TIME FOR DEMENTIA
A NEW MODEL OF UNDERGRADUATE HEALTHCARE DEMENTIA EDUCATION?

Dr Stephanie Daley,
Yvonne Feeney, Molly Hebditch, Dr Wendy Grosvenor,
Professor Juliet Wright, Professor Sube Banerjee
Overview of symposium

- Time for Dementia education programme
- Time for Dementia research study
- Preliminary student outcomes
- Time for Dementia and Adult Nursing students – Dr Wendy Grosvenor
- Implementation of Time for Dementia – Yvonne Feeney
- Preferences for working with people with dementia – Molly Hebditch
Key learning

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

➢ Novel educational programme for future health professionals to learn about dementia

➢ Introduced in 2015 at Brighton and Sussex Medical School and University of Surrey

➢ Longitudinal contact between students, a person living with dementia and their carer

➢ Visit family in their own home

➢ Pairs of students visit 3 times per year for 2 years

➢ Supported by workshop, reflection sessions & stakeholder symposium

➢ Aim to improve knowledge, attitudes and empathy towards people with dementia
Based on Longitudinal Clerkship model

Mandatory component of curricula

Person with dementia and carer as ‘expert’ teachers

Novel approach within non-medical training

5 student cohorts at University of Surrey and Brighton and Sussex Medical School

2600 students to date

Partnerships with key organisations & family network (n=550)
One student’s experience

I'm not a particularly overly confident person so for me I proved to myself that I could go into somebody else's home...
Research study

➢ Mixed methods evaluation
➢ Two phases

➢ Quantitative student measures at baseline, 12 and 24 months
➢ Student qualitative interviews and focus groups
➢ Student satisfaction surveys

➢ PPI Involvement
➢ Qualitative interviews with person with dementia and their carer
➢ Family satisfaction surveys & free-text responses
➢ Quantitative measures – person with dementia and carer
Phase 1: Quantitative Evaluation

Baseline
969 students
400 families

12 months
759 Students
296 Families

24 months
453 Students
203 Families

Next phase
Control groups
Ongoing…

Phase 2
Measures

- Alzheimer’s disease Knowledge Scale (Carpenter et al., 2009) - a brief 30-item questionnaire designed to assess students’ knowledge of AD

- Dementia Knowledge Questionnaire (Shanahan et al., 2013) - a brief 20-item questionnaire designed to assess dementia knowledge;

- Approaches to Dementia Questionnaire (Lintern et al., 2000) - a 19-item questionnaire designed to assess attitudes toward dementia patients

- Dementia Attitude Scale (O’Connor and McFadden, 2010) - a 20-item questionnaire designed to assess attitudes toward dementia;

- Medical Condition Regard Scale (Christison et al., 2002) - a measure of biases, attitudes and emotions in relation to specific medical conditions

- Jefferson Scale of Empathy: Health Professional/Medical Student Version (Hojat et al., 2001) - 11 item questionnaire of empathy in healthcare students

- Student Satisfaction Survey
## Student outcomes
### Change over two years

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<tr>
<th>Measure</th>
<th>Range</th>
<th>Mean at Baseline</th>
<th>N</th>
<th>Mean at 24M</th>
<th>N</th>
<th>Change in Mean score</th>
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<td>0-30</td>
<td>22.9</td>
<td>692</td>
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<td>302</td>
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<td>699</td>
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<td>15.1</td>
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<td>700</td>
<td>54.8</td>
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<td>118.9</td>
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<td>Jefferson Empathy Scale</td>
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<td>116.0</td>
<td>691</td>
<td>116.5</td>
<td>293</td>
<td>+0.50</td>
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</table>
Student Experience Qualitative Research

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

- Understanding impact of dementia
- Relational learning
- Challenging attitudes
- Thinking psychologically
- Enhanced dementia practice,
UNDERSTANDING THE IMPACT OF DEMENTIA

1. Understanding person with dementia and carer’s perspective

2. Understanding how families view professionals and services

3. Understanding the global impact of dementia

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

1. “Real life” learning is easily absorbed and retained

2. Relationship with family

3. Benefits to learning in a student partnership

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

1. Changing attitudes towards person with dementia

2. Challenging misunderstandings about dementia/ stigma

3. Promoting a positive view of working with patients with dementia

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

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

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

1. Improvement in clinical skills; e.g. communication & rapport

2. Personal development; e.g. confidence & patience

3. Applying skills to own practice

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

When they very first came into Uni and asked us to be part of the study I did think I’m a mature student and I did think
Time for dementia
What’s next?

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

Follow us on Twitter

@Time4Dementia

s.daley@bsms.ac.uk
WHOLE SIGHT: New Ways Of Seeing Dementia Resulting From Relational Learning With People Living With Dementia

Dr Wendy Grosvenor
Lecturer Older Adult Care

w.grosvenor@surrey.ac.uk
What are student nurse perspectives on the impact of longitudinal home visits to people with dementia and their carers?
Emergence of New Theory

Theory: Whole Sight

New Ways of Seeing

Adaptive Thinking
Building Relationships
Transformative Learning

CORE CATEGORY

Interrelated sub-categories
‘Person is more than their dementia… Dementia does not define the person’.

(P5, Phase 1)

- Participants’ reframed their perceptions of dementia:
  - attention was given to broadening their views of dementia to encompass the person’s lives and relationships

- Seeing and treating people with dementia as wholes, and not just focusing on their dementia.

- Consequently viewed the person more holistically - resulted in adapting their thinking about dementia.
The core category of *New Ways of Seeing*, illustrates the impact of entering the world of a person with dementia.

Visits challenged participants’ perceptions and attitudes towards dementia.
Programmes such as this illuminate the experience of dementia… talking about it helps to reduce stigma… gives an opportunity to slowly face our misconceptions and gives the next generation of healthcare professionals a better understanding of how to go about approaching dementia.’

(P12, Phase 3)

» Participants made frequent references throughout the study to focusing less on the task and doing.

» They spoke of providing care that focused on the person; care that prioritised their understanding of a person’s experiences; planning and providing care that enabled and affirmed the person, all of which correlates with Kitwood’s concept of person-centred.
Building Relationships

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

(P1, Phase 2)

– Participants reflected on the importance of being with rather than doing to - fundamental to person-centred care.

– The resulting impact was seen in changes to participants’ practice; illustrated by their change of focus from working on tasks to working with, from managing patients to actively listening to and hearing the person.

– Participants’ experienced and established presence though these behaviours, resulting in increased empathy and connectedness.
‘We read a lot about caring and dementia but it’s when you meet the person and spend time with them that you begin to learn about living with dementia and how we can change our practice to make a difference’.

(P12, P3)

Findings from all three phases of this study demonstrate that the impact of visits to people with dementia and their carers were transformational.

Participants’ perceptions of dementia were challenged and changed.
Students questioned and changed their own approaches to people with dementia and their carers

Action: Challenged Practice → ‘Moral Courage’

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

(P2, Phase 3
Dementia is a global challenge of the 21st Century; how well we respond to the projected doubling of the numbers with dementia in the next generation will depend to a large extent on the quality of our future healthcare workforce.

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

*Time for Dementia* visits created a positive dementia discourse that led to significant changes in practice. This study offers new insights in developing dementia education that focuses on interconnectedness and caring relationships, promoting a Whole Sight focus on the person rather than on their dementia.
UNDERSTANDING THE BARRIERS AND FACILITATORS AFFECTING IMPLEMENTATION OF TIME FOR DEMENTIA INTO HIGHER EDUCATIONAL INSTITUTE’S (HEI).

Yvonne Feeney
Dr Stephanie Daley
Breda Flaherty
Professor Sube Banerjee
Good quality education provided at undergraduate level is needed to prepare the next generation of healthcare students support people with dementia (1,2).

Longitudinal programmes can enhance attitudes and understanding of long term conditions (3-5).

The Time for Dementia programme is now a mandatory component of the curricula at five UK Higher Educational Institutions (HEI's).

Introducing a longitudinal programme can be a complex task that requires change to established curriculum.
• To facilitate implementation in a new site, a core team supports each HEI
• Core team consists of research staff, the programme lead, an experienced administrator, and Alzheimer’s Society Network Manager
• A HEI faculty and pathway lead are identified in each site
• A suite of templates and guidance are provided to new sites
• Longitudinal programmes are not new
• An understanding of the common complexities involved across sites when implementing the programme is essential to support future roll out
STUDY AIMS

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

Apply the findings to an implementation manual to guide new sites manage common barriers and facilitators.
Qualitative design, multi site study

Semi structured interviews with key staff experienced implementing the programme

Data collected between October 2018 – December 2018

Data analysed – an inductive approach using thematic analysis
DEMOGRAPHICS

Participants (n=12)

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

Mean age 46 years

Gender female (n=12)

Average time working on Time for Dementia 17 months
Five key barriers and facilitators were identified:

1. Leadership
2. Buy-in
3. Perceived Value
4. Team Coalition
5. Time and Fit
LEADERSHIP
FACILITATING FACTORS

Confident leadership with clear understanding of roles and responsibilities

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

Ability to build trust within the organisation

“I think institutions often what will happen if something happens, what if the patients really confused, what if there’s distress, what if... what if... but actually just being pragmatic about it and I know [NAME1] was very confident and reassuring and most of those things melted away.” (Participant 5)

Commitment and Enthusiasm

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

Resilience

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

Apprehension due to unfamiliarity

Additional workload for HEI leads

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

• Shared vision for success amongst all partner organisations

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

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

• Wider faculty awareness to increase student engagement

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

• Introduction and preparation sessions, peer to peer student influence

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

• Student buy-in

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

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

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

• **Valuable opportunity**

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

• **Positivity and pride**

• **Enhanced learning experiences for students**

• **Value to the organisation**

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

• **Opportunity for networking with peers**
TEAM COALITION
FACILITATING FACTORS

• **Supportive environment, team commitment and enthusiasm**
  
  “…the only way this is successful is I think really having a mentality of the team effort, and everyone behind TfD as a programme…” (Participant 10)

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

• **Close working relationships**

• **Regular contact – site meetings, phone calls, Sharepoint**
TEAM COALITION
BARRIERS

• **Clarity of roles**

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

• **Interorganisational working and logistics**
TIME AND FIT
FACILITATING FACTORS

• Passing of time increased programme stability, student engagement increased, wider faculty awareness increased

• Iterative learning

• Administrative support

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

• Programme fit – fit within appropriate modules that make sense to students
TIME AND FIT
BARRIERS

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

- Curricular change is a complex task (6) and introducing a longitudinal programme can be daunting.
- Leaders need to create a culture prepared to embrace change, they need to have the commitment and enthusiasm to make the change.
- There was a lack of resistance reported.
- A resilient approach.
- Participants were motivated by their own core values and beliefs.
- Perceived value acted as a major motivational factor influencing participants to implement and remain engaged despite challenges.
• Extrinsic factors were important motivational drivers for participants i.e. value for the organisation
• Buy-in and team coalition are essential to motivate change efforts
• The relationship between intrinsic and extrinsic factors can positively or negatively effect motivation, i.e. pressure, reward, punishment (7)
• Barriers to implementation need to be managed, but importantly, facilitators identified must be nurtured to motivate change
Review
Apply the findings to an implementation manual

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


Acknowledgements

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• Professor S Banerjee
• This study was conducted as Yvonne Feeney Dissertation for the University of Brighton MSc in in the Division of Medical Education - Postgraduate Medicine - at the Brighton & Sussex Medical School.

• Contact: y.feeney@bsms.ac.uk
• Twitter: @time4dementia
STUDENT NURSE PREFERENCES’ FOR WORKING WITH PEOPLE WITH DEMENTIA

Ms Molly Hebditch
Dr Stephanie Daley
Dr Wendy Grosvenor
Ms Gina Sherlock
Professor Sube Banerjee
Professor Juliet Wright
Why is it important to understand the career preferences of nurses in relation to dementia?

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

Conclusion

Preferences need to be understood for workforce planning.
BACKGROUND

Systematic Literature Review:
Medical and nursing students’ preferences for working with people with dementia; a systematic review

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PROSPERO [CRD42018104647].
1. Previous studies suggest preferences towards working with older adults decrease over training (Gould et al., 2012; Happell & Brooker, 2001; Lee et al., 2006; Stevens, 2011; Zisberg et al., 2015).


**Sig factors:** Age & Ageism.

**Non-significant factors:** Aged care placement.

**Barriers:** Emotional personal demands and communication difficulties.

**Systematic Literature Review:**
Medical and nursing students’ preferences for working with people with dementia; a systematic review

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PROSPERO [CRD42018104647].
OBJECTIVES

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

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

Design and Procedure

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

3 Timepoints: T1, T2 & T3.

Study setting and sample

4 cohorts (2 TFD programme, 2 comparison cohorts)
METHODS

Measures

Ranking exercise of career preferences (Stevens, 2011)

1 (there most preferred) \(\rightarrow\) 11 (their least preferred).

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

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

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

Research Question 1:

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

Median ranking of working with people with dementia (11 = Least preferred).

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<tr>
<th></th>
<th>Median</th>
<th>IQR</th>
<th>Rank</th>
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<tr>
<td>T1 (n=342)</td>
<td>6.0</td>
<td>4.0-8.0</td>
<td>7</td>
</tr>
<tr>
<td>T2 (n=250)</td>
<td>7.0</td>
<td>5.8-9.0</td>
<td>7</td>
</tr>
<tr>
<td>T3 (n=103)</td>
<td>7.0</td>
<td>5.0-9.0</td>
<td>7</td>
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Wilcoxon Matched Pairs Signed-Ranks test.

<table>
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<tr>
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<th>n</th>
<th>P value</th>
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<tr>
<td>T1-T2</td>
<td>210</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>T1-T3</td>
<td>93</td>
<td>0.209</td>
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RESULTS

Research Question 2:

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

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

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<tr>
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<th>Mean</th>
<th>Std. Deviation</th>
<th>Pearson correlation</th>
<th>Sig.</th>
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<tbody>
<tr>
<td>T1 People with Dementia (1-11)</td>
<td>5.95</td>
<td>2.63</td>
<td></td>
<td></td>
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<tr>
<td>University Course (Ad vs MH)</td>
<td>0.21</td>
<td>0.41</td>
<td>-0.17</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>University (UoS vs UoB)</td>
<td>0.16</td>
<td>0.37</td>
<td>0.07</td>
<td>0.700</td>
</tr>
<tr>
<td>Student Gender (Female vs Male)</td>
<td>0.11</td>
<td>0.31</td>
<td>-0.01</td>
<td>0.458</td>
</tr>
<tr>
<td>Ethnicity (White British/Euro Vs Other)</td>
<td>0.17</td>
<td>0.38</td>
<td>0.06</td>
<td>0.117</td>
</tr>
<tr>
<td>Dementia experience (Yes vs No)</td>
<td>0.42</td>
<td>0.49</td>
<td>0.18</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Student Age</td>
<td>24.88</td>
<td>8.03</td>
<td>-0.08</td>
<td>0.066</td>
</tr>
<tr>
<td>ADKS at T1 (0-30)</td>
<td>22.87</td>
<td>3.00</td>
<td>-0.04</td>
<td>0.212</td>
</tr>
<tr>
<td>DK at T1 (0-20)</td>
<td>15.19</td>
<td>2.57</td>
<td>-0.12</td>
<td>0.008</td>
</tr>
<tr>
<td>MCRS at T1 (11-66)</td>
<td>55.86</td>
<td>6.25</td>
<td>-0.35</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ADQ at T1 (19-95)</td>
<td>79.70</td>
<td>5.62</td>
<td>-0.21</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>DAS at T1 (20-140)</td>
<td>115.15</td>
<td>13.04</td>
<td>-0.28</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Jefferson at T1 (20-140)</td>
<td>116.54</td>
<td>10.54</td>
<td>-0.14</td>
<td>0.003</td>
</tr>
</tbody>
</table>
## Factors associated with preferences for working with people with dementia in Year 1 (n=396)

**Multiple regression:** 12 predictors explained 16% of the variance ($R^2=.16, F (11,383) =6.25, p>.001$).

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Pearson correlation</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1 People with Dementia (1-11)</td>
<td>5.95</td>
<td>2.63</td>
<td>-0.17</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>University Course (Ad vs MH)</td>
<td>0.21</td>
<td>0.41</td>
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<tr>
<td>University (UoS vs UoB)</td>
<td>0.16</td>
<td>0.37</td>
<td>0.07</td>
<td>0.700</td>
</tr>
<tr>
<td>Student Gender (Female vs Male)</td>
<td>0.11</td>
<td>0.31</td>
<td>0.01</td>
<td>0.458</td>
</tr>
<tr>
<td>Ethnicity (White British/Euro Vs Other)</td>
<td>0.17</td>
<td>0.38</td>
<td>0.06</td>
<td>0.117</td>
</tr>
<tr>
<td><strong>Dementia experience (Yes vs No)</strong></td>
<td>0.42</td>
<td>0.49</td>
<td>0.18</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Student Age</td>
<td>24.88</td>
<td>8.03</td>
<td>-0.08</td>
<td>0.066</td>
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<tr>
<td>ADKS at T1 (0-30)</td>
<td>22.87</td>
<td>3.00</td>
<td>-0.04</td>
<td>0.212</td>
</tr>
<tr>
<td>DK at T1 (0-20)</td>
<td>15.19</td>
<td>2.57</td>
<td>-0.12</td>
<td>0.008</td>
</tr>
<tr>
<td>MCRS at T1 (11-66)</td>
<td>55.86</td>
<td>6.25</td>
<td>-0.35</td>
<td>&lt;0.001</td>
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<td>116.54</td>
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<td>-0.14</td>
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</tr>
</tbody>
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### RESULTS

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

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

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

Research Question 3:
What do students report as the reasons for their career preferences?
<table>
<thead>
<tr>
<th>Area</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aligns with personal skill set (n=10)</td>
<td>“I have had experience with dementia hence high rank, I feel confident working with people with dementia”</td>
</tr>
</tbody>
</table>
| Positive aspects of work (n=12)           | “I find working with people with dementia are challenging but rewarding. I enjoy building a relationship with them”  
“ I love being able to empower them to live as independently as possible in their homes” |
| Enjoyment and interest (n=10)             | “Enjoy working with dementia patients”  
“I’m interested in the decline of the mind, especially interested in vascular dementia”   |
<p>| Positive past experiences (n=7)           | “Following placements working in a community mental health team for older people and on an acute elderly specialist dementia ward I’ve grown great interest to work within the field of dementia” |</p>
<table>
<thead>
<tr>
<th>Prefer other areas (n=12)</th>
<th>“I'm happy working with people with dementia but I prefer other disciplines”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negatives characteristics work (n=17)</td>
<td>“I found dementia care understaffed, testing and stressful”</td>
</tr>
<tr>
<td></td>
<td>Low down on my list because as an illness it tends to deteriorate so I find it more difficult to find the ways to win at work”</td>
</tr>
<tr>
<td></td>
<td>“I had HCA experience and they have been one of the most difficult people to care of because it's distressing that they don't understand sometimes”</td>
</tr>
<tr>
<td>Lack of skills or experience (n=7)</td>
<td>“Minimal experience. Similarly, with rank 11 it's a skill set I am not too fond of using. I enjoy working with more active people.”</td>
</tr>
<tr>
<td></td>
<td>“I am not overly familiar with the appropriate ways to care for people with dementia or the typical symptoms of it”</td>
</tr>
<tr>
<td>Personal Experiences (n=2)</td>
<td>“As I have had experience with people with dementia in both professional and personal life, I would find it really difficult to cope with a full-time job in this sector”</td>
</tr>
</tbody>
</table>
CONCLUSIONS

Working with people with dementia is not popular choice, and may decrease
**Implication: role of education**

MCRS measures what extent students:

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

**Implication: importance of attitudes**

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

**Implication: Perceived competence and work characteristics**
THANK YOU!!

m.hebditch@bsms.ac.uk


