greater focus on discharge planning processes and holistic management.
- An exploration of how current teaching on topics such as communication and dementia can be made more relevant and meaningful to students.
- A review of how the skills inherent in complex clinical reasoning and problem-solving can be more explicitly and cohesively developed over the course of the physiotherapy programme to enhance the clinical education experience for both students and educators.
- An exploration of how the university can best share current teaching and seek educator validation to ensure a more cohesive student learning experience.

- Education of physiotherapy students about ageism per se, including recognising their own attitudes towards and perceptions of older adults and older patients, and facilitating in students an understanding that overly positive narratives around ageing and older adults may have hidden implicit negative attributes that may in turn influence their perceptions about this population.

7.11 Recommendations for future research

Given the pedagogic recommendations generated by this research, future research on the success (or otherwise) of implementing these recommendations would be valuable. Evaluation is important in assessing the effectiveness of teaching and teaching strategies, facilitating ongoing development of curricula, and having a societal role (Ifeoma, 2022), in this instance the successful performance of Keele physiotherapy students within the acute care older adult clinical environment. This evaluation could include:

- Pre and post implementation assessment (via both clinical educator and student) of students' perceived confidence in effective management of:
    - More complex communication situations (including with older adults)
    - Discharge planning processes
    - Complex clinical reasoning and decision making in relation to patient management within the clinical environment.
- Post implementation survey of the usefulness of the skills list in enabling clinical educators to determine programme expectations of students' clinical reasoning and decision-making skills at each stage of training.
- Post implementation of teaching on successful ageing and of ageism within healthcare: further exploration of the perceived impact of the clinical education environment on students' perceptions of older adult rehabilitation; students' perception of their readiness for clinical practice with older patients; and, in

particular, their perceptions of the impact of clinical education experiences with older adults: all following on from the work of Watkins and Waterfield (2010).

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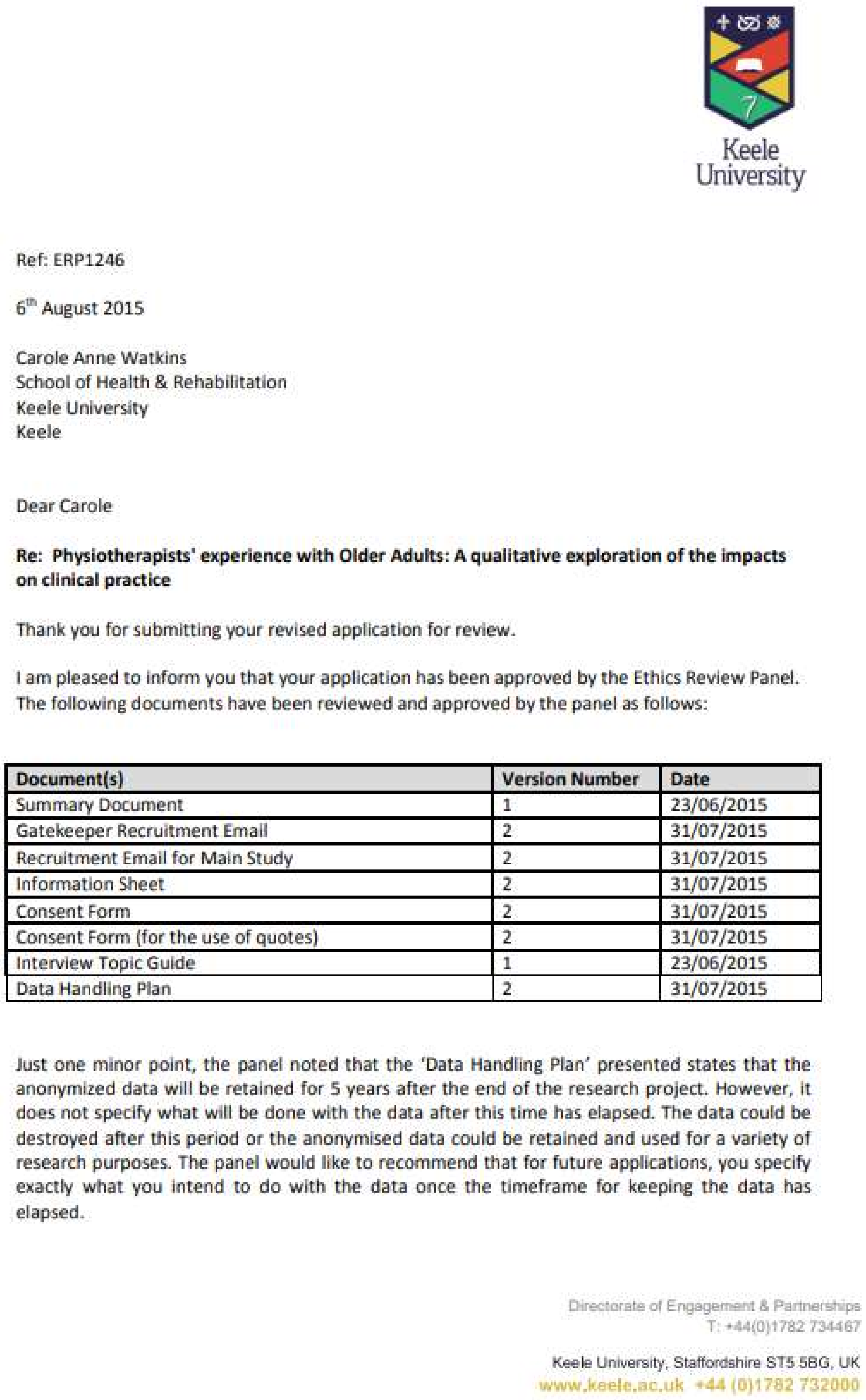
Appendices

Appendix 1 – university ethics approval



Keele University

Ref: ERP1246

6th August 2015

Carole Anne Watkins
School of Health & Rehabilitation
Keele University
Keele

Dear Carole

Re: Physiotherapists' experience with Older Adults: A qualitative exploration of the impacts on clinical practice

Thank you for submitting your revised application for review.

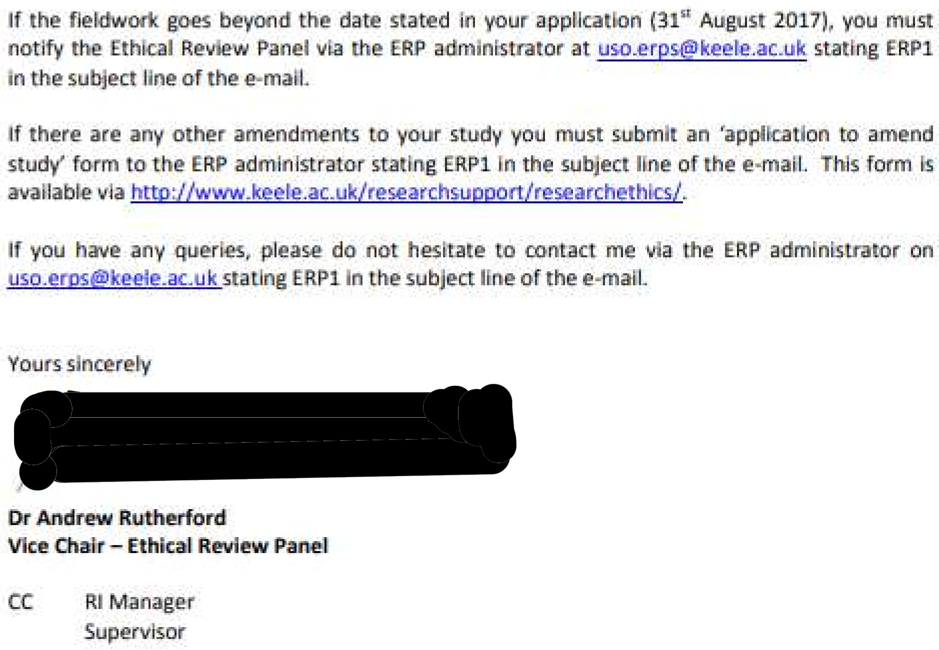
I am pleased to inform you that your application has been approved by the Ethics Review Panel. The following documents have been reviewed and approved by the panel as follows:

Document(s)	Version Number	Date
Summary Document	1	23/06/2015
Gatekeeper Recruitment Email	2	31/07/2015
Recruitment Email for Main Study	2	31/07/2015
Information Sheet	2	31/07/2015
Consent Form	2	31/07/2015
Consent Form (for the use of quotes)	2	31/07/2015
Interview Topic Guide	1	23/06/2015
Data Handling Plan	2	31/07/2015

Just one minor point, the panel noted that the 'Data Handling Plan' presented states that the anonymized data will be retained for 5 years after the end of the research project. However, it does not specify what will be done with the data after this time has elapsed. The data could be destroyed after this period or the anonymised data could be retained and used for a variety of research purposes. The panel would like to recommend that for future applications, you specify exactly what you intend to do with the data once the timeframe for keeping the data has elapsed.

Directorate of Engagement & Partnerships
T: +44(0)1782 734467

Keele University, Staffordshire ST5 5BG, UK
www.keele.ac.uk +44 (0)1782 732000



If the fieldwork goes beyond the date stated in your application (31st August 2017), you must notify the Ethical Review Panel via the ERP administrator at uso.erps@keele.ac.uk stating ERP1 in the subject line of the e-mail.

If there are any other amendments to your study you must submit an 'application to amend study' form to the ERP administrator stating ERP1 in the subject line of the e-mail. This form is available via http://www.keele.ac.uk/researchsupport/researchethics/.

If you have any queries, please do not hesitate to contact me via the ERP administrator on uso.erps@keele.ac.uk stating ERP1 in the subject line of the e-mail.

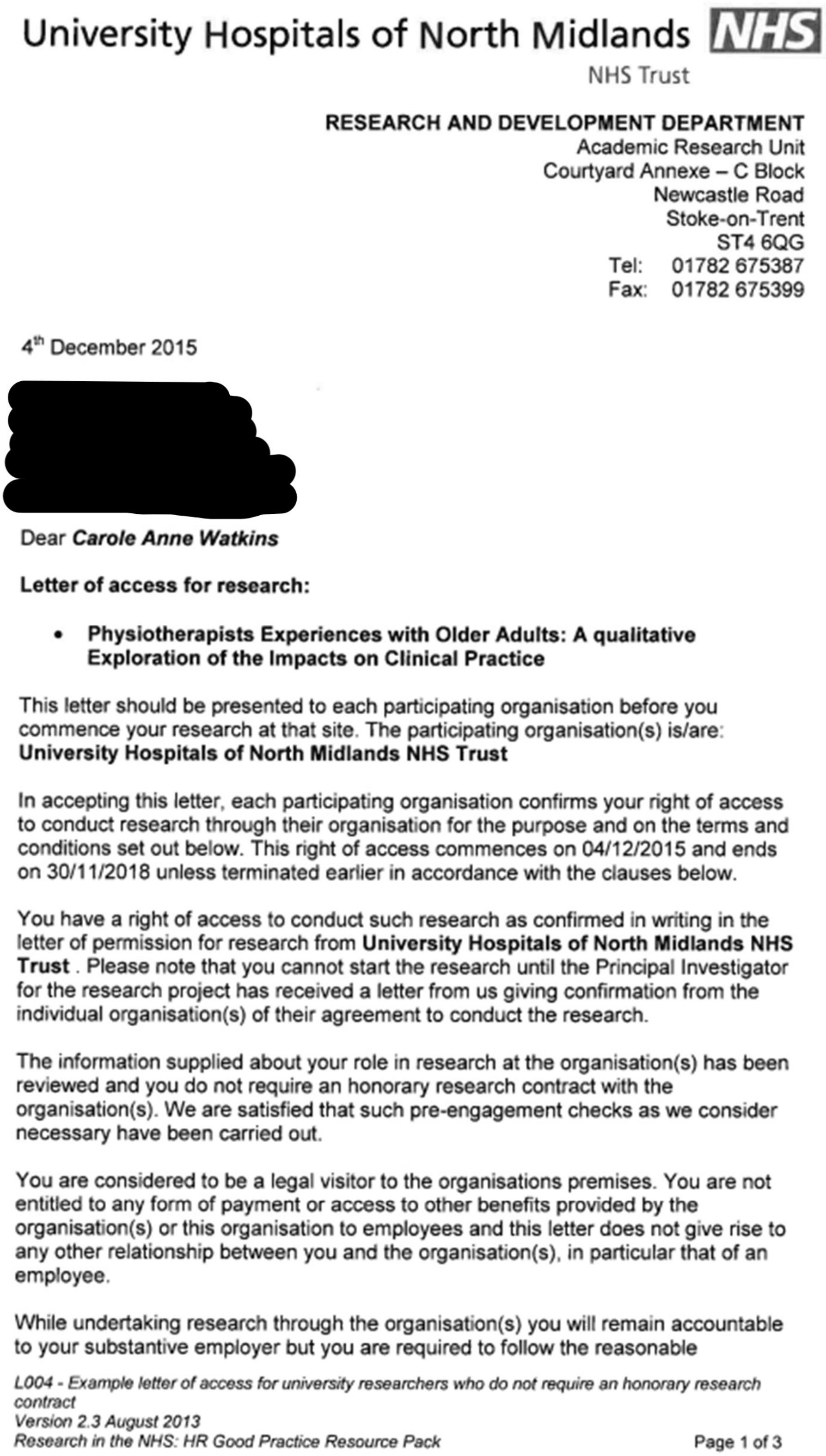
Yours sincerely

[redacted]

Dr Andrew Rutherford
Vice Chair – Ethical Review Panel

CC RI Manager
Supervisor

Appendix 2 R & D approval



University Hospitals of North Midlands **NHS**
NHS Trust

RESEARCH AND DEVELOPMENT DEPARTMENT
Academic Research Unit
Courtyard Annexe – C Block
Newcastle Road
Stoke-on-Trent
ST4 6QG
Tel: 01782 675387
Fax: 01782 675399

4th December 2015

[redacted]

Dear ***Carole Anne Watkins***

Letter of access for research:

- **Physiotherapists Experiences with Older Adults: A qualitative Exploration of the Impacts on Clinical Practice**

This letter should be presented to each participating organisation before you commence your research at that site. The participating organisation(s) is/are: **University Hospitals of North Midlands NHS Trust**

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 04/12/2015 and ends on 30/11/2018 unless terminated earlier in accordance with the clauses below.

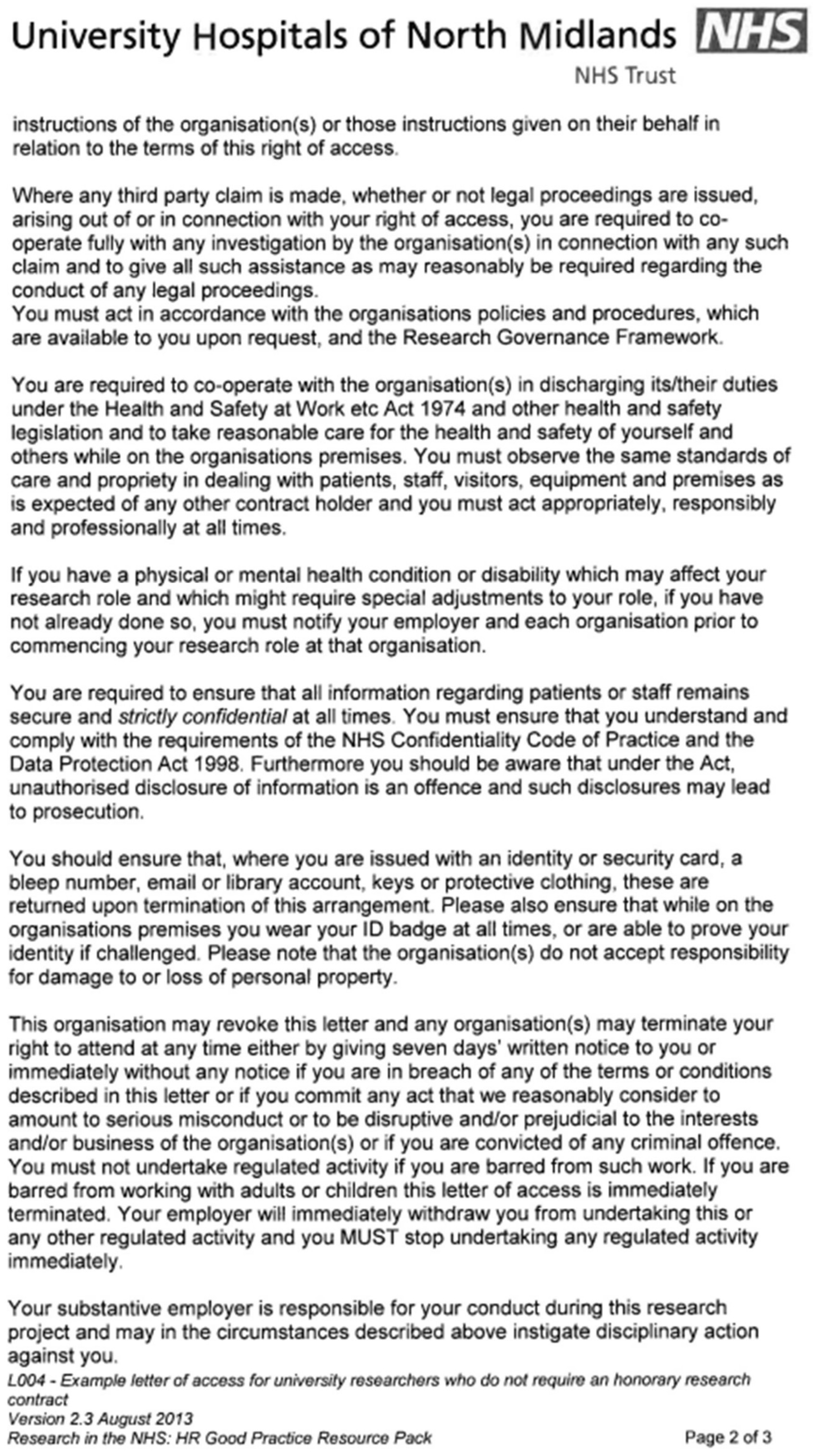
You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from **University Hospitals of North Midlands NHS Trust** . Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation from the individual organisation(s) of their agreement to conduct the research.

The information supplied about your role in research at the organisation(s) has been reviewed and you do not require an honorary research contract with the organisation(s). We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to the organisations premises. You are not entitled to any form of payment or access to other benefits provided by the organisation(s) or this organisation to employees and this letter does not give rise to any other relationship between you and the organisation(s), in particular that of an employee.

While undertaking research through the organisation(s) you will remain accountable to your substantive employer but you are required to follow the reasonable

L004 - Example letter of access for university researchers who do not require an honorary research contract
Version 2.3 August 2013
Research in the NHS: HR Good Practice Resource Pack



instructions of the organisation(s) or those instructions given on their behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the organisation(s) in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.
You must act in accordance with the organisations policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the organisation(s) in discharging its/their duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the organisations premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

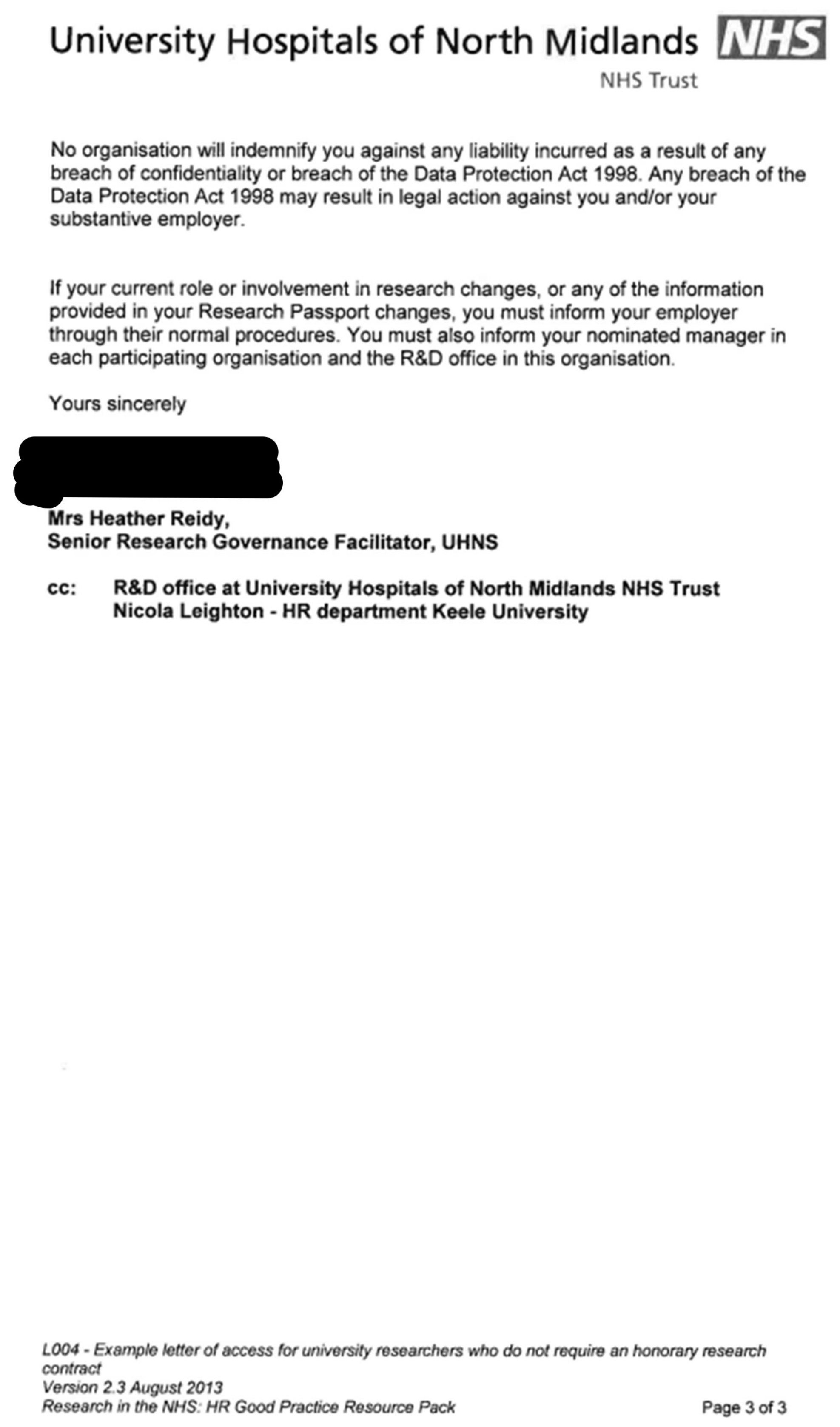
If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each organisation prior to commencing your research role at that organisation.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the organisations premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation(s) do not accept responsibility for damage to or loss of personal property.

This organisation may revoke this letter and any organisation(s) may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation(s) or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.



University Hospitals of North Midlands NHS
NHS Trust

No organisation will indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in each participating organisation and the R&D office in this organisation.

Yours sincerely

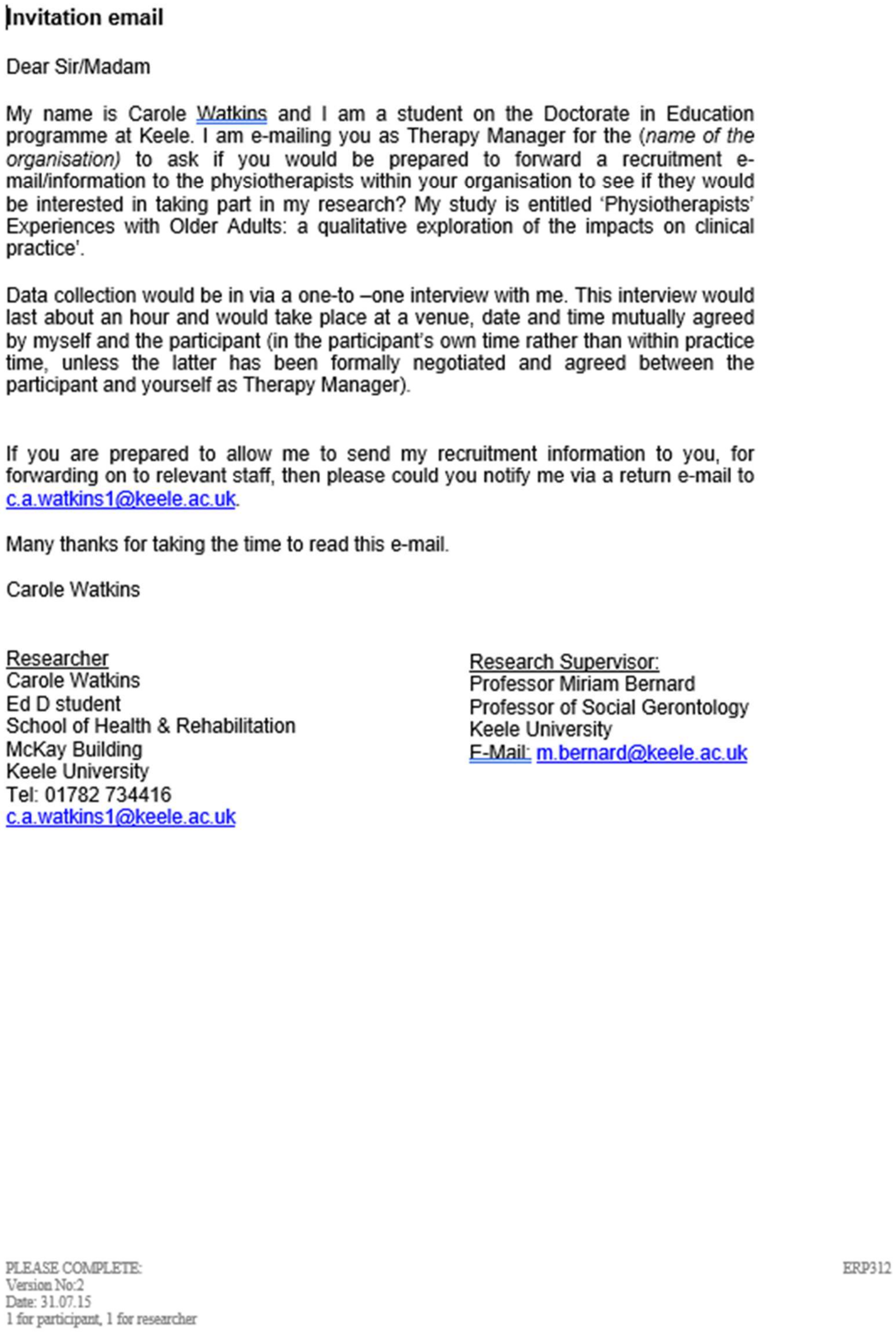
[redacted]

Mrs Heather Reidy,
Senior Research Governance Facilitator, UHNS

cc: **R&D office at University Hospitals of North Midlands NHS Trust**
Nicola Leighton - HR department Keele University

L004 - Example letter of access for university researchers who do not require an honorary research contract
Version 2.3 August 2013
Research in the NHS: HR Good Practice Resource Pack Page 3 of 3

Appendix 3 Gatekeeper recruitment email



Invitation email

Dear Sir/Madam

My name is Carole Watkins and I am a student on the Doctorate in Education programme at Keele. I am e-mailing you as Therapy Manager for the (*name of the organisation)* to ask if you would be prepared to forward a recruitment e-mail/information to the physiotherapists within your organisation to see if they would be interested in taking part in my research? My study is entitled 'Physiotherapists' Experiences with Older Adults: a qualitative exploration of the impacts on clinical practice'.

Data collection would be in via a one-to –one interview with me. This interview would last about an hour and would take place at a venue, date and time mutually agreed by myself and the participant (in the participant's own time rather than within practice time, unless the latter has been formally negotiated and agreed between the participant and yourself as Therapy Manager).

If you are prepared to allow me to send my recruitment information to you, for forwarding on to relevant staff, then please could you notify me via a return e-mail to c.a.watkins1@keele.ac.uk.

Many thanks for taking the time to read this e-mail.

Carole Watkins

Researcher
Carole Watkins
Ed D student
School of Health & Rehabilitation
McKay Building
Keele University
Tel: 01782 734416
c.a.watkins1@keele.ac.uk

Research Supervisor:
Professor Miriam Bernard
Professor of Social Gerontology
Keele University
E-Mail: m.bernard@keele.ac.uk

PLEASE COMPLETE:
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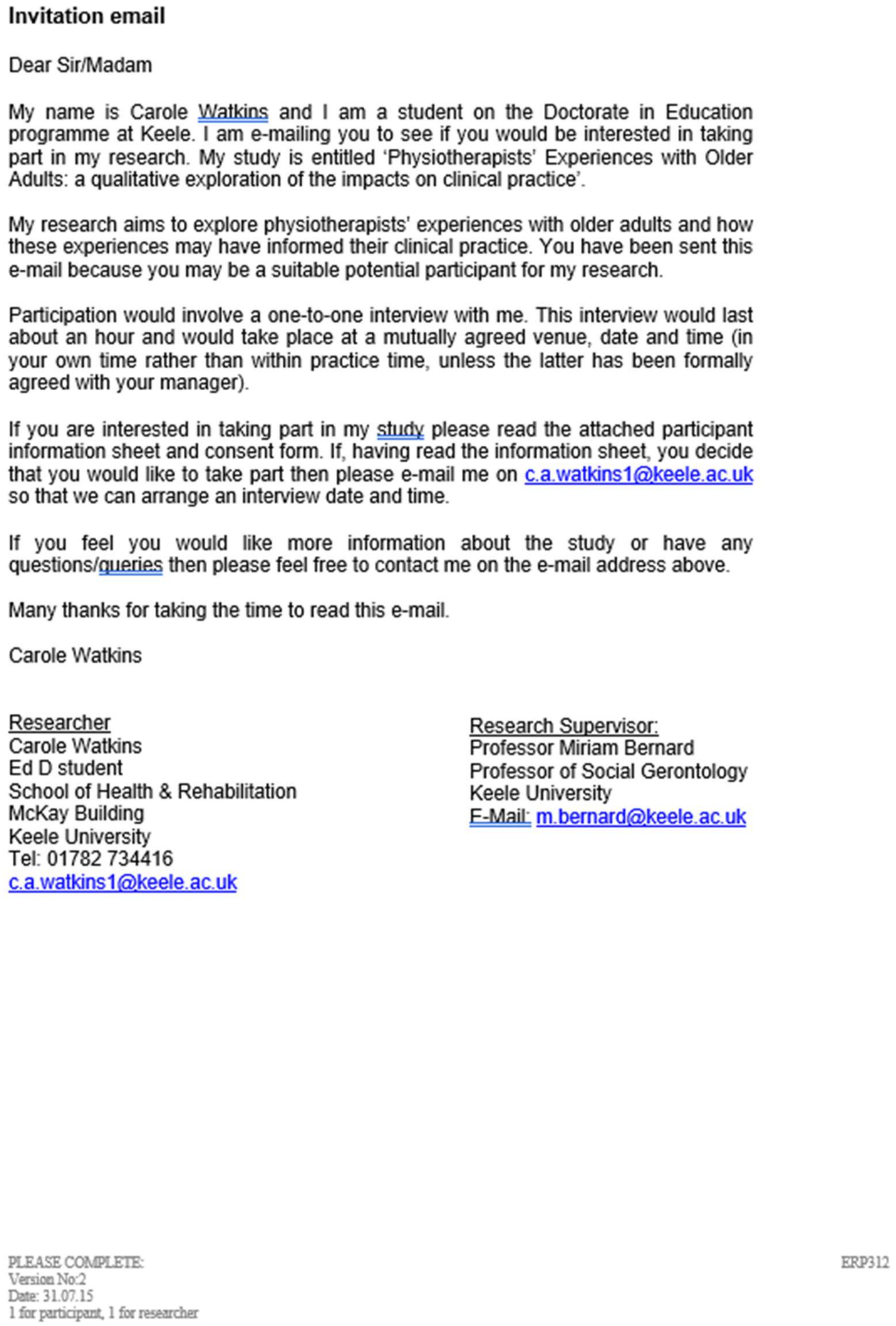
Date: 31.07.15
1 for participant, 1 for researcher

ERP312

Appendix 4 Recruitment email for main study



Invitation email

Dear Sir/Madam

My name is Carole Watkins and I am a student on the Doctorate in Education programme at Keele. I am e-mailing you to see if you would be interested in taking part in my research. My study is entitled 'Physiotherapists' Experiences with Older Adults: a qualitative exploration of the impacts on clinical practice'.

My research aims to explore physiotherapists' experiences with older adults and how these experiences may have informed their clinical practice. You have been sent this e-mail because you may be a suitable potential participant for my research.

Participation would involve a one-to-one interview with me. This interview would last about an hour and would take place at a mutually agreed venue, date and time (in your own time rather than within practice time, unless the latter has been formally agreed with your manager).

If you are interested in taking part in my study please read the attached participant information sheet and consent form. If, having read the information sheet, you decide that you would like to take part then please e-mail me on c.a.watkins1@keele.ac.uk so that we can arrange an interview date and time.

If you feel you would like more information about the study or have any questions/queries then please feel free to contact me on the e-mail address above.

Many thanks for taking the time to read this e-mail.

Carole Watkins

Researcher
Carole Watkins
Ed D student
School of Health & Rehabilitation
McKay Building
Keele University
Tel: 01782 734416
c.a.watkins1@keele.ac.uk

Research Supervisor:
Professor Miriam Bernard
Professor of Social Gerontology
Keele University
E-Mail: m.bernard@keele.ac.uk

PLEASE COMPLETE:
Version No:2
Date: 31.07.15
1 for participant, 1 for researcher

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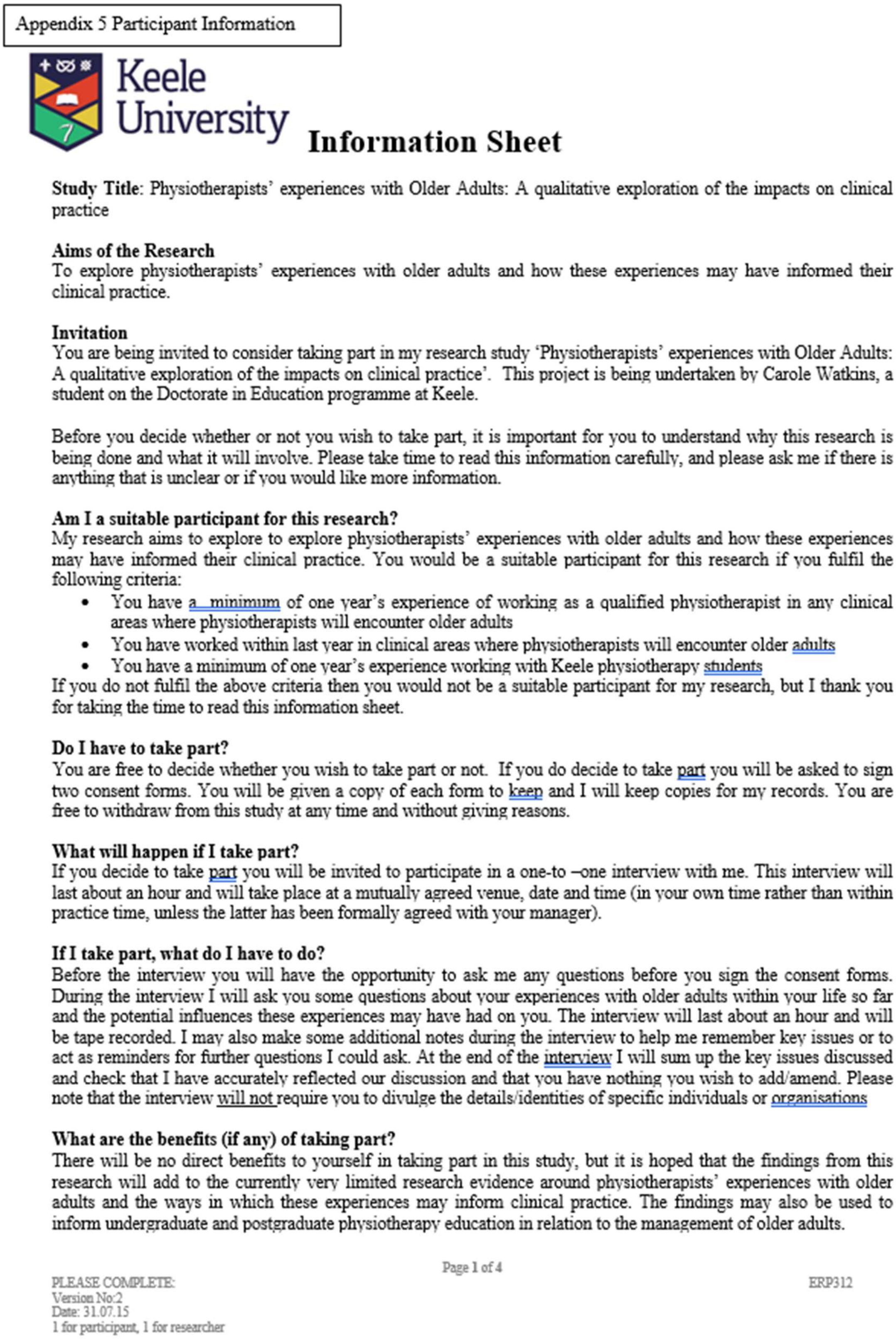

Appendix 5 Participant Information

Keele University

Information Sheet

Study Title: Physiotherapists' experiences with Older Adults: A qualitative exploration of the impacts on clinical practice

Aims of the Research
To explore physiotherapists' experiences with older adults and how these experiences may have informed their clinical practice.

Invitation
You are being invited to consider taking part in my research study 'Physiotherapists' experiences with Older Adults: A qualitative exploration of the impacts on clinical practice'. This project is being undertaken by Carole Watkins, a student on the Doctorate in Education programme at Keele.

Before you decide whether or not you wish to take part, it is important for you to understand why this research is being done and what it will involve. Please take time to read this information carefully, and please ask me if there is anything that is unclear or if you would like more information.

Am I a suitable participant for this research?
My research aims to explore to explore physiotherapists' experiences with older adults and how these experiences may have informed their clinical practice. You would be a suitable participant for this research if you fulfil the following criteria:

- You have a minimum of one year's experience of working as a qualified physiotherapist in any clinical areas where physiotherapists will encounter older adults
- You have worked within last year in clinical areas where physiotherapists will encounter older adults
- You have a minimum of one year's experience working with Keele physiotherapy students

If you do not fulfil the above criteria then you would not be a suitable participant for my research, but I thank you for taking the time to read this information sheet.

Do I have to take part?
You are free to decide whether you wish to take part or not. If you do decide to take part you will be asked to sign two consent forms. You will be given a copy of each form to keep and I will keep copies for my records. You are free to withdraw from this study at any time and without giving reasons.

What will happen if I take part?
If you decide to take part you will be invited to participate in a one-to –one interview with me. This interview will last about an hour and will take place at a mutually agreed venue, date and time (in your own time rather than within practice time, unless the latter has been formally agreed with your manager).

If I take part, what do I have to do?
Before the interview you will have the opportunity to ask me any questions before you sign the consent forms. During the interview I will ask you some questions about your experiences with older adults within your life so far and the potential influences these experiences may have had on you. The interview will last about an hour and will be tape recorded. I may also make some additional notes during the interview to help me remember key issues or to act as reminders for further questions I could ask. At the end of the interview I will sum up the key issues discussed and check that I have accurately reflected our discussion and that you have nothing you wish to add/amend. Please note that the interview will not require you to divulge the details/identities of specific individuals or organisations

What are the benefits (if any) of taking part?
There will be no direct benefits to yourself in taking part in this study, but it is hoped that the findings from this research will add to the currently very limited research evidence around physiotherapists' experiences with older adults and the ways in which these experiences may inform clinical practice. The findings may also be used to inform undergraduate and postgraduate physiotherapy education in relation to the management of older adults.

Page 1 of 4

PLEASE COMPLETE:
Version No:2
Date: 31.07.15
1 for participant, 1 for researcher

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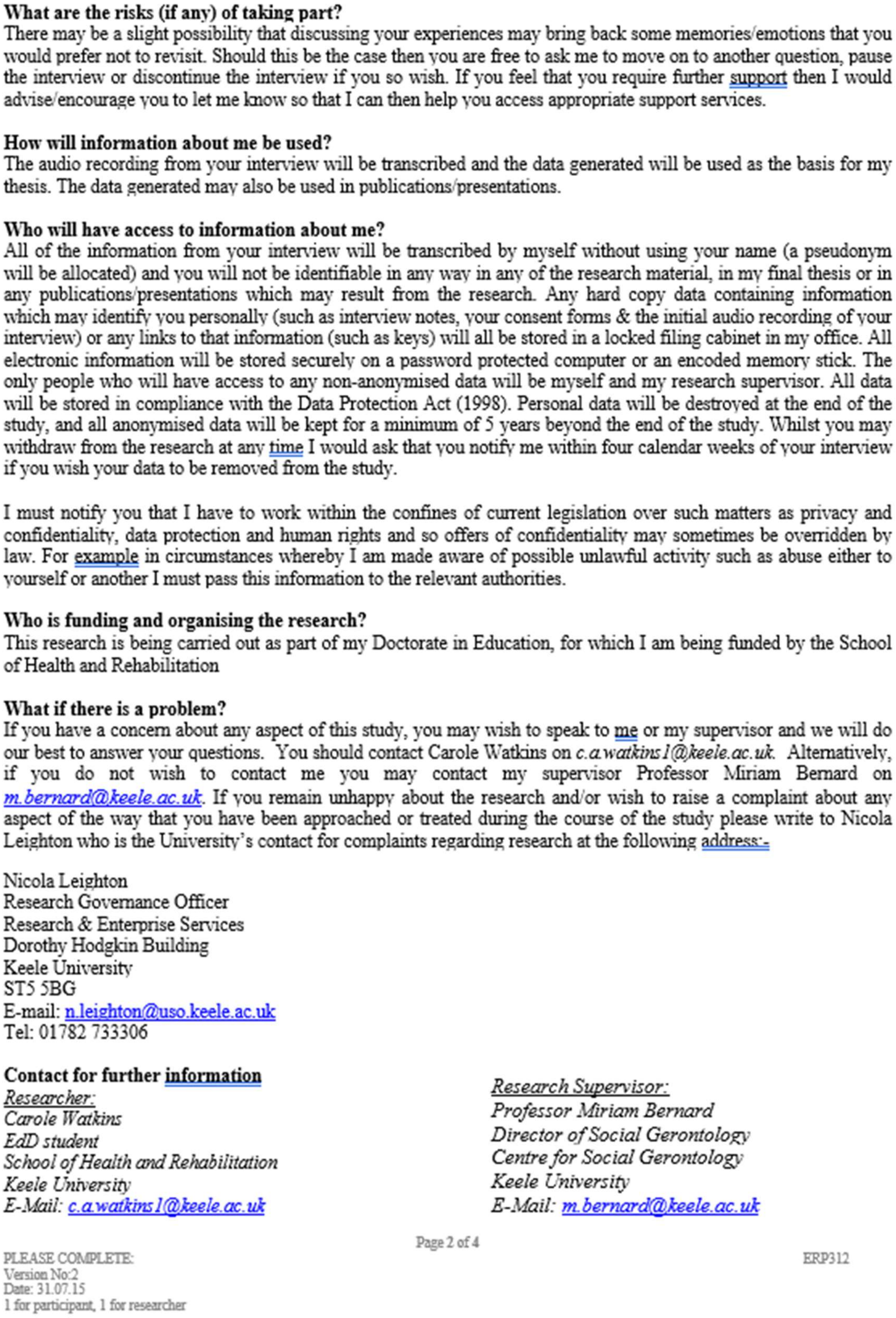

What are the risks (if any) of taking part?
There may be a slight possibility that discussing your experiences may bring back some memories/emotions that you would prefer not to revisit. Should this be the case then you are free to ask me to move on to another question, pause the interview or discontinue the interview if you so wish. If you feel that you require further support then I would advise/encourage you to let me know so that I can then help you access appropriate support services.

How will information about me be used?
The audio recording from your interview will be transcribed and the data generated will be used as the basis for my thesis. The data generated may also be used in publications/presentations.

Who will have access to information about me?
All of the information from your interview will be transcribed by myself without using your name (a pseudonym will be allocated) and you will not be identifiable in any way in any of the research material, in my final thesis or in any publications/presentations which may result from the research. Any hard copy data containing information which may identify you personally (such as interview notes, your consent forms & the initial audio recording of your interview) or any links to that information (such as keys) will all be stored in a locked filing cabinet in my office. All electronic information will be stored securely on a password protected computer or an encoded memory stick. The only people who will have access to any non-anonymised data will be myself and my research supervisor. All data will be stored in compliance with the Data Protection Act (1998). Personal data will be destroyed at the end of the study, and all anonymised data will be kept for a minimum of 5 years beyond the end of the study. Whilst you may withdraw from the research at any time I would ask that you notify me within four calendar weeks of your interview if you wish your data to be removed from the study.

I must notify you that I have to work within the confines of current legislation over such matters as privacy and confidentiality, data protection and human rights and so offers of confidentiality may sometimes be overridden by law. For example in circumstances whereby I am made aware of possible unlawful activity such as abuse either to yourself or another I must pass this information to the relevant authorities.

Who is funding and organising the research?
This research is being carried out as part of my Doctorate in Education, for which I am being funded by the School of Health and Rehabilitation

What if there is a problem?
If you have a concern about any aspect of this study, you may wish to speak to me or my supervisor and we will do our best to answer your questions. You should contact Carole Watkins on *c.a.watkins1@keele.ac.uk*. Alternatively, if you do not wish to contact me you may contact my supervisor Professor Miriam Bernard on *m.bernard@keele.ac.uk*. If you remain unhappy about the research and/or wish to raise a complaint about any aspect of the way that you have been approached or treated during the course of the study please write to Nicola Leighton who is the University's contact for complaints regarding research at the following address:-

Nicola Leighton
Research Governance Officer
Research & Enterprise Services
Dorothy Hodgkin Building
Keele University
ST5 5BG
E-mail: n.leighton@uso.keele.ac.uk
Tel: 01782 733306

Contact for further information
Researcher:
Carole Watkins
EdD student
School of Health and Rehabilitation
Keele University
E-Mail: c.a.watkins1@keele.ac.uk

Research Supervisor:
Professor Miriam Bernard
Director of Social Gerontology
Centre for Social Gerontology
Keele University
E-Mail: m.bernard@keele.ac.uk

Page 2 of 4

PLEASE COMPLETE:
Version No:2
Date: 31.07.15
1 for participant, 1 for researcher

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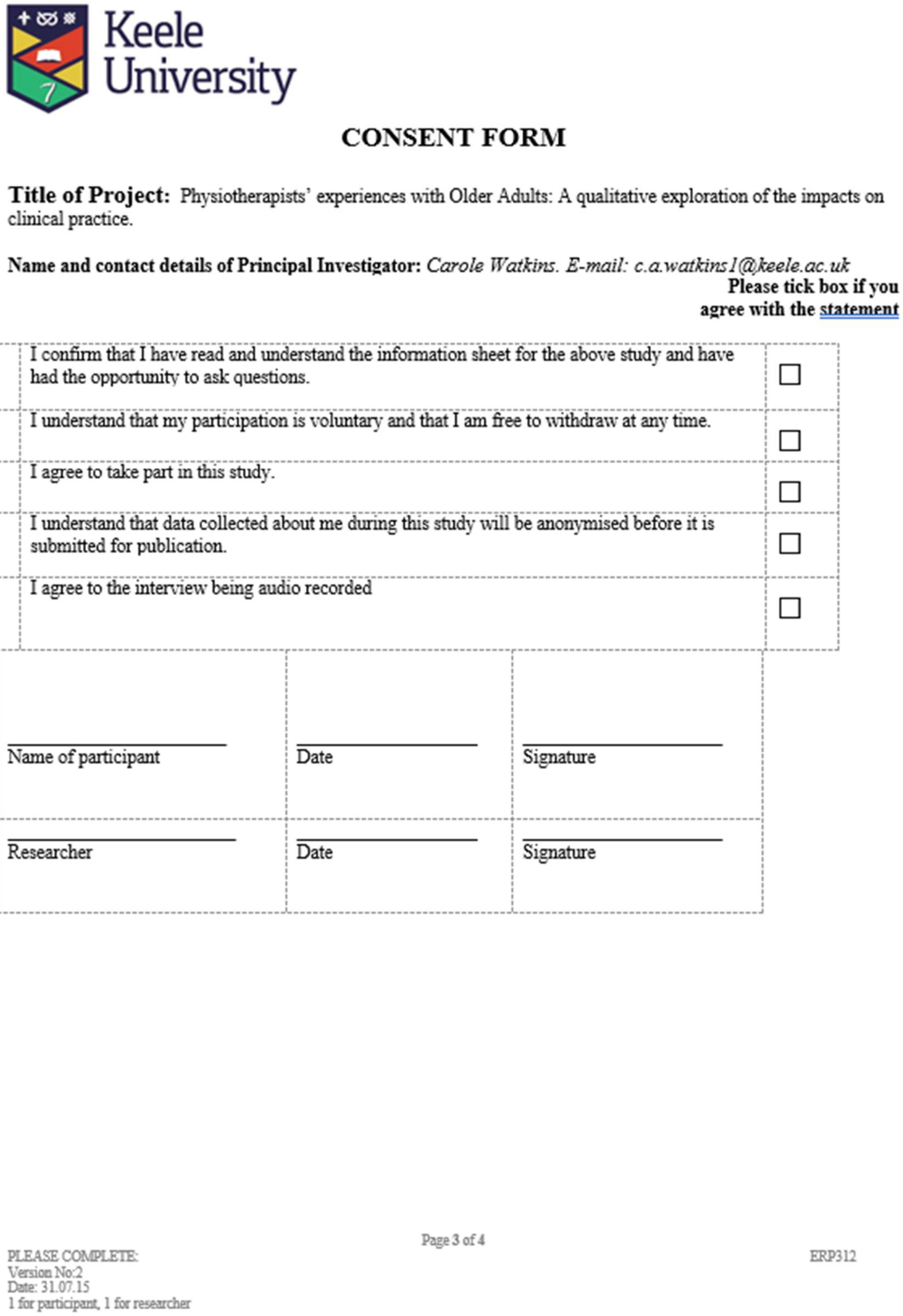
Appendix 6 Consent form



Keele University

CONSENT FORM

Title of Project: Physiotherapists' experiences with Older Adults: A qualitative exploration of the impacts on clinical practice.

Name and contact details of Principal Investigator: *Carole Watkins. E-mail: c.a.watkins1@keele.ac.uk*

Please tick box if you agree with the statement

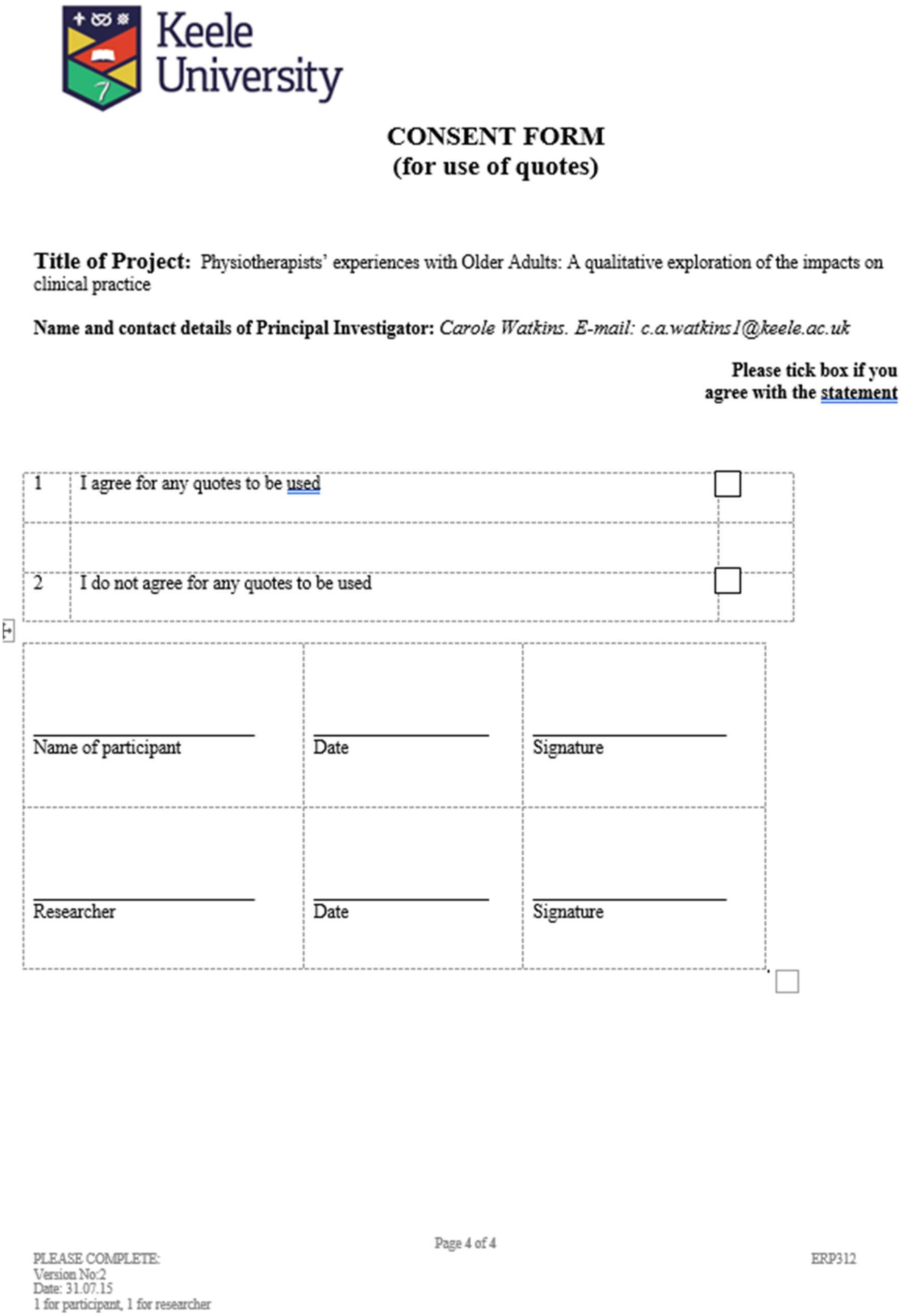
1	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2	I understand that my participation is voluntary and that I am free to withdraw at any time.	☐
3	I agree to take part in this study.	☐
4	I understand that data collected about me during this study will be anonymised before it is submitted for publication.	☐
5	I agree to the interview being audio recorded	☐

Name of participant	Date	Signature
Researcher	Date	Signature

Page 3 of 4

PLEASE COMPLETE:
Version No:2
Date: 31.07.15
1 for participant, 1 for researcher

ERP312



Keele University

CONSENT FORM
(for use of quotes)

Title of Project: Physiotherapists' experiences with Older Adults: A qualitative exploration of the impacts on clinical practice

Name and contact details of Principal Investigator: *Carole Watkins. E-mail: c.a.watkins1@keele.ac.uk*

Please tick box if you agree with the statement

1	I agree for any quotes to be used	☐
2	I do not agree for any quotes to be used	☐

Name of participant	Date	Signature
Researcher	Date	Signature

PLEASE COMPLETE:
Version No:2
Date: 31.07.15
1 for participant, 1 for researcher

Page 4 of 4

ERP312

Appendix 7 Interview guide

Physiotherapists' experiences with Older Adults: A qualitative exploration of the impacts on clinical practice and physiotherapy education

Researcher: Carole Watkins

<u>Introduction to the interview process:</u>

Thank the participant for agreeing to take part in the research, and provide them with a copy of the Participant Information Sheet.

Reiterate the following:

- The interview should last no longer than 1hour, but can go on for longer if you want it to
- During the interview I will be asking you some questions about your experiences with older adults within your life so far and the potential influences these experiences may have had on you. These questions will help guide the interview but are not meant to constrain our discussion.
- To ensure everything discussed is accurately captured the interview will be audiotaped. I may also make some additional notes during the interview to help me remember key issues or to act as a reminder for further questions to ask.
- Please note that the interview <u>will not</u> require you to divulge the details/identities of specific individuals or organisations
- At the end of the interview I will sum up the key issues discussed and check that I have accurately reflected our discussion and that you have nothing you wish to add/amend.
- All information relating to your participation in the study will be strictly confidential and neither you nor anyone you mention will be identifiable in any way in the transcription or in any dissemination of the research either within or beyond the university. I will change all names, including any individuals mentioned such as students, colleagues and family, and any organisations will be anonymised.
- During the interview can ask me to move on to another question, pause the interview or discontinue the interview at any point should you decide you don't wish to continue. You can also withdraw from the study at any time

Turn on digital recorder

Check that they have no questions they want to ask before signing the consent forms.

1. Experiences of older adults pre training

I’m interested in finding out how physiotherapists develop their understandings of older people, both inside and outside of professional practice. Tell me a bit about that. For example, what had you known/thought about older people before you decided to become a physiotherapist?

Did any particular relationships or experiences shape how you felt/thought about older people and the ageing process?

What were these experiences?

Which ones in particular made the greatest impact on what you knew/thought about older people?

How did they influence how you thought about older people/the ageing process?

2. Career choice

Did these events/experiences influence your choice of career? How so?

3. Significant events

I’d like to move on to discuss how your understanding of older people developed within your clinical practice. What particular events in your own clinical practice do you think have most influenced your attitudes towards older adults?

When did this happen? What was going on at the time?

How did this affect you?

Emotionally?

The way you thought about yourself?

Your professional identify?

The direction you were moving in professionally/career choices made?

Did this change your clinical practice? How so?

4. Education of physiotherapy students

You've shared some significant events in your clinical practice
Or
We have discussed some issues around your experiences of older people in general and within your physiotherapy practice

> Have these events shaped how you approach educating physiotherapy students? How so?
>
> Do you think that physiotherapy students come into clinical placements prepared to work with older people as a distinct patient population?
>
> > What do these students do well?
> >
> > What knowledge and skills do they lack, and why do you think this is?

I'd like to know more about what you'd like physiotherapy students to learn about older people during their placements.

> What skills that would affect how they work with older people in clinical practice would you like them to take away from placement?
>
> Why these particular skills?

As you know there isn't a lot of time in undergraduate physiotherapy study to cover all topics in great depth, including the management of older people in health and social care.

> Given this challenge, in what ways do you think any mismatch between clinicians expectations and students abilities can be best addressed?

5. Physiotherapy approach to older people in general

> Looking back at when you started your training, do you think that the way physiotherapists manage older people has changed? Differs from what you were taught?
>
> What do you think are the greatest challenges today for physiotherapists in the management of older people?

6. Additional information

> Is there anything else you would like to tell me about physiotherapy and older adults? About educating physiotherapy students? About the needs etc. of older adults in physiotherapy?

Is there anything you think I need to consider/ask other interviewees that we haven’t covered today?

Researcher to then summarise key issues discussed and check with participant that these are an accurate reflection of the discussion that has taken place and the issues raised.

Thank participant for their time and the information they have shared.

Check that consent is still in place, and reiterate that all information will be confidential and data will be anonymised.

Remind participant re process should they wish to have their data removed from the study - whilst you may withdraw from the research at any time I would ask that you notify me within four calendar weeks of your interview if you wish your data to be removed from the study

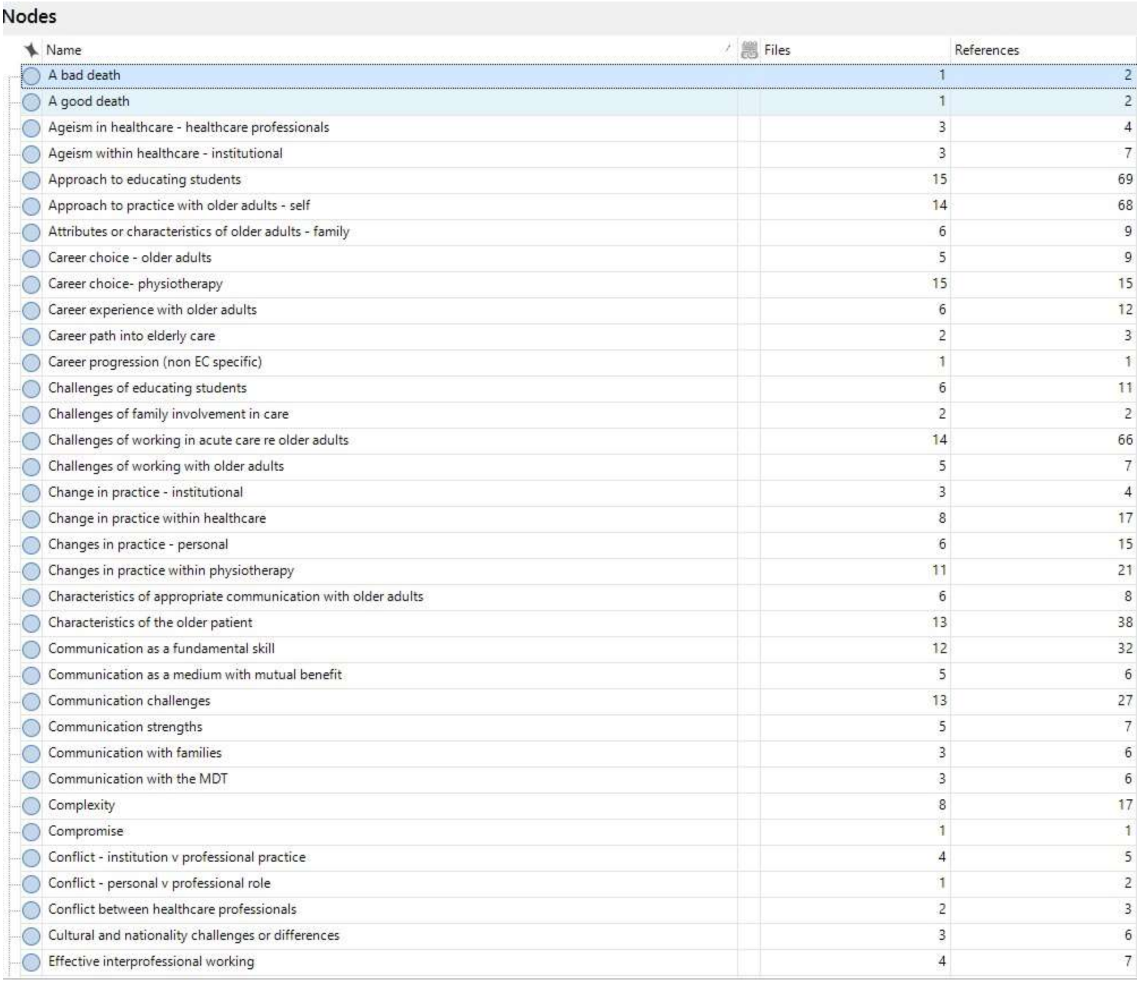
Advise them that they can contact me after today using the details on the participant information sheet if they have any further questions or think of any additional points they would like to make

Advise them that if there has been anything discussed during the interview which has caused them any distress to please let me know so that I can provide them with contact details for support services.

Turn off digital recorder

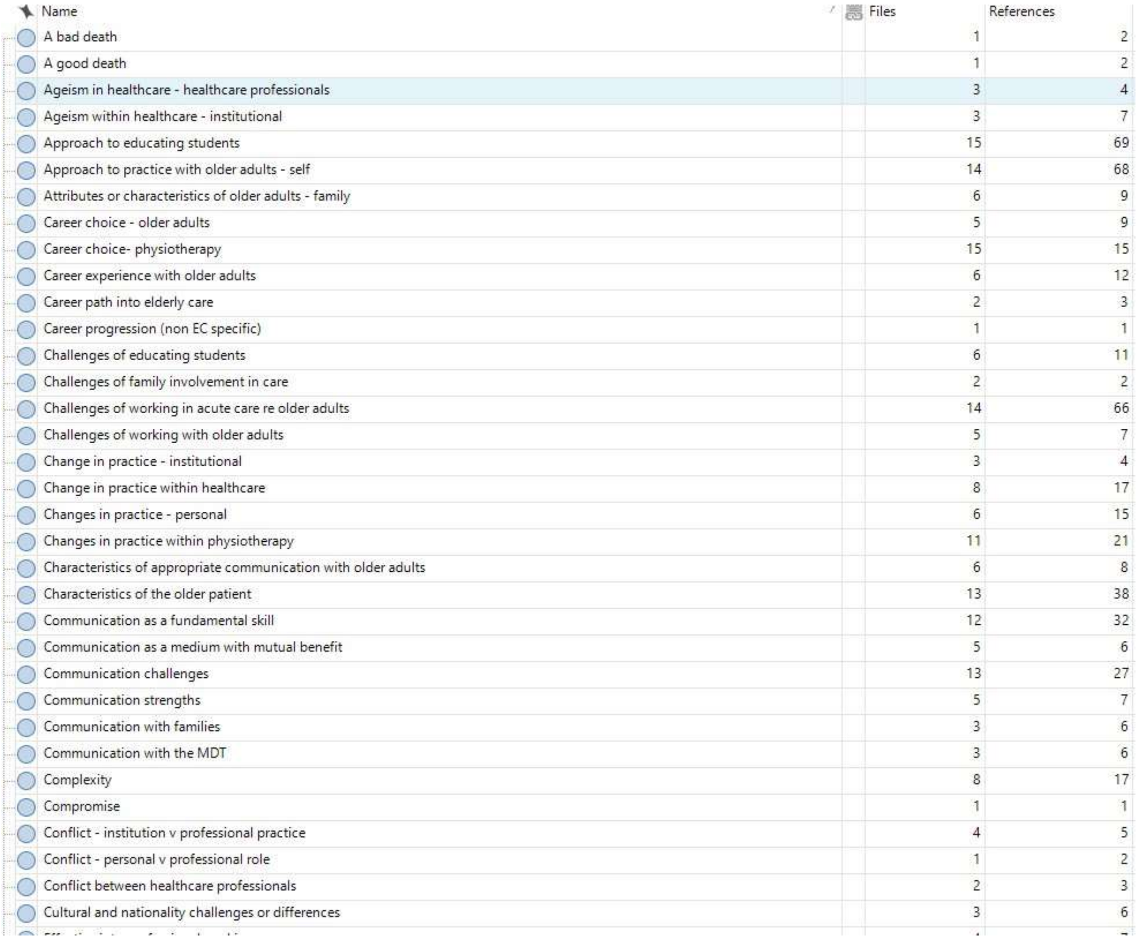
Appendix 8: Examples of coding process

Initial nodes (Categories) – first stage coding in NVivo



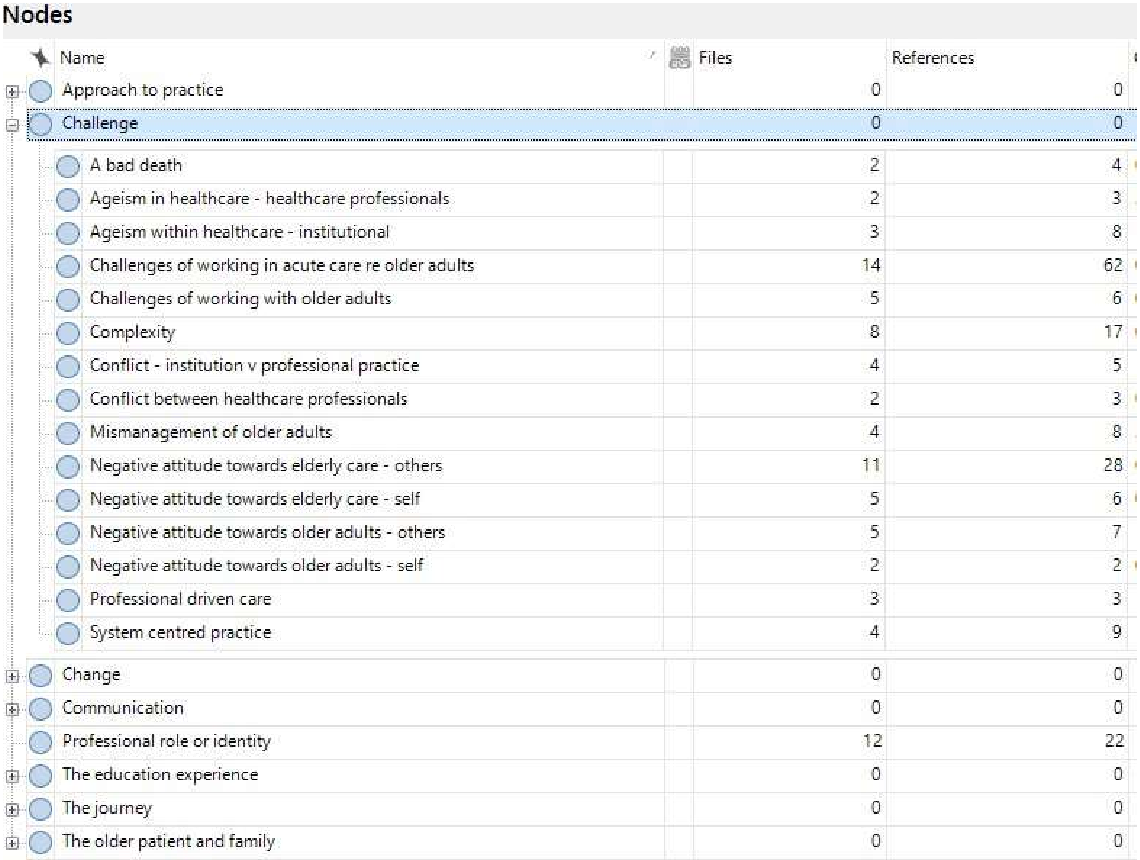
Name	Files	References
A bad death	1	2
A good death	1	2
Ageism in healthcare - healthcare professionals	3	4
Ageism within healthcare - institutional	3	7
Approach to educating students	15	69
Approach to practice with older adults - self	14	68
Attributes or characteristics of older adults - family	6	9
Career choice - older adults	5	9
Career choice- physiotherapy	15	15
Career experience with older adults	6	12
Career path into elderly care	2	3
Career progression (non EC specific)	1	1
Challenges of educating students	6	11
Challenges of family involvement in care	2	2
Challenges of working in acute care re older adults	14	66
Challenges of working with older adults	5	7
Change in practice - institutional	3	4
Change in practice within healthcare	8	17
Changes in practice - personal	6	15
Changes in practice within physiotherapy	11	21
Characteristics of appropriate communication with older adults	6	8
Characteristics of the older patient	13	38
Communication as a fundamental skill	12	32
Communication as a medium with mutual benefit	5	6
Communication challenges	13	27
Communication strengths	5	7
Communication with families	3	6
Communication with the MDT	3	6
Complexity	8	17
Compromise	1	1
Conflict - institution v professional practice	4	5
Conflict - personal v professional role	1	2
Conflict between healthcare professionals	2	3
Cultural and nationality challenges or differences	3	6
Effective interprofessional working	4	7

Refinement of nodes (categories) – second stage coding in NVivo



Name	Files	References
A bad death	1	2
A good death	1	2
Ageism in healthcare - healthcare professionals	3	4
Ageism within healthcare - institutional	3	7
Approach to educating students	15	69
Approach to practice with older adults - self	14	68
Attributes or characteristics of older adults - family	6	9
Career choice - older adults	5	9
Career choice- physiotherapy	15	15
Career experience with older adults	6	12
Career path into elderly care	2	3
Career progression (non EC specific)	1	1
Challenges of educating students	6	11
Challenges of family involvement in care	2	2
Challenges of working in acute care re older adults	14	66
Challenges of working with older adults	5	7
Change in practice - institutional	3	4
Change in practice within healthcare	8	17
Changes in practice - personal	6	15
Changes in practice within physiotherapy	11	21
Characteristics of appropriate communication with older adults	6	8
Characteristics of the older patient	13	38
Communication as a fundamental skill	12	32
Communication as a medium with mutual benefit	5	6
Communication challenges	13	27
Communication strengths	5	7
Communication with families	3	6
Communication with the MDT	3	6
Complexity	8	17
Compromise	1	1
Conflict - institution v professional practice	4	5
Conflict - personal v professional role	1	2
Conflict between healthcare professionals	2	3
Cultural and nationality challenges or differences	3	6

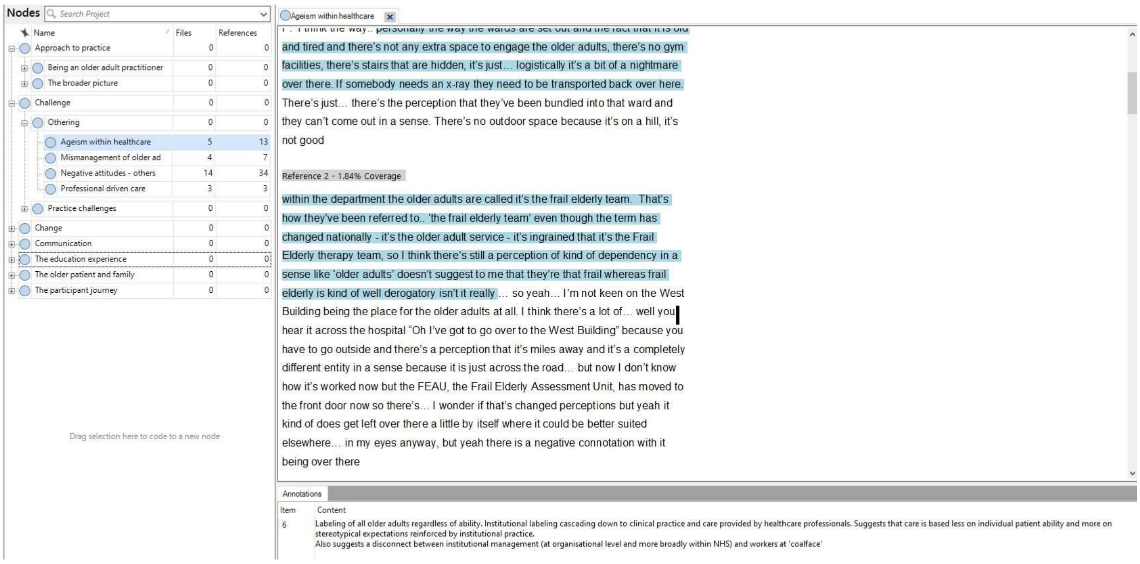
Example of initial development of subthemes (with categories shown)



Nodes

Name	Files	References
Approach to practice	0	0
Challenge	0	0
A bad death	2	4
Ageism in healthcare - healthcare professionals	2	3
Ageism within healthcare - institutional	3	8
Challenges of working in acute care re older adults	14	62
Challenges of working with older adults	5	6
Complexity	8	17
Conflict - institution v professional practice	4	5
Conflict between healthcare professionals	2	3
Mismanagement of older adults	4	8
Negative attitude towards elderly care - others	11	28
Negative attitude towards elderly care - self	5	6
Negative attitude towards older adults - others	5	7
Negative attitude towards older adults - self	2	2
Professional driven care	3	3
System centred practice	4	9
Change	0	0
Communication	0	0
Professional role or identity	12	22
The education experience	0	0
The journey	0	0
The older patient and family	0	0

Example of codes within category and use of annotation facility



Nodes

Name	Files	References
Approach to practice	0	0
Being an older adult practitioner	0	0
The broader picture	0	0
Challenge	0	0
Othering	0	0
Ageism within healthcare	5	13
Mismanagement of older ad	4	7
Negative attitudes - others	14	34
Professional driven care	3	3
Practice challenges	0	0
Change	0	0
Communication	0	0
The education experience	0	0
The older patient and family	0	0
The participant journey	0	0

and tired and there's not any extra space to engage the older adults, there's no gym facilities, there's stairs that are hidden, it's just… logistically it's a bit of a nightmare over there. If somebody needs an x-ray they need to be transported back over here. There's just… there's the perception that they've been bundled into that ward and they can't come out in a sense. There's no outdoor space because it's on a hill, it's not good

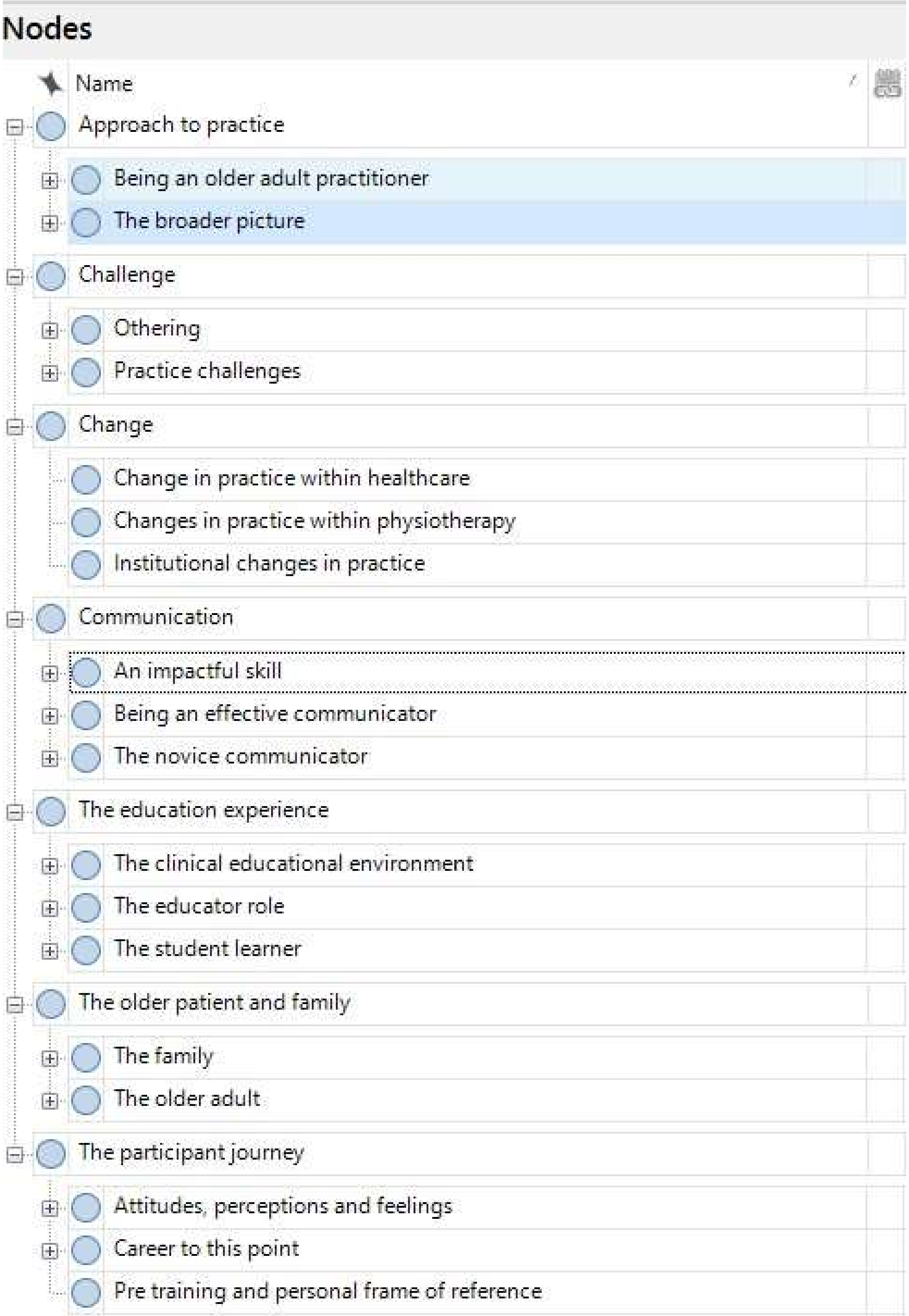
Reference 2 - 1.84% Coverage

within the department the older adults are called it's the frail elderly team. That's how they've been referred to.. 'the frail elderly team' even though the term has changed nationally - it's the older adult service - it's ingrained that it's the Frail Elderly therapy team, so I think there's still a perception of kind of dependency in a sense like 'older adults' doesn't suggest to me that they're that frail whereas frail elderly is kind of well derogatory isn't it really … so yeah… I'm not keen on the West Building being the place for the older adults at all. I think there's a lot of… well you hear it across the hospital "Oh I've got to go over to the West Building" because you have to go outside and there's a perception that it's miles away and it's a completely different entity in a sense because it is just across the road… but now I don't know how it's worked now but the FEAU, the Frail Elderly Assessment Unit, has moved to the front door now so there's… I wonder if that's changed perceptions but yeah it kind of does get left over there a little by itself where it could be better suited elsewhere… in my eyes anyway, but yeah there is a negative connotation with it being over there

Annotations

Item	Content
6	Labeling of all older adults regardless of ability. Institutional labeling cascading down to clinical practice and care provided by healthcare professionals. Suggests that care is based less on individual patient ability and more on stereotypical expectations reinforced by institutional practice. Also suggests a disconnect between institutional management (at organisational level and more broadly within NHS) and workers at 'coalface'

Finalised themes and subthemes. (N.B. Challenge and Change subthemes were merged during write up of findings and Communication renamed Communication and Engagement)



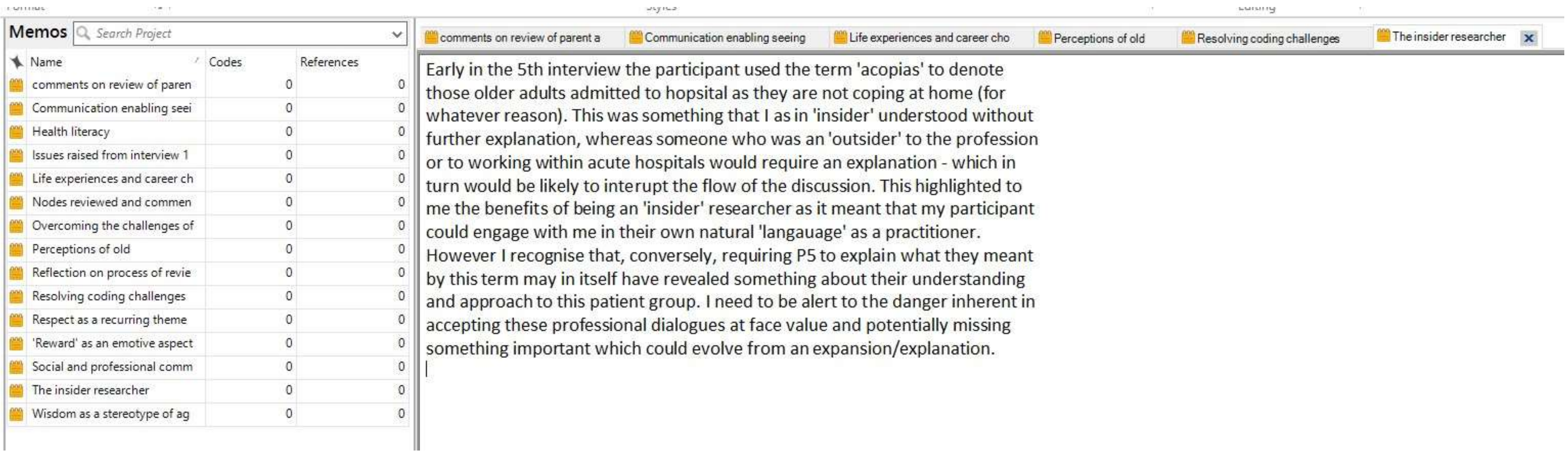
Nodes

Name

- Approach to practice
  - Being an older adult practitioner
  - The broader picture
- Challenge
  - Othering
  - Practice challenges
- Change
  - Change in practice within healthcare
  - Changes in practice within physiotherapy
  - Institutional changes in practice
- Communication
  - An impactful skill
  - Being an effective communicator
  - The novice communicator
- The education experience
  - The clinical educational environment
  - The educator role
  - The student learner
- The older patient and family
  - The family
  - The older adult
- The participant journey
  - Attitudes, perceptions and feelings
  - Career to this point
  - Pre training and personal frame of reference

Appendix 9

Example of analytic memo used during data analysis



Name	Codes	References
comments on review of paren	0	0
Communication enabling seei	0	0
Health literacy	0	0
Issues raised from interview 1	0	0
Life experiences and career ch	0	0
Nodes reviewed and commen	0	0
Overcoming the challenges of	0	0
Perceptions of old	0	0
Reflection on process of revie	0	0
Resolving coding challenges	0	0
Respect as a recurring theme	0	0
'Reward' as an emotive aspect	0	0
Social and professional comm	0	0
The insider researcher	0	0
Wisdom as a stereotype of ag	0	0

Early in the 5th interview the participant used the term 'acopias' to denote those older adults admitted to hopsital as they are not coping at home (for whatever reason). This was something that I as in 'insider' understood without further explanation, whereas someone who was an 'outsider' to the profession or to working within acute hospitals would require an explanation - which in turn would be likely to interupt the flow of the discussion. This highlighted to me the benefits of being an 'insider' researcher as it meant that my participant could engage with me in their own natural 'langauage' as a practitioner. However I recognise that, conversely, requiring P5 to explain what they meant by this term may in itself have revealed something about their understanding and approach to this patient group. I need to be alert to the danger inherent in accepting these professional dialogues at face value and potentially missing something important which could evolve from an expansion/explanation.

Appendix 10 Example of reflective account

Interview 8 post interview reflexive notes

This interview shocked me a bit in terms of the participant's views on working on elderly care. This was the first participant to distinguish between working with older adults (which they enjoyed) and working in elderly care (which they described as boring and repetitive with limited reward). Working in elderly care was seen as not requiring much in terms of physiotherapy skills (technicians could do much of the work) and was negatively compared to clinical areas such as intensive care which required significant skills and where physiotherapy interventions had a major impact on the patient (life or death). This contrasted with previous participants who have focused more on the skills required to enable older adults to successfully achieve rehabilitation goals. I myself have never viewed elderly care as boring but have always felt that this patient group are complex and require advanced knowledge, skills and problem solving, so it felt rather soul destroying to have it perceived so negatively. However, I have to accept that these views have been formed by P8s experiences, which seem to have been mainly around marked frailty and dementia and perhaps chime with the research evidence suggesting that working with less able older adults can make some healthcare staff hold more negative attitudes towards this group. Yet in contrast P8 personal views about older adults were much more positive – they liked working with them as a patient group (more so that younger adults) and they described an emotive role that went way beyond the professional physio role e.g. staying with dying older patients so that they had someone with them. At times there was an evident conflict between the professional (e.g. getting someone more mobile) and the personal (not wanting to disturb them if they were asleep and respecting confused patients' normal routines).

This was another participant who demonstrated clear links between seminal experiences and professional (& in this case personal) practice with older adults. Experiences with an older lady they knew on a personal level and professional experiences with inappropriate (in their eyes) management/resuscitation of older patients meant that they placed significant emphasis on a ‘good’ death i.e. no inappropriate CPR, dying quickly as opposed to a prolonged death, dying with someone with them instead of alone.

I had been concerned about social desirability bias given that some of my participants know me either in terms of my teaching re older adults (including my emphasis on positive attitudes) or as a clinical visiting tutor, and indeed in previous interviews there has been nothing too contentious said. However, this participant expressed views which directly opposed my professional views about older adult rehabilitation and indeed talked about their negative views in some detail. As a result, this would suggest that my interview style and the questions asked have not inhibited expression of more negative views – at least in this participant. Upon reflection some other participants have also expressed more negative viewpoints on some subjects (e.g. towards younger patients; negative attitudes towards elderly care in others, system centric care which pigeon-holes and labels all older adults) although all of these were discussed in the context of a more positive approach to older adults by the participants themselves. Thus, it is difficult to tease out if this is evidence of a social desirability bias or just that previous participants have had a more positive perception of older adult rehabilitation.

This participant proposed that I asked future participants if they liked older adults and working with older adults (i.e. separating out the two) and I will be adding this question at the end of my interview schedule

Appendix 11

Part of transcript: interview with participant 12

I: okay right so you know that I'm interested in finding out how physiotherapists develop their understanding of older people both inside and outside their professional practice so I wonder if you could tell me perhaps what you had known or thought about older people before you decided to become a physiotherapist?

P: erm… ok that's a big topic… so before I went and did my degree I worked as a receptionist in a GP centre as a student so I did that for quite a few years and I suppose it was in a largely elderly demographic and I was working with elderly people there, quite a lot with the communication issues and things like that which receptionists have to get used to. I also did a bit of work in a care home as well while I was a student so I think I'd already started to think about… well not think about but worked with elderly people… I suppose also my family as well and the relatives I've got. I was very close to my granddad and my nan, who's just called me, my nan so my grandparents so I think they partly helped my mum and dad bring me up so that was obviously a big influencing factor in my childhood, so I've always felt quite comfortable communicating with older people which I think helps when you get into being a professional with older people. If you're comfortable already with how to start a conversation and what small talk could be it makes it easier to start a professional dialogue if that makes sense

I: it does yeah

P: so yeah I think I'd already formed personal ways of communication that I maybe I probably don't even realising I'm using in the workplace to…

I: so with your grandparents you said they helped bring you up. Were they or are they fit and active?

P: so… obviously I've got two sets of grandparents I had ones that lived further away and they were the more holiday grandparents, so we'd go and spend time with them. They've both passed away now and they were a bit older, and then on my mums side they were *slightly* younger but they were more hands on and when my mum and dad were at work - my mum and dad both worked full time - so they would often do the school run and any days I was off sick and things like that they would always pick up the pieces, so I spent a lot of time with them after school waiting for mum and things like that… dinners… so they were more the hands on and day to day they were probably I would well… I would say they were older grandparents but they.. I didn't see them… they were never particularly disabled or there was never anything that limited them up until the point really when my granddad unfortunately passed away quite quickly so it was almost he was fit then he wasn't, so in my mind they were always quite able… now I suppose my surviving grandparent does now need a bit more support but she is still living independently and you know mobile and things like that. It's more emotional support I think now as she's the surviving member which I think as a family we do quite a lot of. I don't know whether it's my relationship with her that has meant that I take a bit of a lead in that or whether it's because I work with elderly people, which one came first I don't know, but I do contact her every day and see her regularly because I know I think I've seen what it's like to be lonely in old age with my job and I also just care about her, so you do don't you, so which one came first I don't know, whether I've seen what being elderly is like from work and therefore I've adopted that role or I already would have done that I don't know… (7.06)

I: or maybe the two

P: maybe, maybe

I: so what were your experiences working in the centre and the care home were those older adults…

P: yeah they were quite physically disabled older adults… I think I probably went into that quite young, 15 or so, and I think that was probably the first shock I've seen somebody physically disabled or the physical approach to ageing which I suppose was the first experience I've had.. you get somebody out of bed or when they're you know when they're bed bound and needing changing things like that those practical elements I don't think I'd probably dealt with, experienced until then which I suppose is a reality check I think sometimes physio's students maybe need because it's not all about sports and it's not all about… there's a big wide range of ways you can have to get involved with physio so having those experiences young I suppose, well not young 15's not young, but before you go to be a student I think helped

I: so you used the work shock

P: not… yeah shock… I think because maybe because my grandparents and because working in a GP centre they were always mobile or they were always able cognitively it was almost ‘okay this is the other side of ageing where you have got cognitive issues or you’ve got immobility issues’ so yeah… I suppose no one really wants to think about themselves getting into a situation where they can’t get out of bed. I think that’s… or being physically dependant on other people that’s where the shock comes in I think, that’s what I meant by that… I think

I: so you have those two contrasts you’d got your grandparents who were fit able and then you’d got almost the other end of the scale where you’d got these people who were much more dependant… did you have… other than your grandparents and that were there any other frames of reference or was it just your grandparents

P: I’d say maybe seeing patients… potentially the ones that I’d worked with in the GP centre who were probably an in-between, were there were coming in for an illness reason but still mobile, still able to get to the GP centre, often the most challenging parts of that would be communication… hearing things like that trying to get Bill to his appointment with the doctor and he didn’t know where he was going or what’s going on and things like that so that’s maybe a middle ground between the two. I can’t think of anyone else specifically… family members maybe older family members but they would have again been similar to my grandparents

I: so how do those two different aspects of that experience of ageing make you think about older adults and ageing?

P: I think I’m quite protective in the way I think about the ageing process. I get quite defensive about certain things you hear in the news about care homes and things like that and funding when it’s all debated I think I probably come from quite a passionate area for the elderly because… you know potentially somebody has worked their entire life or they’ve had a whole life before they’ve come to a certain situation where now they need more help and I don’t know I think that’s maybe the insight you get working in a hospital that you realise actually these people are now just unwell or they’re now just immobile or whatever the complaint is, and actually have had such a vast life before… I don’t know, I don’t quite know what I’m trying to say but I think I get quite protective about old age *issues* because I do think.. well they’re vulnerable members of society aren’t they… they’ve got to be

I: and has that come from both sides, from those experiences in the care home and recognising those more dependant or from your grandparents as they've got older or…

P: maybe yeah… I think it has probably has come from both of those aspects. I think it's also being cemented by working in frail elderly on the wards, working on AMU where you see people first coming in through the doors and what kind of situations and presentations they can have, and you've seen sometimes the best of what how people can look after the elderly but also sometimes the worst and you think 'oh actually this person needs to get into this situation' so I think that's maybe were it comes from more than anything, that's really consolidated it for me… yeah just a protective nature I suppose if you see somebody vulnerable… I think elderly are vulnerable

I: so in terms of career choice did those experiences influence your choice of career in any way?

P: no… I think I knew I wanted to do something in healthcare before I… the reasons I went into those work experiences like junior part time jobs because I always knew I wanted to do something in healthcare and it was exploring which area I wanted to go into really. I've got quite a medical family basically, we've got doctors and nurses and I wanted to find out which role I wanted to take within that but I knew that in order to job satisfaction tick box list I was going to be in healthcare… unfortunately ha ha ha… it would have been easier if I had have changed my mind but it was a case of exploring which role I wanted to take, and then I think I enjoyed working in the receptionist but it also helped me to work out some of those issues as to what areas I'd like to work in how… you know start to think about communication with different people and seeing different parts of the NHS so I think I used… I knew I wanted to do something in the NHS so which bit

I: and why physiotherapy?

P: it seemed to make the most sense at the time as in it kind of had the… when I thought about medicine it seemed to have the clinical academic side to it but interested me but also I felt that physios tended to have a bit more time, touch wood, with patients physical contact… my dad did a good job in trying to put me off medicine… and it was a bit different and I think at the time I was thinking I want to do something a little bit different to everyone else so it's probably not the most worthwhile answer I'd say at interview but I knew I wanted to do something in healthcare and something to improve… it sounds cringey doesn't it but I knew I wanted to do something to help people and it seemed to tick the most boxes

I: ok… so you've talked quite a bit about the experiences we talked about working in the GP centre and the care home and the impact of that in terms of physical disability and cognitive disability and experiencing ageing and what the reality of ageing was, and then the contrast between that and your grandparents who on your mums side helped bring you up and were very fit and active and… your granddad was fit and active until he passed away and your grandma still going and the way that those two difference situations made you feel about older adults in terms of you say that protective nature seeing them as vulnerable, having had all of these life changes and as such needing protecting in some way

P: sometimes... sometimes… what are you talking about, fine dear

I: but when we talk about protective I guess there are quite a few contexts that you could talk about protecting people. Is that physical protecting? Is that looking after the emotional, psychosocial? Are there any of those in particular that stand out or is it a combination when you talk about feeling protective

P: I suppose… yeah you're right there are many ways. I think my job means I focus more on the physical side of it and that's probably where physio's become more confident, you can't ignore one without the other if there's an emotional or cognitive element or something like that, you can try all you like but you're not going to get through to the physical side of it… but I think we're better at thinking about the 'how do I improve function and how do I improve mobility' and things like that… emotionally I think I'm probably drawing most experience from family. I think I mentioned before, I seem to be talking about it quite a lot, but I mentioned before my grandmother who's physically very able. She now needs the emotional support to keep her from being just low and therefore affecting *her* life so yeah… it's often you don't get one without the other, but there's a big greyscale in between… I don't know. I think I probably experience both but I think in work you tend to focus on the physical

I: so if we think perhaps more if we move onto clinical practice now and thinking about how your understanding of older people developed as you'd gone through your clinical practice I wondered if there were particular events in your own clinical practice that you think have most influenced your attitudes towards older adults? (18.01)

P: okay… specific events?

I: some people have been able to identify perhaps specific patients that have made a big impact on them. Other people have talked more about general areas they've worked in or… it's very individual

P: it's hard isn't it I because I did… I've probably done maybe a couple of years, maybe 18 months on different elderly wards. I think most recently and maybe why I'm talking about the protective side of it is we had a gentleman who came in who was … well there was a lot of investigations as to how he'd been treated because he'd been in a care home and he wasn't well cared for at all and the family had described that as you wouldn't treat an animal the way he was treated, so I think maybe if I'm saying protective it's because experiences like that have made me go 'wow this is a vulnerable person and look what's happened to them' so maybe that protective nature has come from some of those worst situations I have seen… or relatives who have been left on Christmas eve in A&E and when you start to investigate and they say why can't you put the heating on and you realise that actually the family haven't been quite as honest and money is going missing and things like that and has become big question marks about safeguarding. I think they're probably to most extreme things that have made me really question how vulnerable these people ar Day to day though… I'm trying to think… no I don't think anyone is sticking out in my mind… I think for me when I was working on frail elderly unit I took quite a lot of enjoyment with the communication side of working with elderly people. I enjoyed the conversation and the general chit chat and 'come let's get going' and sometimes the attitude that elderly patients can have is sometimes more positive than you've got a 20 year old who doesn't want to get out of bed but you've got an 80 year old who's like 'oh come on we'll go round the ward once more' and actually that's quite, I don't know, heart warming really when you've got somebody who's really keen, and it's just a different generation really… I had a lady who… you were asking… she was 100 and asking what have you done so well because she was walking around no problems and she said it was because she didn't live with a man but I don't know it's just silly little things that make you laugh and make you have general conversations is part of the satisfaction I suppose

I: so you say… you talk about communication. What is it about that communication because you… I watch you smiling as you talk about communication

P: yes I am… it can't be formal. I think that's what I've learnt or the majority of the time unless it's a very traditional older person who wants to be addressed in their traditional title or whatever it is. Normally you have to strike up a conversation rather than say right today's physio's goal is this. I think you have to build up a bit more of a rapport which I think once you do it's nicer because you get to know the individual a bit better

I: and is that important?

P: I think so. I think it's important. It would be the way I'd prefer to treat somebody, the way I prefer to go about something than keep it all very rigid

I: because?

P: because… why is it important build good rapport… I think it's the better way of communicating because you probably put the person more at ease. I'm hoping you get the most out of them when they're at ease and get to know them on a little bit more of a personal level in order to know what they want out of what you're doing. If you're not really engaging with them then I don't think you're going to get the best results

I: so just thinking about that old man or the man that you talked about who'd been in the care home and had been neglected… how did that… I mean you talked about that vulnerability but from emotional perspective and I guess professional perspective as well, how did you feel about that?

P: that it was sad it was… it was upsetting to think that people can do that to one and other

I: yeah

P: and I also noticed that the staff went out of their way to be… almost singled that patient out as their project to make him feel more protected and more fussed than ever, so I think we all went over the top to try and compensate for what we'd known potentially he'd gone through before

I: and how did he respond?

P: he.. at that stage because I saw him on AMU he was still very unwell. He was in and out of knowing what was going on so… I think he did get better but I don't think he had a great quality of life after that. I think we all tried to make the most of a poor situation really… but yeah I think that was just maybe an example of an extreme, and I've probably experienced patients that through no fault of anyone else's have also been in a neglectful situation and I think people do go overboard by trying to compensate and look after them while they're in hospital

I: so how does that emotional response differ from that lady of 100 that you know was bright and chirpy or the 80-year-olds that are very positive that kind of thing

P: how does it change…? I think it's the contrast of feeling almost… it's an upsetting… you don't want to feel pity for somebody but you do feel sorry for the person who sitting in that situation compared to you'll go round to the other lady who is making a joke that's almost light hearted conversation instead, so yeah I just suppose it does contrast your emotions with the two… I think you're probably more proud of being involved with the gentleman who needed more help than slightly more straightforward 'come on let's get walking' lady who's fine if that makes sense so maybe a little more emotionally taxing but your probably more proud at the end of it when you see them improve, that's probably what I'd say about that

I: so in your clinical experience what is the balance? I mean you talked about those being extremes obviously but on the one hand we've got a very emotional emotive situation where people are struggling and you kind of mention words like vulnerable, lonely that kind of thing them on the hand you've got those people who seem to be doing well and focused and the rest of it. In terms of clinical experiences do they balance out or is there a feeling that one dominates more than the other from your experience or… ?

P: I suppose it's hard to tell isn't it because if they're in hospital they're not… there's a problem isn't there and I have to sometimes have to remember not all older people are unwell, not all older people are going to struggle in these ways and that's maybe when I see you know when I see my grandmother I go 'you know you're doing really well', because every so often I go to her you know 'actually for your age you're doing fantastically' so maybe my perspective is slightly skewed because I'm saturated in the unwell people. I don't think those neglectful ones thankfully I think are the exception and I would hope I'm staying optimistic that that's not an ongoing thing you know, that's rare, they sit normally in between in the hospital environment normally a UTI and they're delirious or an infection and they'll come round, you almost patch them up and they're maybe not perfect but they're better than when they came in that kind of situation. You might find that they're going round in those kind of situations for a few years really they're well and they're doing ok, then something then happens then they become unwell and we get them back on their feet, sort out the medical issues and things like that then they go home again then.. there's that slight conveyor belt which sometimes goes on… which is…I suppose it's good that you're getting them *back* home but can feel a little bit like ‘oh here we go again… oh I don’t know Bob or whoever he is he’s had another fall or what can we do to try and stop this?’ That’s sometimes difficult when they keep on coming back in… that’s what I found on AMU

I: because?

P: because… you want them to be at home, you want them to be well, you don’t want them to be in hospital, you want to go through the whole situation cycle again. It’s a bit… not demoralising but not what you’re aiming for is it? You’re aiming to go home, stay home. When you see them oh something’s happened again, you just don’t want that for them… I’m starting to forget the questions I’m sorry Carole if I’m jabbering on

I: no that’s fine the questions are only meant to…

P: prompt things

I: prompt things yes

P: halfway through I’m not sure what the question was… sorry

I: No no no, I’m interested in… you talk about this cyclical process as opposed to people coming in and out. You talk about how you.. mention the word demoralising, and demoralising in terms of that person having to go through that process. Is there an element of feeling demoralised as a healthcare professional that those people are coming in, or is it more about the person? (29.32)

P: it’s both, it’s both isn’t it. You feel they’re here again that’s not great for them but also we’re going to have to start again from the top again and actually can we not do something to put a stop to this and actually make it work. I think sometimes when… not always do physio’s have the answer but sometimes we can step back and say ‘well of course that’s going to happen’. You see it from a different kind of perspective maybe to the medics who are focusing on the medication or whatever else. It can be a bit frustrating when you’re going round in circles and sometimes I’ve found that you also… because people want to go… patients want to go home, people want to be at home, you almost have to set them up in the best situation that you can but it’s not perfect and you know it’s not perfect because there is still a chance that they are going to fall and there is still a chance that they’re going to be unwell, but you have to go with that and if it doesn’t work then at least you’ve tried it, so I think sometimes in my experiences I know the medics will know and the physios will know it's not necessarily the perfect situation but it's what the patient wants so we'll give it a go and if it doesn't work then we start again. So I suppose maybe that going round in circles is almost testing 'actually no this isn't working now, we need to do something different' and actually I know what the patient wants but what's the most safe thing.. almost have to test that out whether it's safe to follow what the patients wanting. You always make that your priority, you have to think about safety to don't you

I: so in some instances that cyclical process can be a positive process in terms of coming to some kind of final decision about that patient and…

P: yeah because if you went for that route straight off it's almost like the patient and the relatives and everyone else hasn't had the chance to realise that that's the way we all saw it going anyway, they've not had the chance to go through the journey that it almost takes to realise that this is the best thing, because I think most people want to go , most people want to carry on being the way they were when they were at their best but sometimes it's not possible.. I think we have to kind of try and pick up pieces in the middle and find a middle ground until they're ready to… I don't know maybe to go to a care home or 24 hour care or change their social situation or whatever it is. I don't think you can jump straight to it, you can't take somebody's independence away from them just like that without them going through that process of 'actually I need a bit more help here'

I: so how do you balance out that with those risks that are potentially inherent in sending somebody home that you perhaps…

P: how do I justify it?

I: I guess it's not so much justifying because justifying implies that in some way you're to blame, do you know what I mean it's more just

P: how do you do it?

I: Yeah

P: I think the majority of the frail elderly wards I've worked on they've got a good team approach to things because I think it would be very hard for one person to make that call.. sometimes if it is one person it's a consultant but otherwise I think you want the reassurance of all the other different professions to say ‘no I think this’ ‘no we all think the same thing’ erm… so that I think helps when you can discuss it with different people, different perspectives, and then almost you have to be guided by the person as well as long as they’re cognitively okay to make those choices, as long as you’ve reasoned it through, talked it through, found every possible way of making it as safe as possible, and you’ve got to remember it’s their choice as well because they might be elderly but… yeah I think I’ve had challenging conversations with other people who’ve gone ‘no you can’t do that’… I know what you’re saying but it’s not your choice it’s theirs… so I think sometimes that’s when we’ve had to go and do cognitive assessments and make sure they understand and things like that because actually at the end of the day you can try to do everything you want to do but it’s their choice so you’ve got to support that with the resources you’ve got. I think that’s the way I justify it it’s what do they want to do and I make it as safe as possible and do everyone else agree ha ha ha…

I: in that team approach how much do you feel you that you have an influence on the final decision that’s made?

P: I think we do have quite a lot. I think we do because I don’t think… I think physio’s and OT’s take a lot of the social element of a patients care so I think the team will often say ‘what does the physio think?’ so that’s quite a nice way of going about it. I think sometimes you’d find actually the nursing staff think differently and when you unpick that it’s because they have different knowledge and things like that so it could be anyone but I do think we are normally considered as long as we treat the patient after obviously