

✧ RESEARCH PAPER ✧

A comparison of acute and long-term health-care personnel's attitudes towards older adults

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Considerable variations in the quality of care older adults receive may depend much on the attitude of staff towards them. The attitudes of nurses, assistant personnel and porters towards older adults were assessed. Determinants affecting this judgement, such as age, gender, education, years in practice and care setting, were also assessed. Ninety-nine (acute) and 87 (long-term) hospital employees completed the self-report Kogan's Attitude Towards Old People scale. Significant statistical differences in negative attitudes were found between assistant personnel and nurses and between porters and nurses; these non-professionals believed that older adults were irritable, grouchy, complaining and untidy. Practice area had no influence on attitudes; attitudes were, however, significantly predicted by education levels. Findings suggest that, irrespective of setting, assistant personnel and porters possess significantly greater negative attitudes towards older adults than nursing staff. Furthermore, these negative attitudes seem to be a function of lower educational achievement. Implications for informing practice, education and policy-makers are discussed.

Key words: acute, attitudes, health-care personnel, long-term, older adults.

INTRODUCTION

Health services have been identified as one of the main public agencies at the interface of ageism and negative attitudes.¹ In fact, a plethora of international nursing studies indicate that nurses and nursing students often possess unfavourable attitudes towards older adults.^{2–5} In Sweden, for example, nursing students were found to

have more negative attitudes than qualified nurses,⁶ and in the UK the ageist attitudes held by nurses were found to affect the dignity and autonomy of older patients.⁷ Evidence also demonstrates that when older patients are perceived as being cantankerous and complaining by nurses, the quality of care delivered and the recovery of patients are affected.² In the Republic of Ireland, however, the attitudes of nurses towards older adults have yet to be assessed, and this is at a time when adults aged ≥65 account for >11% of the Irish population.⁸ If elder care is being affected by ageist attitudes, it is imperative to measure such attitudes in Irish nurses, as the

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possibility exists to change attitudes through education and training.⁹

Furthermore, because of the global shortage of nurses, increasing numbers of unlicensed and unregulated non-professionals (assistant personnel, e.g. attendants, aides and care assistants) employed mostly in elder care have been recruited to meet this shortfall.^{10,11} It has been suggested that substituting unlicensed assistant personnel for skilled nursing staff may result in a poorer quality of care.¹² In fact, 38% of support workers believe that they have received insufficient training to perform their role effectively;¹³ and others believe that their education, training and competency revalidation should be ongoing in order to broaden their knowledge base and enhance their skills.¹⁴ It could be that, as a consequence of inadequate training, assistant personnel may possess higher negative attitudes towards older adults than nurses. In addition, because of their training and position, nurses have a key role to play in assistant personnel's tuition and skill attainment,¹⁵ and, if negative attitudes exist among this group, nurses have the power and the potential to contribute to, and develop education programmes that reduce such ageist stereotypes.

Another health-care group having day-to-day contact with older patients are porters. In hospitals, porters are perceived as having modest patient contact or care responsibility. Nevertheless, porters are key workers within health-care settings, doing work that involves moving, lifting and transporting patients from wards to theatres—a position that brings close contact with sick, and sometimes vulnerable, older patients. It is often the role of porters to work alongside nurses and assist them in delivering care to older adults; it is important then, as porters contribute to elder care, to assess their attitudes because, as yet, this type of assessment is absent from current research.

A collection of studies have identified factors, such as area of practice, age, gender and years in clinical practice, as affecting nurses' attitude strength.⁵⁻⁷ Soderhamn and colleagues found younger and male nurses to possess more negative attitudes in comparison with older and female nurses.⁶ This research also demonstrates that higher education, gerontology courses and more years of clinical experience were found to be associated with less negative attitudes.^{5,6} Area of clinical practice was also found to influence attitude strength.^{5,6} For example, nurses working in acute settings have been found to use more negative stereotypical labelling to describe their

older patients to student nurses than those working in elder-care settings.¹⁶ Such contributing factors to ageism are important to delineate as they have implications for nurse education and training. The present investigation extends, and contributes to research on ageism, by assessing the attitudes of Irish health-care personnel, including nurses, assistant personnel and porters, towards older adults. The study will determine: (i) what health-care personnel group (nurses, assistant personnel or porters) possess more negative attitudes towards older adults; (ii) do health-care personnel who work in acute settings have more negative attitudes than personnel from long-term settings; and (iii) in terms of health-care personnel's demographics, years experience and training, what is associated with negative attitudes?

METHODS

Design and sample

In this study, a cross-sectional between-subjects design was used. Data were collected from personnel working at two hospitals controlled and funded by a Health Board in southern Ireland: a non-acute long-term care facility specializing in long-term extended and convalescent mental-health and rehabilitation respite care, and a full-service acute general hospital providing services from Accident and Emergency to psychiatric and coronary care. As it was not possible to determine how many of each health-care group would participate, power and effect size analyses were conducted retrospectively. A purposive sample of health-care personnel ($n = 192$) were recruited from the two hospitals. These comprised nurses ($n = 99$) with ages ranging from 21 to 55 years, assistant personnel ($n = 73$) with ages ranging from 18 to 55 and 15 porters with ages ranging from 20 to 55 years.

Measures

Participants completed Kogan's Attitude Towards Old People scale,¹⁷ which has been used successfully in previous nursing research.^{5,6} It has 17 positive and 17 negative statements concerning older adults, and it uses a Likert-type scale of five response categories ranging from 'strongly agree' to 'strongly disagree', with higher scores indicating less favourable attitudes. Cronbach's alpha coefficients were 0.75 and 0.73 for the negative and positive scales, respectively, indicating that the questionnaire was reliable. Items also included on the questionnaire were demographic questions pertaining to participants' work and educational details.

Procedure

Study posters were displayed in hospital canteens and project details sent to each ward electronically. In order to avoid disruption of hospital care, questionnaires were placed within easy access by staff on wards. Health-care personnel, if they wished, had the option to complete questionnaires at home. The researchers returned every second day for a period of 3 weeks to collect completed measures and to debrief participants and answer any questions. Ethical approval for the study was obtained from relevant research ethics committees. Signed informed consent was obtained from all participants before completing the measurement, and issues of confidentiality were addressed.

Data analysis

Data were checked for normality and assumptions of fit, using the Statistical Package for the Social Sciences/Personal Computer (SPSS, Chicago, IL, USA) Version 11. However, because of heterogeneity of variance, differences were analysed by non-parametric ANOVA (χ^2), post-hoc independent samples, and, due to uneven sample sizes, Mann–Whitney *U*-tests. Demographic predictor variables were analysed by multiple regression. In addition, Cohen suggests that 0.2, 0.5 and 0.8 are small, medium and large effect sizes for independent group samples, respectively, and, in order to reduce the risk of a type II error, a test power close to 0.8 is conventional.¹⁸ Because of their low response rate, porters in long-term settings ($n = 3$) were excluded from statistical analyses, making a total cohort of $n = 189$. An alpha (α) level of less than $P < 0.05$ was accepted for all experimental and exploratory hypotheses.

RESULTS

Participants' demographics, including education, gerontology courses and years in practice, are shown in Table 1. Response rates of 69% and 57% were achieved from both acute and long-term settings, respectively. Of non-professionals, 56% left school aged ≤ 16 years, and 46% completed their leaving certificate or high-school equivalent. Similarly, 89% of health-care personnel had no specialist gerontology education; 29% had ≤ 3 years, 46% had 5–10 years and 35% had ≥ 10 years of experience.

Means and standard deviations were obtained for all groups' attitude scores and can be visually inspected in Table 2. As shown in Table 2, porters and assistant personnel in both acute and long-term settings had lower

Table 1 Participant characteristics and demographics ($n = 189$)

Items	N
Years in employment	
1–3	55
3–5	37
5–10	31
10+	66
Highest level of education	
Primary [†]	15
Intermediate certificate [‡]	33
Leaving certificate [§]	38
Nurse diplomate/degree	103
Specialist gerontologist education	
Yes	17
No	172

[†] Left school aged < 15 . [‡] Left school aged 15–17. [§] Finished high school.

Table 2 Health-care personnel's mean scores and standard deviations (SD) for both KOP scales ($n = 189$)

Scale	Setting	Mean	SD	Mean rank
KOP+	Acute			
	Nurses ($n = 55$)	41.95	5.36	—
	AP ($n = 37$)	43.86	8.01	—
	Porters ($n = 12$)	44.67	4.92	—
	Long term			
	Nurses ($n = 45$)	40.37	5.33	—
AP ($n = 39$)	42.54	8.02	—	
KOP–	Acute			
	Nurses ($n = 55$)	68.13	6.54	66.51
	AP ($n = 37$)	59.14	9.88	37.85
	Porters ($n = 12$)	60.17	4.38	33.46
	Long term			
	Nurses ($n = 45$)	66.54	8.10	—
AP ($n = 39$)	56.90	8.32	—	

AP, assistant personnel; KOP, Kogan's Old People attitude scale.

mean scores compared with nurses on the KOP(–) negative scale, but not KOP(+) positive scale. A Kruskal–Wallis *H* revealed that there were no differences between health-care personnel's median scores on the positive

attitude scale ($\chi^2 = 6.935$, d.f. = 4, $P > 0.05$). However, statistically significant differences were found between all groups' median scores on the negative attitude scale ($\chi^2 = 50.875$, d.f. = 4, $P < 0.001$). For example, most of the non-professional staff agreed with the statement 'Most old people are irritable, grouchy and unpleasant', and agreed with the statement 'Most old people make excessive demands for love and reassurance'.

A statistically significant difference was found between acute-setting assistant personnel's (59.14 ± 9.88) and nurses' (68.13 ± 6.54) negative attitudes ($t = 4.865$, $P < 0.001$), and a large effect Cohen's $d = 0.9$ was found. An unrelated t -test revealed that assistant personnel in long-term settings had more negative attitudes than nurses (56.90 ± 8.32 vs. 66.54 ± 8.10), and this was statistically significant ($t = 5.40$, $P < 0.001$), and Cohen's $d = 0.8$. A power of 0.99 was achieved for both tests. Findings indicate that in both acute and long-term settings, assistant personnel have more negative attitudes towards older adults than nurses.

A Mann-Whitney U -test revealed a statistically significant difference in mean ranks between porters (33.46) and nurses (65.51) in the acute setting ($U = 103.5$,

$P < 0.001$), and a medium effect size of $r = -0.45$ and a power of 0.88 was achieved. For example, Porters agreed more with this statement than acute-care nurses: 'Most old people make one feel ill at ease'. No differences were found between porters and assistant personnel mean ranks (33.46 vs. 37.85) in acute settings ($u = 220.0$, $P > 0.05$), therefore suggesting that porters in acute settings possess significantly more negative attitudes than nurses, but not assistant personnel. Examination of the negative attitude scale revealed statistical group differences between nursing personnel and the non-professional staff (porters and assistant personnel) independent t -tests on almost all of the items (Table 3).

Unrelated samples t -tests were performed to examine group differences across clinical settings. No statistically significant differences were found between nurses in acute and long-term settings, or between acute and long-term assistant personnel on the negative or positive scales. Contrary to expectations, these results demonstrate that area of clinical practice does not affect health-care personnel's attitudes towards older adults.

A multiple regression was performed to investigate whether the independent variables of age, level of educa-

Table 3 Independent t -tests, for differences in negative attitudes between all nurses (N; $n = 101$) and non-professional staff (NP; assistant personnel and porters; $n = 88$)

Negative item	Mean (NP vs. N)	P
1. It would probably be better if most old people lived in residential units with people of their own age	3.80 vs. 3.42	0.023
2. There is something different about most old people: it's hard to figure out what makes them tick	3.94 vs. 3.29	0.000
3. Most old people would prefer to quit work as soon as pensions or their children can support them	4.04 vs. 3.60	0.004
4. Most old people tend to let their homes become shabby and unattractive	4.16 vs. 3.88	0.033
5. Old people have too much power in business and politics	4.13 vs. 3.85	0.022
6. Most old people make one feel ill at ease	4.42 vs. 3.94	0.000
7. Most old people bore others by their insistence on talking about the 'good old days'	4.16 vs. 3.60	0.000
8. In order to maintain a nice residential neighbourhood, it would be best if too many old people did not live in it	4.40 vs. 3.76	0.000
9. There are a few exceptions, but in general most old people are pretty much alike	4.17 vs. 3.42	0.000
10. Most old people should be more concerned with their personal appearance; they're too untidy	4.26 vs. 3.56	0.000
11. Most old people spend too much time prying into the affairs of others and giving unsought advice	4.19 vs. 3.52	0.000
12. Most old people are irritable, grouchy and unpleasant	4.43 vs. 3.79	0.000
13. Most old people are constantly complaining about the behaviour of the younger generation	3.48 vs. 2.64	0.000
14. Most old people make excessive demands for love and reassurance	3.87 vs. 3.25	0.000
15. If old people expect to be liked, their first step is to try and get rid of their irritating faults	3.76 vs. 3.25	0.000
16. Most old people get set in their ways and are unable to change	2.91 vs. 2.58	0.001
17. It is foolish to claim that wisdom comes with old age	3.30 vs. 3.00	0.057

Table 4 Multiple regression analyses for the participants' demographic, work and educational predictors of attitude scores ($n = 189$)

Variables	R^2	R^2 change	β	t	P
KOP+	0.038	0.017	—	—	—
Age	—	—	-0.123	-1.447	0.15
Education level	—	—	-0.066	-0.894	0.37
Gerontology course	—	—	0.023	0.305	0.76
Years in practice	—	—	-0.096	-1.166	0.24
KOP-	0.224	0.208	—	—	—
Age	—	—	0.097	1.276	0.20
Education level	—	—	0.486	7.921	0.00
Gerontology course	—	—	0.053	0.797	0.42
Years in practice	—	—	-0.020	-0.267	0.78

KOP, Kogan's Old People attitude scale.

tion, gerontology education and years in practice were predictive of health-care personnel's positive and negative attitude scores (Table 4). Analyses revealed that age predicted only 2% of the variance in positive attitude scores. Level of education was a significant predictor of health-care personnel's negative attitude score ($\beta = 0.464$; $P < 0.001$), thus a higher education level predicted lower negative attitude scores and vice versa. In fact, a total of 21.6% (adjusted 21.1%) of the variability in negative attitudes was predicted by health-care personnel's level of education.

DISCUSSION

Descriptively, nurses and non-professionals had similar positive attitudes, but significant differences in mean negative attitudes scores. In fact, some of these negative attitudes suggest that non-professional health-care staff believe that older adults are 'untidy, irritable and unpleasant', and that they make excessive demands for 'love and reassurance'. Additionally, and more important for elder care, they agreed more with the statement 'Most old people make one feel ill at ease', suggesting that they are uncomfortable in the company of older adults. They also agreed with the statements indicating that older people are 'complaining' and 'irritable'. Interestingly, nurses' mean attitude scores for these items were also above a neutral score, indicating that they also believed these ageist misconceptions. If these negative beliefs are held by health-care staff, including nursing personnel, it might have serious consequences for delivery and provision of

elder care by both professional and non-professional health-care personnel. In order to reduce and improve ageist attitudes, these findings highlight possible key areas and topics for nurse educators to focus their education and training efforts on.

The first aim of this study was to examine differences between various health-care groups' attitudes towards older adults. Analyses revealed that porters and assistant personnel had significantly higher negative attitudes towards older adults compared with nurses from both acute and long-term settings. No differences were found between assistant personnel and portering staff. This finding also indicated that there were no gender differences, as all the assistant personnel in the acute setting were women and the porters were all men, which is in contrast with other studies, which found men to hold more negative attitudes than women.⁶ However, our finding should be interpreted with caution, as assistant personnel and porters play different roles in delivering elder care, and in previous studies both sexes when they were assessed came from the same profession (i.e. nurses).⁷

Our investigation supports and extends the findings of previous research, which found differences in negative attitudes across health-care staff. To our knowledge, it provides the first empirical evidence that porters hold more negative attitudes towards older adults in comparison with nurses. Similarly, we found long-term assistant personnel to have significantly more negative attitudes than nurses in those elder-care settings. Similarly, in the acute hospitals, assistant personnel practising in this

setting possessed significantly more negative attitudes than acute-care nurses. This particular finding encompasses an interesting point when there are increasing amounts of care and treatment being delivered to older adults in acute settings.² It raises many serious dilemmas for the provision of elder care and perhaps highlights the lack of inadequate and insufficient training given not only to assistant personnel but also to portering staff. If these negative attitudes are present in non-professionals working in hospital settings, could they also be present and in the same format in those health-care workers practising, often working unsupervised, in community settings?

Another aim was to examine group attitudes differences across hospital settings. Contrary to previous findings,⁴ the area of clinical practice did not influence the attitudes of either nurses or assistant personnel. This is incongruent with the results of Lookinland and Anson⁵ and Soderhamn and colleagues,⁶ who found differences in nurses' ageist attitudes across clinical settings. Regardless of practice area, Irish nurses or assistant personnel who practise in acute settings do not possess more negative attitudes towards older adults than their counterparts practising in long-term care settings. More importantly, it could be that these attitudes are a function of societal attitudes and not nursing practices per se.

Finally, age and years in clinical practice were significant predictors of positive attitudes, whereas personnel's level of education was a significant predictor of negative attitudes. Higher educational levels were predictive of lower negative attitudes and vice versa, and these results are consistent with those found elsewhere.⁴ Based on this, one could argue that the possession of negative attitudes by assistant personnel and porters is a function of poor education, as both groups receive less training and have less education in comparison with nurses. In fact, 56% of non-professional staff reported that they left school before the age of 16 or just before receiving their intermediate certificate, implying that educational attainment within this health-care group is extremely low and possibly influencing attitude strength.

The limitations of this investigation must be acknowledged: first, the use of a single attitude measurement and a cross-sectional design. Second, any sex differences cannot be directly inferred from this study. Future investigations could combine both qualitative and quantitative techniques with prospective designs, try to recruit more men and possibly determine whether ageist attitudes are impacting the quality of care delivered to older adults.

CONCLUSIONS

These findings extend and contribute to the existing body of knowledge on ageist attitudes, and suggest that nurses from the Republic of Ireland do not possess more negative attitudes than assistant personnel and portering staff. As the profile of the world's population is changing, the current findings have several implications for the provision of elder care and future health-care research. First, it has implications that health services must be informed, regarding practice and policy, about the distribution of negative attitudes among its non-professional health-care staff, whose numbers are increasing within health services. Second, these findings should be utilized to provide appropriate training to combat stereotypical perceptions about older adults that assistant personnel, porters, as well as nursing staff hold. If health-care staff believe that older adults make them feel ill at ease, and that older adults are untidy and irritable, it might impact quality of care; therefore, such misconceptions need to be addressed. Moreover, if the demand for assistant personnel increases within health services, then it is imperative that nurses, if they are to work alongside a cadre of adequately trained staff, contribute to the development, implementation, monitoring and evaluation of assistant personnel's education and training programmes. In recent times, there has been some implementation of a variety of vocational and national qualifications for assistant personnel; however, the monitoring and content of these programmes may need to be evaluated and modified in consideration of these findings.

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