

Student experiences in learning person-centred care of patients with Alzheimer's disease as perceived by nursing students and supervising nurses.

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ABSTRACT

Aims and objectives

The aims and objectives of this paper are to illuminate and discuss the experiences and perceptions of nursing students and supervising nurses regarding the students' learning of person-centred care of patients with Alzheimer's disease in a teaching nursing home. This information is then used to develop recommendations as to how student learning could be improved.

Background

The clinical experiences of nursing students are an important part of learning person-centred care. Caring for patients with Alzheimer's disease may cause frustration, sadness, fear and empathy. Person-centred care can be learned in clinical practice.

Design

A qualitative study

Methods

The study was performed in 2006 using field work with field notes and qualitative interviews with seven fifth-semester nursing students and six supervising nurses.

Results

This study determined the variation in the perceptions of nursing students and supervising nurses with regards to the students' expertise in caring for patients with Alzheimer's disease. The nursing students experienced limited learning regarding person-centred approaches in caring for patients with Alzheimer's disease. However, the supervising nurses perceived the teaching nursing home as a site representing multiple learning opportunities in this area.

Conclusions

Nursing students perceived limited learning outcomes because they did not observe or experience systematic person-centred approaches in caring for patients with Alzheimer's

disease. It is important that measures of quality improvements in the care of patients with Alzheimer's disease are communicated and demonstrated for nursing students working in clinical practices in a teaching nursing home.

Relevance to clinical practice

Introduction of person-centred approaches is vital regarding learning outcomes for nursing students caring for patients with Alzheimer's disease.

Key words

Person-centred care, Alzheimer's disease, learning, nursing home, nursing student, teaching nursing home.

What is known about this topic:

- Nursing students feel uncertain about caring for patients with Alzheimer's disease.
- Knowledge about person-centred care of patients with Alzheimer's disease can be obtained through clinical practice.

What this paper adds:

- Nursing students need support to practice person-centred care of patients with Alzheimer's disease.
- Supervising nurses must articulate and demonstrate person-centred approaches in the care of patients with Alzheimer's disease in collaborative situations with the nursing students.

INTRODUCTION

Like the rest of the world, Norway is experiencing a general aging of the population (Statistics Norway 2005). In 2007, approximately 66 000 of the total population of 4.6 million Norwegians, had Alzheimer's disease (AD). As the population ages, this number is expected to increase (Statistics Norway 2005). Approximately 80% of roughly 40 000 patients in Norwegian nursing homes (NHs) have cognitive impairments such as AD (Directorate for Health and Social Affairs 2007).

The Norwegian nursing education is a three-year university college programme based on national guidelines (Ministry of Education and Research 2004). Normally theoretical studies serve as a preparation for clinical practice. The clinical experiences of nursing students (NSs) impact their preferences in their choice of future workplace (Bergland & Lærum 2002, Kloster *et al.* 2007). Edwards *et al.* (2004) found that graduating nurses often return to practice in areas where they had positive learning experiences as NSs. The clinical experiences of NSs regarding their knowledge of and attitudes toward caring for patients with AD are important (Robinson & Cubit 2007). Most knowledge concerning dementia care is obtained through clinical practices (Skog *et al.* 2000).

Patients with AD may have problems with both verbal and non-verbal communication (Normann 2001). They may engage in deviant behaviour, exhibiting characteristics such as aggressiveness, unpredictability and un-cooperativeness (Brodaty *et al.* 2003) and these behaviours are sometimes difficult to understand (Taft & Cronin-Stubbs 1995). The behaviour may be caused by the frustration these patients feel when they are unable to express themselves verbally (Normann 2001).

A study by Beck points out that NSs consider the care for patients with AD to be exhausting. Caring problems are connected to communication, disorientation, mood changes, anxiety and aggression (Bottril & Mort 2003). A study by Kim (2006) shows that NSs hold more negative attitudes toward elderly patients with AD than toward elderly patients in general. Dewing (1999) found that patients with AD are sometimes treated as 'non-persons.' Validation therapy (VT) (Feil 1993) and reminiscence therapy (RT) (Butler 1963) are recognised as person-centred care techniques. The aim of the person-centred care techniques is to keep the personality alive despite cognitive impairment (Dewing 2000). Kitwood and Bredin (1992) showed that patient-centred care can be obtained if the nursing staff understand the patients' needs and engage in positive interactions with them. This requires that the nurses listen to the patients and that their perceptions are explored before actions are initiated. The knowledge and attitudes of supervising nurses (SNs) toward the care of patients with AD are important for the patients, as well as for the NSs learning to care for them.

Few studies have investigated the experiences of NSs in learning how to care for patients with AD. Investigations of the attitudes of NSs toward patients with AD indicate that the students experience several emotions, such as frustration, sadness, fear and empathy (Beck 1996). Robinson & Cubit (2007) found that the complexities in caring for patients with AD, in conjunction with pre-existing ageist attitudes, can result in NSs having a negative experience in their clinical practice. This undermines the importance of supporting NSs in person-centred approaches under supervised circumstances.

Aims and objectives

The objective of this paper is to illuminate and discuss the experiences and perceptions of NSs and SNs regarding the students' learning of person-centred care of patients with AD in a

teaching nursing home (TNH) to make recommendations as to how student learning may be improved.

Methods

A qualitative design (cf. Polit & Beck 2008) including field observations with field notes and qualitative research interviews (cf. Hammersley & Atkinson 1990) was used in this study. Qualitative interviews examine the subjective experiences and perceptions of individuals (Graneheim & Lundman 2004) and field observations reveal practice in a structural and cultural context (Polit & Beck 2008). At the end of the clinical practice, semi-structured interviews (Kvale 2001) were conducted with each participant. A search of relevant literature was conducted in Cinhal, ProQuest and PubMed using the key words: Alzheimer's disease, elderly care, learning, nursing home, nursing student, person-centred care and teaching nursing home

Sample/participants

The NSs were in the final year of study and had 10 weeks clinical practice in care for the elderly in a TNH. The students received lectures on person-centred care in preparation for their clinical practice in their third and final year of study. The lectures focused on validation and reminiscence therapy. The supervising nurses had the opportunity to participate in domestic teaching (DT) on person-centred care of patients with Alzheimer's disease.

During the first study year, all students (n=7) had six weeks of clinical experience in nursing homes. They were exposed to patients with AD in this clinical practice, but did not have theoretical knowledge, as they were learning basic nursing skills. The SNs (n=6) who participated in this study were appointed as SNs for the NSs in a one-to-one relationship

except from one SN who supervised two NSs. The SNs conducted the assessment of the students' learning outcomes along with a nursing teacher from the university college when the clinical practice was completed.

The Teaching Nursing Home

The TNH included in this study has been part of a national teaching nursing home project since 1999. The TNH receives special funding for projects and measures initiated to improve the quality of care and to develop good learning environments for students (Kirkevold & Kårikstad 1999). The ideology of this TNH was based on the principles of a learning organisation. Learning organisations are described as 'organisations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free and where people are continually learning how to learn together' (Senge 1990, p.3). In the TNH, one of the aims was to: 'improve and secure quality and competence for patients in nursing homes' and 'establish an environment that stimulates professional development and research on questions attached to care and treatment of patients in nursing homes' (Kirkevold & Kårikstad 1999, p. 18).

The TNH project was characterised as a change-oriented applied research project (cf. Polit & Beck 2008) designed to help the staff explore and improve their professional knowledge. This approach was chosen because it has a bottom-up perspective (cf. Tones *et al.* 1990). In the TNH-concept, the staff could apply for funding to carry out projects in areas in need of improvements, as determined by daily experiences.

Due to the high number of patients with AD, a substantial number of projects and a large amount of the DT conducted in the TNH, both prior to and at the time of this study dealt with issues related to person-centred care for patients with AD. An acknowledgement that improvements in the quality of care for patients with AD were necessary was the foundation for this focus. Domestic teaching was offered through weekly voluntary lectures. The wards included in this study were general wards which had no special arrangements for patients with AD except from a reminiscence room in the NH. All patients required help with personal hygiene and daily living activities. About 80 % of the patients were estimated to suffer from cognitive impairment, which is in agreement with the percentage reported by the Directorate for Health and Social Affairs (2007). The patient to staff ratio was 9/3.

Data collection

Data collection was conducted in 2006. Field observations and field notes (cf. Hammersley & Atkinson 1990) were made prior to and during clinical practice. Observations prior to the clinical practice of the NSs took place in the living room, the duty room and the corridors. This period of field observations, was conducted to allow the first author to become familiar with the TNH as a site for clinical practice. Field observations in the clinical practice of the NSs were conducted over a 10-week period in which the NSs focused on elderly care and the care of patients with AD. Observations on the activities of patients and on the collaborations and communication between patients, NSs and SNs were made. The technique described by Schatzman & Strauss (1973) was used when writing field notes: specifically, the writings included observational, theoretical, methodological and personal notes. Based on the literature review and observations of the TNH, an interview guide was developed with thematic questions involving aspects of the care for patients with AD (cf. McCormack 2003, Robinson & Cubit 2007). In the interviews the first author asked the NSs an introductory question with

follow up questions regarding the experiences and perceptions related to person-centred care of patients with AD. The interviews lasted between 40-70 minutes and took place in a shielded room in the TNH toward the end of the clinical practice. The interviews were taped and transcribed verbatim.

Data analysis

Field notes were analysed according to the procedure described by Hammersley & Atkinson (1990) starting with broad descriptive categories. Then the material was sorted in relation to persons, places, activities, collaboration and communication. The field notes contributed to the interpretation of the interview materials. The interviews were analysed by qualitative content analysis (Graneheim & Lundman 2004), while the texts were read and re-read to grasp a thorough understanding of each individual interview. Interviews with the NSs were condensed to determine meaning units as constellations of words related to the same central meaning (ibid). The analysis of the interviews with the NSs served as the basis for the themes inherent in the SNs' statements as well as in the field notes.

From the interviews with the NSs, 16 sub-themes emerged and were grouped into the following broad themes relating to person-centred care of AD patients:

- Attitudes regarding approaches in caring for patients with AD
- Perceptions of knowledge regarding person-centred approaches
- Views and perspectives of learning person-centred approaches
- Perceptions of implementation of person-centred approaches

Ethical considerations

This study was approved by the Norwegian Social Science Data Service. The head of the TNH granted written permission for field observations. The participants received an explanatory letter about the study and were asked to participate. Informed written consent was obtained before data collection. Confidentiality was granted and participants were assured that participation was voluntary; the subjects had the right to withdraw from the study at any time without consequences and without having to state a reason.

RESULTS

All students reported low expectations prior to entering clinical practice in a NH. However, after being given information about the TNH ideology, the development projects and the DT programme, students had positive expectations about entering an arena characterised by updated knowledge and good care, both in general and especially for patients with AD. The NSs anticipated having rich opportunities to gain insight into person-centred approaches such as VT (Feil 1993) and RT (Butler 1963) and this was stated in their learning objectives.

Attitudes regarding approaches in caring for patients with Alzheimer's disease.

One student (5) said the following about experiences of person-centred approaches in caring for patients with AD: 'Validation...well I have not experienced it here. It is more about reprehensions and corrections'. Another student (7) said: 'Validation and reminiscence work is not spoken about and I cannot remember seeing it practiced. It is all about taking care of personal hygiene and serving meals...every day follows a routine'. Similar comments were heard by other students. One student (6) said: 'They do not talk much about how to care for those with AD', while another student (2) felt that: 'Discussions are more about how to shield them so that they don't get agitated'. Another student (3) said: '...so what I figured was that if

the patient sat quiet and dozed, then she was regarded as calm and settled'. In one situation a student (4) experienced a professional attitude that she found objectionable: 'They made jokes about it...'is it medication or placebo...no it must be sweets, she is just as crazy'.

All SNs expressed that caring for patients with AD was an important part of their daily work that was interesting, demanding and challenging. Their attitudes regarding this care were based on a genuine concern about what they saw as the consequences of cognitive impairment. One SN (5) said: 'Patients with AD are fearful, have anxieties...are afraid'. The care of patients with AD was regarded by SNs as being as demanding and challenging as expressed by a SN who said that: 'What is needed the most in care for the elderly is knowledge about AD'.

These statements confirmed that SNs understood the complexity in caring for AD patients. The importance of issues regarding care for these patients was expressed with reference to development projects and DT in the TNH on for example, validation and reminiscence therapy. The statements of the SNs support the first author's impressions from conversations with them, as they expressed concern about the well-being of patients with AD and their low threshold for stress. However, the observations indicated a somewhat different practice, as maintaining order in the unit rather than person-centred care seemed to guide the practice. The concern of the SNs for patients with AD was observed as forthcoming and joyful, but the SNs often passed by too quickly for their concern to be perceived by the patient in question.

The experiences narrated by the NSs contradict the expressed interest and commitment in the statements given by the SNs: the expressed interest and commitment were only articulated and made known to the NSs to a limited extent. The experiences of the NSs from field

observations exhibited a discrepancy between the SNs' expressed attitudes, perceptions and concerns and the factual practice in the care of patients with AD.

Perceptions of knowledge regarding person-centred approaches.

The NSs looked forward to taking part in and learning from what they expected to be knowledge-based practice of person-centred care. One student (7) said the following about how deviant behaviour was dealt with: '...so maybe there is a lack of knowledge? It does not seem as if they know how to deal with it'. Another student (5) said: 'I think knowledge about AD and care for patients with AD is very important, but...it seems as if they don't think much about it. They are very kind and caring toward them, but that is not enough'. A third student (2) asked: 'What happened to the knowledge about reminiscence work...and deviant behaviour?'. Another student (6) said: 'I feel that I have learned little about care of patients with AD'.

One of the SNs (1) said: 'We have had meetings with faculty to make them prepare students about what they will experience here; deviant behaviour, use of committal protocol etc.'.

Another SN (5) said: 'We have learned about how patients with AD experience their situation'. A third SN (3) said: 'The entirety...how to handle patients with AD; that is important for them (NSs) to learn about doing clinical practice here'.

The statements show that both NSs and the SNs recognised knowledge as necessary in meeting the complex needs of AD patients. Field observations showed few initiatives from the SNs to communicate knowledge about person-centred approaches to the students. The first author made no observations of interactions with NSs that included VT or RT. These observations support the statements from the NSs.

Views and perspectives of learning person-centred approaches.

The NSs had expectations about observing and learning specific approaches in caring for and communicating with AD patients. With regards to this one student (5) said: 'I had planned being with a patient with AD one day, but then there was lack of staff and I was asked to care for several other patients'. Another student (4) said: 'Well, from lectures at the university college I looked forward to practicing in a TNH...you know...the projects...but I haven't experienced the professionalism I had expected'. A third student (6) said: 'I had planned to spend some time with a patient in the reminiscence room when the SN wanted me to join in preparing blood samples'. Another student (7) said: '...and the reminiscence room...I have not ever seen it being used'.

The SNs' perceptions regarding how to learn to care for AD patients can be summarised from two quotes. One SN (3) said: 'Care for patients with AD...I think it can be learned from observing how we (staff) act toward them. NSs can learn from that and from caring for them'. Another SN (4) stated: 'I don't know, maybe they (NSs) haven't learned so much about reminiscence work and validation here, but they have learned about taking care of patients with AD in providing basic needs like personal hygiene and nutrition'.

The first author observed that the method of learning by doing was practiced. The additional supervision was observed to be limited. As a result, the NSs experienced limited learning from the SNs as role-models in demonstrating person-centred approaches and paying attention to the socio-emotional aspects of patients with AD. The statements from the NSs and SNs reveal discrepancies in perceptions of how to learn to care for patients with AD. The SNs underpin the importance of learning from observing what they perceived as the best practice. Field observations were contradictory in that they showed that the NSs, usually practiced

independently or with a fellow student. The NSs were also guided toward activities that were mostly task oriented, even though they wished to practice VT and RT in caring for patients with AD. Initially, the NSs spent some time communicating with patients with AD, but as the clinical practice continued, they spent more time retreating to the duty room when not occupied with physical care and other routine work. Limited field observations of the NSs and SNs engaged in shared interactions with these patients agree with the perceptions of the NSs that the clinical practice in the TNH was less profitable than expected.

Perceptions of implementation of person-centred approaches.

Referring to the expectations regarding clinical practice in a TNH, one NS (1) said: ‘Actually, I am disappointed over the professional outcomes. This is a TNH and that gave me some expectations about learning from professional development work, the projects you know, but I have not noticed them’. Another student (3) said the following about an experience: ‘We (NSs and doctor) have discussed an ongoing research project and the possible use of placebo for a patient with deviant behaviour because of AD; that was interesting’.

One SN (1) said: ‘Our routines are good in creating quietness during meals for those with AD’. Another SN (5) said ‘I think they could have been better cared for than what they are here’. A third SN (3) said: ‘I have not participated in project work or domestic teaching. It has been too much’. One SN (1) said: ‘It would have been nice if we had time to take part in domestic teaching regarding AD. That is important when working here’. Another SN (4) said the following about a project: ‘In our project we wanted to continue reminiscence work; create activity and fellowship...but there is no time to continue doing it’.

These statements show that the SNs found it difficult to participate in development projects and DT. These difficulties were observed by the first author on the days in which DT occurred, but the work was not organised in a way that facilitated participation. The fact that there was insufficient time available for the SNs to attend DT and to practice the knowledge obtained from development projects, negatively affected the implementation of person-centred approaches.

The statements of the NSs, demonstrate that they did not experience results from professional development projects and perspectives taught in DT as an integrated part of the care of patients with AD. These statements are in agreement with observations made by the first author prior to and during clinical practice showing that the nurses were busy with daily tasks and that there was a lack of discussion regarding person-centred care for the patients with AD. In meeting with and seeing the patients with AD, the SNs addressed them, made comments or touched them physically. However, these actions were hasty and lacked the significance of genuine person-centred care that requires knowledge, time and tranquillity.

DISCUSSION

The NSs expressed a wish to learn the practice of person-centred approaches for patients with AD. They sought experiences in adapting communication skills toward these patients. Puentes (2000) found that NSs found reminiscence interaction to be positive and enjoyable and that these interactions helped them to view patients in a more positive manner. These positive interactions were not as frequent for the NSs in this study. The SNs articulated commitment, engagement and genuine concern about patients suffering from AD. However, these attitudes did not result in observed systematic person-centred approaches. The care provision was task-oriented (cf. McCormack 2003) with routines and timetables (cf. Roth 1963) structuring the

practice and the main focus was to accomplish the work. Routines are important due to the patients' need for assistance with personal hygiene and meals. The challenge is to carry out routine care activities while providing opportunities for expressive interaction rather than allowing these interactions to occur as solitary acts. This is instrumental in maintaining person-centred care.

The SNs acknowledged that the care of patients with AD requires multiple skills and special training as arranged for in the TNH through development projects and DT. From the perspective of the NSs and the observations of the first author, there is a divide between the espoused theory and the theory in practice (Argyris & Schön 1978). From the SNs' point of view this discrepancy was caused by the staff being time-starved in a situation in which the provision of physical care was so demanding that there was insufficient time for person-centred socio-emotional care. This resulted in patients with AD feeling lonely and unimportant and being treated like members of a homogenous group rather than as individuals. Institutionalisation, ward behaviour and role dispossession may result from this type of treatment (Goffman 1991).

According to the observations of the first author, the staff members did not spend much time with patients with AD. Except for assistance with basic physical needs, most of the contact between the staff and patients was limited to nice, pleasant comments from the staff when passing the patient. Conversations were often ignored when they became demanding due to the degree of the patients' cognitive impairment and thus, their ability to communicate. It has been found that a patients' experience with staff members who do not listen (Tuckett 2007) results in the patients becoming isolated with limited interpersonal relationships. This corresponds with Kitwood's (1997) description of caregivers' work as being done with

kindness and good intentions while still having a traditional view of the outlook of the care of patients with AD. This may result in infantilisation, labelling and objectification and finally de-personalisation as described by Kitwood (1997). These phenomena were observed by the first author when the staff were short and kind in their encounters with the patients and infantilised them by calling them 'sweetheart' while patting their heads.

The observed withdrawal of students from interaction with the patients with AD is interpreted to be a result of limited supervised experiences in practicing person-centred approaches and an experienced lack of support from their SNs in establishing person-centred communication. This may be caused by the emphasis on task-oriented care (cf. Tappen *et al.* 1999) and a ward culture that emphasised ward orderliness (cf. Tuckett 2007) before person-centred socio-emotional focused encounters. A focus on routines and ward orderliness may be interpreted as a defence used to avoid experiences of anxiety (Menzies Lyth 1988) in being together with and communicating with AD patients. Ekman *et al.* (1991) found that patients with cognitive impairment received less nursing time than other patients implying that caregivers seldom address patients with AD for solely communicative purposes. The importance of the SNs as role models (cf. Davies 1993) affected the actions of the NSs as they observed brief interactions between the SNs and patients with AD.

Observations showed that the NSs usually cared for patients with AD on their own or with a fellow student. Thus, they had to rely on themselves to determine how their approaches suited the situations in which they were involved. This coincides with findings showing that NSs spend two-thirds of their time practising alone during clinical practice in NHs but spend three-quarters of their time with a nurse when practicing in a hospital ward (Havn & Vedi 1997).

Norbergh *et al.* (2006) found that in general nurses showed positive to neutral attitudes toward individuals with AD. The findings in this study corroborate this finding. A study by Brodaty *et al.* (2003) showed more negative than positive perceptions in working with demented patients and found that working with cognitively impaired patients is associated with high stress levels. The SNs in this study found that the care of AD patients was interesting but conflicted with their workload and their available time.

Norway has experienced a shortage of nurses, especially in NHs (Ministry of Health and Social Affairs 2005-2006). If the quality of care of patients with AD is to be improved, the number of nurses must be increased. Recruitment and retention of nurses in NHs can be achieved through establishing learning networks (cf. Adams & Richardson 2005), organised as group and individual sessions to improve learning of person-centred care for patients with AD. The sharing of ideas and knowledge, combined with reflection on difficult and challenging situations may provide pathways to support the quality of care for patients with AD.

The SNs stated that knowledge about care for AD patients is important. They discussed the importance of preparedness for clinical practice in the TNH where approximately 80% of the patients suffered from cognitive impairment. They recognised knowledge as the basis for the quality of care for AD patients. The experienced lack of time for attending DT and implementing projects, revealed a conflict between intentions and results. The experiences of the NSs support this. For example, they were directed away from planned person-centred encounters with patients to accomplish routine tasks. The NSs had expectations of learning to practice person-centred communication. These methods have proven to be effective for health care professionals to learn about and appreciate the lives of their patients (Shellman 2006).

The NSs found that their expectations of learning outcomes regarding person-centred care of AD patients were unmet.

In this respect the TNH did not function as a community of practice engaged in a process of collective learning (cf. Wenger 1998) which included the NSs. Whether a health organisation, as a community of practices improves its performance depends on its commitment to taking on responsibilities to implement quality measures achieved by development projects and to ensure participation in DT. The importance of SNs as role models (Tuohy 2003) was not significant for the NSs and learning-by-doing without critical reflections seemed to be the perceived method of clinical learning. The NSs stated that they saw professional discussions as a pathway for learning. According to Martinsen (1989) the NSs' knowledge in clinical practice is from advice and dialogue with an expert. The NSs' experiences in this study did not include dialogues about person-centred approaches in the day-to-day practice. This indicates that the outcomes of the learning experience were incomplete. If the attitudes and learning of NSs regarding care of patients with AD are to be changed, a dynamic process is required. This process should be one in which training, knowledge and measures for quality improvement are internalised in both the clinical organisation and in the individuals working there.

Limitations

The small sample and the qualitative approach in this study limit the application of the findings to other situations. Although the study examined one TNH in a Norwegian context and a small number of participants over one specific period of time, the findings may be relevant for preparing and supporting the learning possibilities and learning outcomes of NSs regarding person-centred care of patients with AD.

Conclusion

Several challenges regarding NSs' learning of person-centred care of patients with AD in clinical practice await solutions. Collaboration between the university-college and NHs concerning person-centred approaches as part of the NSs' learning objectives and appurtenant assessments is important. The NSs entered the TNH for clinical practice with updated knowledge about VT and RT as person-centred approaches. This knowledge was the basis for their expectations that they would learn to practice these therapies in the TNH. Their expectations may have been somewhat unrealistic as individual and organisational learning concerning the outlook of the care of patients with AD take time. Challenges in establishing a culture for learning and implementing principles of a learning organisation are addressed. The establishment of a culture in which knowledge and positive results from research and development projects are actively discussed and mandated in the practice of person-centred care is of great importance. A leadership responsibility is also addressed. The final challenge is to communicate and emphasise knowledge, expertise and professional experiences for NSs. Collaboration between competent SNs and NSs during clinical practice is vital if approaches of person-centred care are to be implemented.

Relevance to Clinical Practice

Unless the knowledge basis of person-centred approaches in the care for patients with AD is strengthened and implemented in practice, NSs will continue to experience a gap between theory and practice (Kirkevold 1996). In addition, patients with AD will continue to experience de-personalisation and institutionalisation caused by staff with the traditional outlook of patients with AD. Subsequently, NSs will continue to experience only limited learning of person-centred care of patients with AD unless changes are implemented.

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Contributions

Study design: MWS, HKN, NH.

Data collection and analysis: MWS, HKN, NH.

Manuscript preparation: MWS, HKN, NH.

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Table 1. Schedule of curriculum for the participating nursing students

	Focus	Clinical practice	Duration	Clinical site
1. year of study	Basic nursing	Basic nursing care and skills	6 weeks	Nursing homes
2. year of study	Acute and critical illness and nursing care	Specialized nursing care and skills	Two periods of 10 weeks	Medical and surgical wards in hospitals
3. year of study	Elderly care and mental health care	Specialized nursing care and skills	Two periods of 10 weeks	Nursing homes, psychiatric institutions and/or home care