Healthcare Support Staff Attitudes Towards Older Adults

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Submission of Thesis and Dissertation

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Abstract

Ireland is experiencing a rise in the population of older adults with the improvement of health services and life expectancy. Ageism can negatively affect older adults and quality of care received. This study aimed to investigate ageism in healthcare support staff. The study also aimed to investigate if gender, age, duration of employment, education and occupation are associated with ageist attitudes. The study was conducted using a quantitative, cross-sectional approach. There were 48 participants recruited from a hospital in Ireland. Participants completed an online survey. Demographic and occupational information were collected. Ageism was assessed using the Fraboni Scale of Ageism. Nurses, MTAs and HCAs have positive attitudes towards older adults. Multiple regression analyses found ageism was not predicted by age, gender, occupation, educational achievement and duration of employment. Additional analyses resulted in no significant associations between ageism and education, duration of employment or age. Gender was also not associated with ageism. There were no significant differences in attitudes by occupation. Education, age, gender, occupation, duration of employment or occupation may not be predictive or associated with ageism. Possible implications for cultural research to be conducted on ageism, and longitudinal research is also required to further investigate the development of ageism.

Keywords: Healthcare Support Staff, Attitudes, Ageism, Older Adults, Health

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Introduction

The world's population is getting older as life expectancy is increasing every year globally. Average Life expectancy is expected to increase from 71.7 years, reported in 2022, to 77.3 years by 2050 (World Economic Forum, 2023). This increase sounds like a small number but in 2022, globally, there were approximately 771 million people aged over 65, and this number is expected to more than double by 2050, to about 1.6 billion (United Nations, 2023). Ireland has experienced a significant growth in the population of people aged 65 and over. In 2016, according to the Central Statistics Office (CSO), the population of older adults (People aged 65 and older) was 637,567. The Irish Longitudinal Study on Ageing (Trinity College Dublin, 2023), currently being conducted is projecting the population of older adults to increase to almost 1.4 million by 2041. Ireland is experiencing a significant growth of the population of older adults along with the world (Liston et al., 2017). It is imperative that we gain an understanding into the attitudes of our healthcare workers towards older adults as with the increasing growth of older adults, they will require the care from our healthcare workers, and healthcare workers will have to work more with older adults as the population increases (Liston et al., 2017).

Ageism

Attitudes are defined as "a relatively enduring and general evaluation of an object, person, group, issue, or concept on a dimension ranging from negative to positive" (American Psychological Society, 2018). The attitude that this study aims to investigate is ageism, which is the discrimination and negative stereotyping of older adults because of their age (World Health Organisation, 2024). Ageism and the negative stereotypes that are conceived about ageing and older adults can have negative effects on older adults. Ageism is very prevalent in today's world and goes by unnoticed, according to the World Health Organisation (2024), one

in two people are ageist. Social Identity Theory (Ayalon & Tesch- Römer, 2018) suggests that people act in accordance with their in-group identity and aim to create a positive self-identity by creating bias and demonstrate discrimination towards individuals not within their group to elevate in-group status. As age can be considered a category for group identification, this theory can explain ageism as discrimination by age. Levy (1996; 2009) found that negative stereotype self-belief had negative effects on memory performance and direct negative physiological impacts. Negative stereotype self-belief is the tendency to view and associate the self with the descriptives of the in-group or stereotype they are aligned with (Burkley & Blanton, 2009). Recent research has also found that it can influence walking ability, handwriting ability (Diongi, 2015) and lower levels of reported subjective health, and higher levels of loneliness and help-seeking behaviour (Coudin & Alexopoulus, 2010).

Effects of Ageism on Older Adults

Negative stereotypes about cognitive decline can lead to an exacerbation and accelerated cognitive decline in older adults as a result from the negative stereotyping of older adults (Marquet et al., 2016) along with increased physical functional decline (Bennet & Gaines, 2010). Attitudes of healthcare staff towards older adults can affect the quality of care provided to older adults, such as nurses who were observed to provide more effective care to older adults if they had more positive attitudes towards older adults (Basturk et al., 2022; Holmberg et al., 2023). Notably about research in the association between quality of care and attitudes towards older adults are conducted using self-report measures, which may not give as an effective representation of quality of care compared to observational data collection. With the implications of previous research on the effects of ageism on older adults, to reduce these effects, the attitudes of people and what variables influence ageist attitudes must be investigated, and it has been well researched, but research has been reported to very diverse and inconclusive on attitudes of healthcare staff such as nursing students (Fhon et al., 2024).

Ageism in Healthcare

Nursing students were found to have positive attitudes towards older adults in a Swedish population (Heckemann et al., 2021), concurring with research across healthcare personnel. Most studies conclude that majority of healthcare personnel such as healthcare assistants, nurses and other staff have positive attitudes towards older adults (Doherty et al., 2011; Nilsson et al., 2012; Coffey & Whiteland, 2015; Rabab & Ammar, 2023). Variables that were commonly investigated and found to be associated with ageism are age, gender, educational level, occupation, and duration of employment. Dhami et al. (2015) conducted a study measuring the attitudes of 220 youths aged 18-25. The study found that there were gender differences in ageist attitudes amongst males and females, which has been supported by other research in healthcare settings (Sahin et al., 2021). Sahin et al., (2021) found females have more ageist attitudes towards older adults and that people who lived with an older adult or had more frequent contact with older adults reduced ageist attitudes, which is supported by other research (Liao et al., 2023). Doherty et al. (2011) found no significant gender differences in hospital workers, but the sample was very disproportionate (Male = 19, Female = 167). This disproportionate sample can have an impact on the generalisability of results. Similarly, Uğurlu & colleagues (2018) found that there were no differences in gender on attitudes towards older adults but 80% of the sample were female. Though the samples of the studies are disproportionately women, 79% employees in the Irish Health Service were female in 2016 (CSO, 2016) so results are to be considered with the current population of healthcare staff and generalisable to a hospital setting population.

Uğurlu & colleagues (2018) also investigated the effect of occupation type on explicit ageism through the Fraboni Scale of Ageism (FSA; Fraboni et al., 1990). Though they investigated the effect of occupation type and found that there were significant differences in FSA scores between only two occupations: nurses and health care technicians. They found that

health care technicians scored higher on the FSA, indicating more negative ageist attitudes towards older adults than nurses. Nilsson et al., (2012) also concluded the same findings while examining predictors of ageism, which were age, duration of employment and level of education. Nilsson et al., (2012) found that an increase in age, duration and employment and higher educational attainment were associated with a reduction in ageist attitudes towards older adults. Doherty et al., 2011 in contrast, found that there were no significant occupational differences in attitudes of older adults amongst nurses, ward managers, and health care assistants (HCAs). Reasons for these findings may be due to the sample majority consisting of mainly nurses (73.8%) and the use of the Kogan's Attitudes Towards Older Adults scale. Doherty et al., (2011) conducted their study on an Irish population, while Uğurlu et al., (2018) conducted their study on a Turkish population, suggesting there may be cultural differences in attitudes towards older adults. Sahin et al., 2021 also investigated occupational differences of attitudes towards older people in physicians, nurses, and midwives, they found that physicians had more positive attitudes towards older adults than midwives and nurses. They deduced that this could be a result of a higher education level as they found the higher a person's education level was, the more positive attitudes they had towards older adults. This effect was observed in the findings from previous research, (Nilsson et al., 2012; Uğurlu et al., 2018) suggesting education has a strong influence on ageism.

Educational level and ageist attitudes amongst healthcare staff has been well researched and results suggest that educational level predicts reduced ageist attitudes by reducing negative attitudes towards older adults, when an individual had higher educational attainment. Other research has found supporting evidence for this (Shermann et al.., 1996; Uğurlu et al., 2018) and found that higher levels of education predicted higher levels of knowledge of ageing and reduced ageist attitudes in healthcare personnel. Rababa & Ammar, (2018) also found that there was a positive association between higher education level and reduction in ageist attitudes. The

evidence accumulated through research strongly suggests that educational level predicts the attitudes of healthcare staff towards older adults. Another variable that has showed consistent supporting evidence is the effect of duration of employment on ageism.

Majority of studies that have investigated duration of employment and its association with ageism have concluded that the more years of employment staff have in healthcare, their ageist attitudes are reduced. Nurses with more years of employment were found to have more preference for older adults than other groups (Sahin et al., 2021), along with similar findings for duration of employment observed in reduction of ageist attitudes in nurses and healthcare technicians in Turkey (Uğurlu et al., 2018). In an Irish population, Doherty et al., (2011) found that there were no differences in ageist attitudes, amongst a healthcare staff population including nurses, ward managers and HCAs. Duration of employment is suggested to be associated with ageism scores, by observed reduction in ageism as a longer duration of employment is observed. In the Irish population, there is a lack of research and there is a possibility that duration of employment could be associated with reducing attitudes. Duration of employment is its own independent variable when investigating ageist attitudes but is very similar to the factor of age in their relationships with attitudes towards older adults.

Nilsson et al. (2012) found staff had more negative attitudes towards older adults when staff were younger, and like duration of employment majority of studies suggest the equivalent effect. Notably, 79% of the sample in Nilsson et al., (2012) were aged 25-49, and age was categorised into 3 groups, with other groups being either aged less than 25 or older than 49, making it difficult to make inferences from the categorisation of groups. Amongst nursing students in Sweden and Austria, ages were split into four groups, and it was found that the older a person was, the more positive attitudes they had towards older adults (Heckemann et al., 2021) with other research amongst physicians and nurses suggesting that those aged 55-64 had the highest preference for older adults (Sahin et al., 2021) Coffey & Whiteland (2015) found

that younger participants had more positive attitudes, but they only categorised age into two wide-ranging age groups (18-44 and 45-64) which does not thoroughly investigate the effect of age. Results suggest that the older a person is, they have more positive attitudes towards older adults. Extensive research has been conducted on ageism within healthcare settings, and into the variables that have an association with reducing or increasing ageist attitudes towards older adults. Results suggest that the variables that have an influence on ageism are age, gender, occupation, education level and duration of employment and most of these have been found to be associated with reducing ageist attitudes in nurses, physicians, and student nurses.

There seems to be a lack of research into the attitudes of staff that support these roles in healthcare settings such as HCAs and porters, and multi-task attendants evident in research reviews (Liu et al., 2012; Wilson et al., 2017). HCAs must conduct baseline clinical observations under delegation of a nurse, such as recording blood pressure, examining urine samples and observing patients. HCAs must assist patients with any needs they may require while also promoting and motivating the patient to act independently. HCAs must treat patients with the upmost dignity and respect while delivering an excellent quality of care to the patient, ensuring the patient is treated with respect, and GDPR regulations must be strictly adhered to when communicating with or about a patient with involved parties (HSE, 2025). Porters and multi-task attendants (MTA) are similar roles that have must directly interact with patients. They must assist patients with any needs appropriately or communicate patient needs to the nurse if this cannot be completed by the porter or MTA. They must transport patients within hospitals to other departments or for procedures, as directed. They must feed patients if requested to do so in line with HSE guidelines and directory and ensure proper cleaning of equipment after patient use, and report any equipment faults (HSE, 2025).

Liu et al. (2012) conducted a review of healthcare personnel attitudes and out of 51 studies selected, only one contained data on porters. Wilson et al. (2017) found no research of

assistant personnel or porters and recommended more research of ageist attitudes in healthcare is required. Studies have suggested that HCAs have positive attitudes towards adults (Doherty et al., 2011; Coffey & Whiteland, 2015). Coffey & Whiteland (2015) observed that of the sample, majority had training in older adult care, which could influence their attitude scores because of their further training. Gallagher et al., 2006 found that porters had more negative attitudes towards older adults than nurses and this was associated with their educational achievement, but on the survey, higher education was labelled as "Nurse diplomate/ degree." This question may be interpreted as asking if participants hold a nursing degree and no other degrees, which may influence the results of the association between educational achievement and attitudes. Further research is required into the attitudes of staff that support nurses (Wilson et al., 2017) as they must work with older adults within their work environment and there is an increasing demand for healthcare for older adults (Liston et al., 2017).

Rationale and Research Hypotheses

With the lack of research into the attitudes towards older adults of HCAs and porters and multi-task attendants, the current study aims to investigate the attitudes of these occupations with comparisons to other occupations such as nurses which have been well researched. It is important to investigate the attitudes of these staff members as they must directly care for and interact with patients. This research could have implications for healthcare services, if healthcare staff have negative attitudes, interventions such as educational interventions (Xu & Li, 2024) which have been effective may be implemented to educate staff and reduce ageism in healthcare. Their attitudes towards older adults may have implications for the quality of care provided to older adults as if they are found to have any prejudice against older adults, staff may not provide proper quality of care, demonstrated in nurses in previous research (Basturk, et al., 2022). Based on current literature for ageism in healthcare, this study

also aims to also investigate ageism after controlling for age, gender, occupation, level of education and duration of employment.

This study is comprised of five hypotheses:

H1: Healthcare support staff (healthcare assistants and multi-task attendants) will have positive attitude scores towards older adults.

H2: Nurses will have positive attitude scores towards older adults.

H3: FSA scores will be significantly predicted by age, gender, education level, occupation, and duration of employment.

H4: Females will have more negative attitude scores towards older adults.

H5: There will be no significant difference in ageist attitude scores towards older adults between nurses, multi-task attendants and healthcare assistants.

Methods

Design

This study was conducted using a quantitative approach with a cross-sectional design. Conducting a cross-sectional approach was appropriate as it was important to collect data on current ageist attitudes in healthcare support staff. This study design was appropriate to investigate the variables that predict or are associated with ageism. A longitudinal design could be used to further the development of negative attitudes over a period, but due to time constraints, this study was restricted from conducting longitudinal research. The independent and criterion variable of this study was ageism. Predictor variables in this study were age, gender, occupation, level of education and duration of employment. Age, gender, education level, occupation and duration of employment were also assessed as dependant variables.

Participants

There was a total of 48 participants recruited from a hospital in Ireland. Participants were divided into groups according to occupation. Nurses, (n = 15, 31%) Healthcare assistants (n = 15, 31%) and multi-task attendants (n = 18, 38%). Other participants that completed the survey were excluded via occupation. The mean age of participants was 39.28 (SD = 10.24). Majority of the sample were female (71%; n = 34), while male participants made up 29% of the sample (n = 14). The mean duration of employment of participants was 11.12 years (SD = 8.6). Over half (56.2%) of the participants currently held a leaving certificate or post-leaving certificate (Leaving certificate: n = 19, 40%; post-leaving certificate: n = 8, 17%; bachelor's degree: n = 14, 29%; honours bachelor's degree: n = 4, 8%; master's degree: n = 3, 6%). To determine the required sample size, a power and effect size analysis was conducted retrospectively using G. Power 3.1 Software. A linear multiple regression fixed model, R^2 deviation from zero. The required sample size was calculated at approximately 100. Upon post-recruitment analysis, it was observed of the hospital population, there is a total of 781 staff

employed within the hospital. With an estimate of a total of 450 staff amongst the groups being investigated (nurses, MTAS and HCAS), this deduces 11% of the total sample population collected for the study, justifying the sample size of this study. The current sample represents 6% of the total sample population.

Measures

Demographic and Occupational Data

Demographical and occupational information was collected from participants. Participants were asked to indicate their gender (male, female, other, or prefer not to say). Participants were then asked for their age. For occupational related information, participants were asked to indicate their occupation (MTA, HCA, nurse, or other). Participants were also asked to indicate the level of education they currently held ranging from leaving certificate to doctorate and lastly participants were asked how long they had been employed.

Fraboni Scale of Ageism (FSA) (Fraboni et al., 1990)

The FSA (Fraboni et al., 1990) is used to measure explicit attitudes towards aging and elderly people. The scale is comprised of 29 items that are all presented on a four-point Likert scale ranging from “strongly disagree”, “disagree”, “agree” and “strongly agree”. Scores range from 29-116 and higher scores indicate stronger negative attitudes towards aging and elderly people. As there is no set cut-off value for the interpretation of results, a value of 78 was set for this study which has been found to be appropriate in healthcare samples (Ozel Bilim & Kutlu, 2020). Items 8, 12, 15, 21, 22, 23 and 24 are positive statements and are reverse scored. The scale was reported to have acceptable internal reliability (Cronbach’s a = .86; Fraboni et al., 1990) and the scale was considered to have good validity when assessed with similar measures, such as Acceptance of Others scale (r = .40, p <.001) according to Lin et al., (2011). Internal reliability was conducted with the current data, and it indicated excellent internal

reliability (Cronbach's a = .82). Sample questions of the FSA include: *"Many old people are stingy and hoard their money and possessions." "I don't like it when old people try to make conversation with me."*

Procedure

Participants were recruited via convenience and purposive sampling within the hospital. Participants were sampled due to access and availability, and the intentional selection based on their employment within healthcare. Participants were recruited from a poster displayed on site, within work departments, providing a link to the survey or a message sent within workplace group chats which had a link to the survey attached. Participants were required to complete a survey on Google Forms. The survey first contained the information sheet and consent form to acquire informed consent. The information contained details of the nature of the study, what participation required of participants, how their data would be used and stored, and details of the researcher and supervisor. This survey collected demographic and occupational information and assessed explicit attitudes towards older adults using the FSA (Fraboni et al., 1990). Upon completion of the survey, participants received the debrief form and sent their response. The debrief form reminded participants they could withdraw before sending their response and relevant support services were attached. All data from participants was anonymised as no identifiable information was collected from participants. The survey took approximately 5 minutes for participants to complete on average.

Ethical Considerations

Ethical approval was obtained from the ethical committee from National College of Ireland, in line with the Psychological Society of Ireland, and the Senior Management Team of the hospital, under assurance that anonymity of the hospital was adhered to. Data was collected from participants anonymously. From the information collected, data could not be paired to

identify individuals. Employment was also not affected for individuals because of their participation. Data were protected and stored on a password locked laptop and the data were protected behind a password secured account on Google Forms before being transferred onto SPSS for analysis. When data was computed into SPSS, data was secured in a password secured folder. Coercion was avoided in cases of sharing the survey via message by providing a message prompted by the researcher, explicitly outlining participation was voluntary.

Data Analysis

Data was analysed using SPSS for Windows v.28 (SPSS inc., Chicago, IL). Descriptive statistics were conducted for the demographical and occupational information collected from the sample. Demographic information collected from the participants included age and gender. Occupational information collected from participants was occupation, duration of employment and education level. Inferential statistics were conducted to investigate the hypotheses composed for the current study. To test hypotheses one and two, to find if healthcare support staff had positive attitudes towards older adults and find if nurses had positive attitudes towards older adults, descriptive statistics were calculated and mean FSA scores for healthcare support staff and nurses were analysed. Standard multiple regression was conducted to investigate hypothesis four and investigate if ageist attitudes were predicted by age, gender, occupation, education level and duration of employment. Additional analyses were conducted to investigate education, age and duration of employment were associated with ageism, due to violations pf the assumptions of regression. To test hypothesis four, to see if there were differences in attitudes towards older adults by gender, an independent samples T-test was conducted to investigate differences in mean FSA scores between males and females. To test hypothesis five, to test for differences between MTAs, HCAs and nurses' attitudes towards older adults, a one-way between groups ANOVA was conducted to investigate if there were differences in mean FSA scores.

Results

Descriptive Statistics

Descriptive statistics were conducted on the sample. A total of 48 participants were recruited for the study; 1 case was excluded due it being an extreme score, and it was 3.5 standard deviations away from the mean, affecting distribution of FSA scores. A total of 47 participants were investigated in the data analysis. There were also two cases excluded pairwise in the analyses due to missing data for age and duration of employment. Descriptive statistics are displayed for age, duration of employment and FSA scores are displayed in Table 1. The age of participants ranged from 19 to 59 (M = 39.28, SD = 10.24). Participant FSA scores ranged from 32 to 68 (M = 47.17, SD = 9.27) displaying positive attitudes towards older adults amongst nurses and healthcare support staff. Further descriptive statistics on demographic and occupational information are displayed in Table 2.

The distribution of FSA scores was subject to tests of normality. The Shapiro-Wilk test indicated that the data with the scale were non-normally distributed with the sample (p = .02). Visual inspection of the distribution of FSA scores also indicated that scores were non-normally distributed. After exclusion of the extreme value, the Shapiro-Wilk test indicated that data were normally distributed (p = .14)

The distribution of the data for duration of employment and age were also subject to tests of normality. The Shapiro-Wilk test indicated that the data for age was normally distributed (p = .20). The Shapiro-Wilk test indicated that data for duration for employment were non-normally distributed (p = .004) Visual inspection of histogram also indicated normality. Visual inspection of the distribution of duration of employment data indicated positive skewness and the statistical value was determined to be .92, indicating moderate skewness. Kurtosis was analysed to be .56, indicating moderate kurtosis.

Table 1

Descriptive Statistics for Age, FSA score and Duration of Employment

Variable	*M* [95% CI]	*SD*	Range
Age	39.28[36.24-42.32]	10.24	19-59
FSA Score	47.17[44.45-49.89]	9.27	32-68
Duration of Employment	11.12[8.55-13.69]	8.6	0-38

Table 2

Frequencies for Gender, Educational Achievement and Occupation

Variable	Frequency	Valid %	FSA (*M*)
Gender			
Female	33	70.2	47.33
Male	14	29.8	46.78
Educational Level			
Leaving Certificate	18	38.3	48.33
Post-leaving Certificate	8	17	48.37
Bachelor's Degree	14	29.8	45.57
Honours Bachelor's Degree	4	8.5	42.25
Master's Degree	3	6.4	41.66
Occupation			
Multi-task Attendant	18	36.2	48.35
Nurse	15	31.9	45.53
Healthcare Assistant	15	31.9	45.46

Inferential Statistics

Hypothesis 3: A regression analysis was performed to investigate if FSA scores were predicted by age, gender, occupation, duration of employment and education level. Preliminary analyses were performed to investigate the violation of the assumptions of normality, linearity and homoscedasticity. The assumption of normality was violated as FSA scores were positively skewed. The assumption of linearity was also violated upon visual inspection of the linearity plot. The assumption of homoscedasticity was not violated. The correlations between the predictor variables and the criterion variable are presented in Table 3. The correlation between the predictor variables (age, gender, occupation, duration of employment and education level) were assessed and *r* values ranged -.20 to .61. Tests for multicollinearity indicated that all Tolerance and VIF values were also within acceptable range.

Table 3

Inter-correlations (Pearson's r) between model variables

Variable	1.	2.	3.	4.	5.	6.
1. FSA Scores	-					
2. Age	-.10	-				
3. Gender	.27	.09	-			
4. Education Level	-.20	-.15	-.08	-		
5. Occupation	-.13	-.01	.14	.57***	-	
6. Duration of Employment	.03	.61***	-.13	-.16	-.03	-

Note: *p < .05, **p < .01, ***p < .001

Since no a priori hypotheses had been made to determine the order of entry of the variables, a direct method was used for the analysis. The five predictor variables explained 6.8% of variance in FSA scores. All five variables were not found to uniquely predict FSA

scores to a statistically significant degree. See Table 4 for full details. Not meeting criteria for regression, it was deemed that a regression analysis may not accurately identify relationships relevant to the hypothesis. Therefore, additional were conducted to investigate the relationships between FSA scores and duration of employment and the relationship between FSA scores and age.

Table 4

Multiple regression predicting FSA scores

Variable	R^2	*B*	*SE*	β	*t*	*p*
Model	.07					
Age		-.20	.18	-.22	-1.09	.28
Gender		1.06	3.26	.05	.33	.75
Level of Education		-1.38	1.42	-.19	-.97	.34
Occupation		-.34	2.11	-.03	-.16	.87
Duration of Employment		.12	.18	.13	.66	.51

Note: Model or predictor variables not statistically significant

A one-way between-groups ANOVA was conducted to determine if there were educational differences in FSA scores. Participants were divided into five groups according to their current level of education (leaving certificate, post-leaving certificate, bachelor's degree, honours bachelor's degree and master's degree). There was no statistically significant difference in FSA scores across five educational groups, F (4, 46) = .64, p = .64

The relationship between duration of employment and FSA scores was investigated using a Spearman's product moment correlation coefficient. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity. The assumptions of normality and linearity in duration of employment data

were violated due to the data being non-normally distributed and a non-parametric alternative was conducted. The correlation between the variables was not statistically significant (r = .12, n = 47, p = .42).

The relationship between age and FSA scores was also investigated using a Pearson's product-moment correlation coefficient. Preliminary analyses were performed to ensure no violation of the assumptions of linearity, normality and homoscedasticity. The correlation was not statistically significant (r = -.10, n = 46, p = .50).

Hypothesis 4: An independent-samples t-test was conducted to compare the FSA scores between males and females. There was no statistically significant difference found in scores for males (M = 46.79, SD = 8.92) and females (M = 47.33, SD = 9.55; t (45) = -.18, p = .86, two-tailed). The magnitude of the differences in the means (mean difference = -.55, 95% *CI*: -6.57 to 5.47) was very small (eta squared = .0007).

Hypothesis 5: A one-way between-groups ANOVA was conducted to determine if there were occupational differences in FSA scores. Participants were divided into three groups according to their occupation (multi-task attendant, healthcare assistant and nurse). There was no statistically significant difference in FSA scores across three occupational groups, F (2, 46) = .39, p = .68.

Discussion

The current study aimed to investigate the attitudes of healthcare support staff (HCAs and MTAs) towards older adults. The study also aimed to investigate variables that are associated with ageism. Five hypotheses were formulated to investigate the aims of the current study. It was hypothesised (**H1**) that healthcare support staff would have positive attitudes towards older adults and (**H2**) nurses would have positive attitudes towards older adults. Hypothesis three (**H3**) was formulated and investigated if ageism would be predicted by age, gender, education level, occupation and duration of employment. Females were also hypothesised to have more negative attitudes towards older adults (**H4**). The last hypothesis of the study (**H5**) hypothesised there would be no differences in attitudes amongst nurses, HCAs and MTAs. Findings of this study were contrasting to previous research findings, having implications and directions for further research in the area of ageism in healthcare.

It was hypothesised (**H1**) that healthcare support staff would have positive attitudes towards older adults. Nurses were also recruited for this study, and it was hypothesised (**H2**) that nurses would have positive attitudes towards older adults. From the analysis, it was found that all three groups (MTAs, HCAs, and nurses) had positive attitudes towards older adults, retaining the null hypothesis. The findings of the current research are an addition to previous research findings that suggest that nurses and HCAs have positive attitudes towards older adults (Doherty et al., 2011; Nilsson et al., 2012; Coffey & Whiteland, 2015). The findings of positive attitudes for MTAs challenges previous research findings which has suggested that porters or MTAs have negative attitudes towards older adults (Doherty et al., 2011). Not only do the findings suggest MTAs and porters may have positive attitudes towards older adults, but healthcare professionals overall which has been evidenced in previous research (Liu et al., 2012).

It was hypothesised (**H3**) that FSA scores would be significantly predicted by age, gender, education level, occupation, and duration of employment. The model was not statistically significant and none of the predictor variables entered into the model uniquely predicted FSA scores. Leading this study to reject the null hypothesis. The findings of the current study do not align with the evidence provided from previous research which strongly suggest educational level, occupation, duration of employment, age and gender are associated with ageist attitudes (Liu et al., 2012; Nilsson et al., 2012). These findings are surprising, as the evidence for associations between the investigated variables and ageism is strong. Educational achievement has been found to be associated with significant reductions in negative attitudes towards older adults as individuals progress academically (Doherty et al., 2011; Shermann et al.., 1996; Uğurlu et al., 2018). Additional analyses were conducted to investigate the relationship between educational level and FSA scores to ensure the result was not affected from the regression analysis being underpowered. No differences in FSA scores were observed across five educational groups.

Additional analyses were conducted also to investigate the relationship between FSA scores and age, and the relationship between FSA scores and duration of employment. Both relationships were found to be statistically insignificant. These results are confounding as they do not align with previous research. Age has been found to be associated with ageism, with previous research investigating the relationship in healthcare staff finding that the older a person is, the more positive attitude they have towards older adults (Heckemann et al., 2021; Nilsson et al., 2012; Sahin et al., 2021). Duration of employment has also been found to be associated with ageism in previous research (Sahin et al., 2021; Uğurlu et al., 2018). However there has been findings that there is no relationship between duration of employment and ageism (Doherty et al., 2011). If age and ageism are not associated with each other, this

challenges the explanation of ageism through the Social Identity Theory (Ayalon & Tesch-Römer, 2018), that claims ageism occurs as bias is developed as age is a group characteristic.

The current study also hypothesised (**H4**) that females would have more negative attitudes towards older adults. Gender was investigated and it was found that there was no significant relationship between FSA scores and gender, resulting in a rejection of the null hypothesis. This finding does not align with previous literature, which suggests that there is a relationship between gender and ageism (Liao et al., 2023; Sahin et al., 2021) though it is supported by other research which has suggested that gender is not associated with ageism (Doherty et al., 2011; Fernández-Puerta et al., 2024; Uğurlu et al., 2018). It is important to highlight that there is a significant majority of female staff that work within healthcare, so this may lead to disproportionate samples and scoring within research on healthcare staff. The current study reflects this in its sample which was mostly females (71%), but a reflection of the general population that work within healthcare, making these results generalisable to the population. From the current study's findings and evidence of literature supporting both that gender is associated with ageism and is not, more research is required to investigate this relationship as findings are mixed.

The last hypothesis (**H5**) postulated that there will be no significant difference in ageist attitude scores towards older adults between nurses, MTAs and HCAs. In line with the hypothesis, found there was no significant differences in FSA scores between the three groups. The result retained the null hypothesis. The finding of the current study is an addition to research suggesting that occupation is not associated with ageism (Doherty et al., 2011). Previous research has also found significant attitude differences (Nilsson et al., 2012; Uğurlu et al., 2018) across occupations, so more research is required to make deductions. The difference between the current study's findings and supporting evidence in comparison to contradicting research evidence is the geographical sample used in these studies. Occupation

may not be the variable associated with ageism, but rather culture, which should be investigated as an implication of the current study's findings.

Implications and Recommendations

The findings of the current study along with Doherty et al., (2011) also denotes that cultural differences may influence not only the relationship between duration of employment, but also occupation. Doherty et al. (2011) conducted their study in several hospitals and community health centres in Co. Donegal, Ireland. They found no differences in attitude scores amongst nurses and HCAs and other occupations. They also found that duration of employment was not associated with ageism. This study was conducted following a similar methodology used within the current study and the study conducted by Doherty & colleagues (2011). These findings paired with the findings of the current study suggest an opportunity to research ageism differences across cultures. The current research was conducted on a sample in Ireland, similarly to Doherty et al., (2011) which may suggest cultural differences have an influence on the relationship between duration of employment and ageism and there are cultural differences in attitudes towards older adults. As gender was also not found to be associated with differences in ageism, this additionally supports that culture, and societal differences may be associated with ageism.

If healthcare professional attitudes are positive towards older adults as found in the current study, then other variables may influence the quality of care being provided to older adults such as gerontological education (Nelson, 2016; Xu & Li, 2024). Ageism interventions should look to target all ageist individuals, such as educational interventions which have evidently shown improvement in attitudes towards older adults (Xu & Li, 2024). As the current study has found that formal education is not predictive of ageism, perhaps workplace training and education should be further investigated along with assessment of its efficacy in reducing

ageism in healthcare. Gerontological education would enable healthcare professionals to gain the required knowledge on how to effectively adhere to the needs of older patients and treat patients effectively. If this was implemented, targeting all individuals, patients of older age would be able to get the correct quality of care as they have a right to. Though as suggested by the findings of the current study, other variables such as culture may influence attitudes and should be investigated to mitigate ageism in healthcare.

The contradiction in findings between the current study and previous research means there is a requirement in the area of ageism for more research to be conducted. A longitudinal approach would be more beneficial in this area of research but due to time restrictions surrounding this dissertation, a longitudinal approach would have been too time constraining. The current study was conducted adopting a cross-sectional approach. This gave current data on attitudes towards older adults amongst healthcare staff. A longitudinal approach would allow for further examination of the development of ageist attitudes amongst healthcare staff and the variables that predict ageism. There is also a need for longitudinal research in this area as it is evident in research little longitudinal research has been conducted. Fernández-Puerta et al. (2024) examined fifteen studies conducted within the last ten years and of these studies, none conducted longitudinal research, highlighting this need.

The FSA does not have a universal cut-off point on the scale that indicates positive or negative attitudes, which makes the interpretation of responses difficult to indicate as positive or negative. Ozel Bilim & Kutlu (2020) examined the psychometric properties of the FSA on a sample of healthcare workers and found a cut-off value of 78 was appropriate for distinguishing participants that had negative or positive attitudes. This cut-off value was used for the purpose of this study as it was conducted on a sample of healthcare workers. The Kogan's Attitudes Towards Older People Scale (KOP) may be a more suitable scale to

investigate attitudes as demonstrated by Doherty et al. (2011). The scale contains a range of defined values ranging from “very negative” to “very positive” based on the score obtained.

Limitations

The findings of this study are to be taken with caution due to the limitations of the study as there is a few significant limitations to the current study including sample and analysis limitations.

The sample of this study came to 48 participants. The number of participants is generalisable to the hospital in which it was studied. The hospital in which the study was conducted has a total number of 781 staff. This number also includes other professionals working within the hospital such as doctors, clerical staff, management staff, laboratory staff and maintenance staff. The study was only investigating nursing, MTA and HCA staff. It was calculated approximately that these staff would account for 400-500 of the total staff count within the hospital, though true numbers were unable to be obtained for the purpose of the study. The study sample is generalisable and applicable to the hospital, but the generalisability and implications of results to Irish healthcare is affected due to the small sample size. This small sample size also affected the statistical analyses, underpowering the analysis. Though this sample was small, it was representative of a gender divided sample within healthcare.

The use of a multiple regression analysis was significantly underpowered due to the sample size. The sample size did not meet the assumptions of multiple regression, along with other assumptions being violated with the non-normal distribution of duration of employment data. Multiple regression analysis was still conducted, and results are to be taken with caution due to the analysis being underpowered. Due to this limitation, additional analyses were conducted and found that there was no relationship between FSA scores and education level and FSA scores and age. These results are confounding as the current research strongly suggests

age and education are significant predictors of ageism (Heckemann et al., 2021; Rababa & Ammar, 2018; Uğurlu et al., 2018). Recent research found in a systematic review conducted on fifteen studies by Fernández-Puerta & colleagues (2024) found gender was not associated with ageism, suggesting that there may have been societal alterations in attitudes towards older adults in recent years compared to past research.

Conclusion

The current study's findings are to be taken with caution due to the discussed limitations of data analysis and methodology. This study suggests that healthcare support staff have positive attitudes towards older adults along with nursing staff. This is of benefit as proper quality of care can be provided to older adults without the effect of negative attitudes deterring healthcare staff from performing their duties to the best of their ability as evidenced by research. This study found that education, age, gender, occupation and duration of employment are not predictive of ageism. These results are to be taken with caution due to the regression analysis being underpowered, though there is supporting evidence to suggest that age and gender are not predictive of ageist attitudes. Gender was found not to be associated with ageism along with education level and occupation. This study has provided implications for further research in this area, as there is a lack of longitudinal research within ageism. Longitudinal research would further explore the development of ageism, and the variables that are associated with and predictive of ageism. This study has also highlighted cultural and societal differences that may be of use to explore differences in attitudes towards older adults occurring in different levels across cultures and societies. This implication was deduced from the comparison of similar research conducted within Ireland compared to research conducted across different cultures. Cultural influences may be an important variable to investigate for further research in ageism to aid in developing effective interventions and preventative programmes to reduce ageism.

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Appendices

Appendix A

Appendix A1: Fraboni Scale of Ageism (Fraboni et al., 1990)

Respondent Anchor. The following scale will comprise of a series of statements measuring your attitude towards older adults. Please select the option that you feel is most suitable.

	1	2	3	4	
Strongly Disagree	◯	◯	◯	◯	Strongly Agree

Items. *Items are reverse scored

1. Teenage suicide is more tragic than suicide among the old.

2. There should be special clubs set aside within sports facilities so that old people can compete at their own level.

3. Many old people are stingy and hoard their money and possessions.

4. Many old people are not interested in making new friends preferring instead the circle of friends they have had for years.

5. Many old people just live in the past.

6. I sometimes avoid eye contact with old people when I see them.

7. I don’t like it when old people try to make conversation with me.

*8. Old people deserve the same rights and freedoms as do other members of our society.

9. Complex and interesting conversation cannot be expected from most old people.

10. Feeling depressed when around old people is probably a common feeling.

11. Old people should find friends their own age.

*12. Old people should feel welcome at the social gatherings of young people.

13. I would prefer not to go to an open house at a senior's club, if invited.

*14. Old people can be very creative.

15. I personally would not want to spend much time with an old person.

16. Most old people should not be allowed to renew their driver's licenses.

17. Old people don't really need to use our community sports facilities.

18. Most old people should not be trusted to take care of infants.

19. Many old people are happiest when they are with people their own age.

20. It is best that old people live where they won't bother anyone.

*21. The company of most old people is quite enjoyable.

*22. It is sad to hear about the plight of the old in our society these days.

*23. Old people should be encouraged to speak out politically.

*24. Most old people are interesting, individualistic people.

25. Most old people would be considered to have poor personal hygiene.

26. I would prefer not to live with an old person.

27. Most old people can be intimidating because they tell the same stories over and over

28. Old people complain more than other people do.

29. Old people do not need much money to meet their needs.

Scoring. Items are scored individually 1-4 based on the respondent's answer as presented on the Likert-scale. Items are scored and totalled with items 8, 12, 14, 20, 21, 22, 23, and 24 reverse scored. Scores range from 29-116. Higher scores indicate negative attitudes towards older adults and lower scores indicate positive attitudes towards older adults.

Appendix A2: Demographical and Occupational Information

Gender (Please tick a box that is suitbale to you)
Male ☐
Female ☐
Other ☐
Prefer not to say ☐

Age
_____

Level of Education (Please tick a box that is suitable to you)
Leaving Certificate ☐
Post-Leaving Certificate ☐
Bachelor's Degree ☐
Honour's Bachelor's Degree ☐
Master's Degree ☐
PhD ☐

Occupation
Nurse ☐
Healthcare assistant ☐
Multi-task attendant ☐
Other ☐

Duration of Employment in Current Occupation (Years)
_____

Appendix B: Information Sheet

Participant Information Leaflet

Attitudes Towards Older Adults in Healthcare Support Staff

You are being invited to take part in a research study, before proceeding, please take the time to read this document to understand what is being asked of the participant and that you understand what this study involves the participant to comply to.

Purpose of this study: I am Adam Breen, a third-year undergraduate student, in the psychology course at National College of Ireland. I am undertaking this research study, *Attitudes Towards Older Adults in Healthcare Support Staff,* as part of a research project to be completed as a part of my course. This study is aiming to investigate the attitudes of healthcare assistants and multi-task attendants towards older adults.

What will this study involve? Participants will have to complete a survey as part of the research process, after which no follow-up data will be collected from participants. The survey will gather demographic and work-related information and data on the participants' attitudes towards older adults.

Who can take part? People that are employed within Midlands Regional Hospital Portlaoise and that are in the following roles: nurse, healthcare assistant and multi-task attendant. All other occupations are excluded from participating within the study due to the aims of the study.

Do I have to take part? No, you are not obliged to take part in this study if you do decide to take part, you will be required to complete a digital consent form attached in the survey, and after completing this you may continue with the study if you wish to participate. Decisions to take part, or not take part, in the research will in no way affect or relate to your employment or in any way impact your role or responsibilities.

What information will be collected? First demographic information and work-related information will be collected, which is age, gender, occupation, duration of employment and level of education. Then information will be collected on your attitudes towards older adults. All information collected will be completely anonymous.

How will information be used? Information provided by participants will be used as part of a dissertation and the data produced by participants will be statistically analyzed and displayed in the results of the dissertation. This study will then be presented in National College of Ireland. The study may also be published in a peer-reviewed journal. Data may be retained for secondary analysis and stored in line with NCI data protection and storage policies.

Will your information provided be kept confidential? Yes, all information provided as part of your participation in the study will be kept completely confidential. The survey is anonymous so it will not be possible to identify individuals, participants will instead be assigned a unique participant ID number. Only the researcher and the academic supervisor will be able to access information provided. Information will be retained until the research student graduates or 3 months upon completion of the course.

Who will be responsible for your data? The researcher, Adam Breen, research supervisor, Dr. Conor Nolan, and NCI will have responsibility for the data generated by the research. All local copies of data saved on personal password protected devices/laptops will be deleted by the student's NCI graduation date or three months after the student exits the NCI psychology programme.

What are the benefits in taking part in the study? There are no personal benefits for individuals that participate in the study, but by providing your information, you can help in furthering the understanding of ageism in healthcare settings and with this information, interventions can be put in place to reduce ageism in healthcare settings.

What are the negatives in taking part in the study? I see it unlikely that any individual will find any negatives or distress from participating in the study but, in the case that an individual finds participating in the study distressing, they are able to withdraw their information and can access supports that are available to them:

HSE Employee Assistance Programme: Call 0818 327 327 or follow the link provided https://healthservice.hse.ie/staff/benefits-and-services/employee-assistance-programme-staff-counselling/

HSE Workplace Health and Well-Being support: https://healthservice.hse.ie/staff/benefits-and-services/workplace-health-and-wellbeing/

Who should you contact for further information? If you have any further enquires you can contact the researcher, Adam Breen (x22425146@student.ncirl.ie) or the research supervisor, Dr. Conor Nolan (conor.nolan@ncirl.ie**)**

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Psychology Programme Director
National College of Ireland

If you agree to take part in this study, please complete the consent form below.

Thank you for taking the time to read this.

Appendix C: Consent Form

In agreeing to participate in this research I understand the following:

- The method proposed for this research project has been approved in principle by the Departmental Ethics Committee, which means that the Committee does not have concerns about the procedure itself as detailed by the student. However, it is Adam Breen's responsibility to uphold the ethical guidelines in conducting the study and responsible for the participants data.
- If I have any concerns about participating in the study, I understand that I can withdraw only in the process of completing the survey, as the data will be anonymised when it has been sent to the researcher.
- I understand that once my participation has ended, that I cannot withdraw my data as it will be fully anonymised.
- I have read the information sheet and am aware of the nature of the study and how my data will be used.
- All data from the study will be treated confidentially. The data from all participants will be compiled, analysed, and submitted in a report to the Psychology Department in the School of Business.
- I understand that my data will be retained and managed in accordance with the NCI data retention policy, and that my anonymised data may be archived on an online data repository and may be used for secondary data analysis. Data will be anonymised at all points of data collection, and analysis.
- At the end of participation in the study, I understand that if I have any further queries, I should contact the researcher or the research supervisor.

☐ Please tick this box if you have read and agree with all the above information.

☐ Please tick this box to indicate that you are providing informed consent to participate in this study.

Appendix D: Debrief Sheet

We thank you for participating in the present study which investigates ageism in healthcare support staff.

If you feel compelled to share this study with your colleagues or friends that may be interested in participating in the study, we ask that you do not discuss the study with the person or share any information about the study until they have participated in the study or if they do not wish to participate. Providing information can invalidate the results of the study, we thank you for your understanding and co-operation.

If you feel the need to withdraw your information from the study, you may do so without any penalties, up until the point of completing the survey. If you have any further enquiries about the study or the use of your data, please contact the researcher, Adam Breen via email (x22425146@student.ncirl.ie) or the research supervisor, Dr. Conor Nolan (conor.nolan@ncirl.ie).

If you have felt any feelings of distress from the content or participation in this study, here are resources that may help in your situation:

HSE Employee Assistance Programme: Call 0818 327 327 or follow the link provided https://healthservice.hse.ie/staff/benefits-and-services/employee-assistance-programme-staff-counselling/

HSE Workplace Health and Well-Being support: https://healthservice.hse.ie/staff/benefits-and-services/workplace-health-and-wellbeing/

Appendix E: Recruitment Poster

Appendix F: Text Message used for Recruitment

Hello,

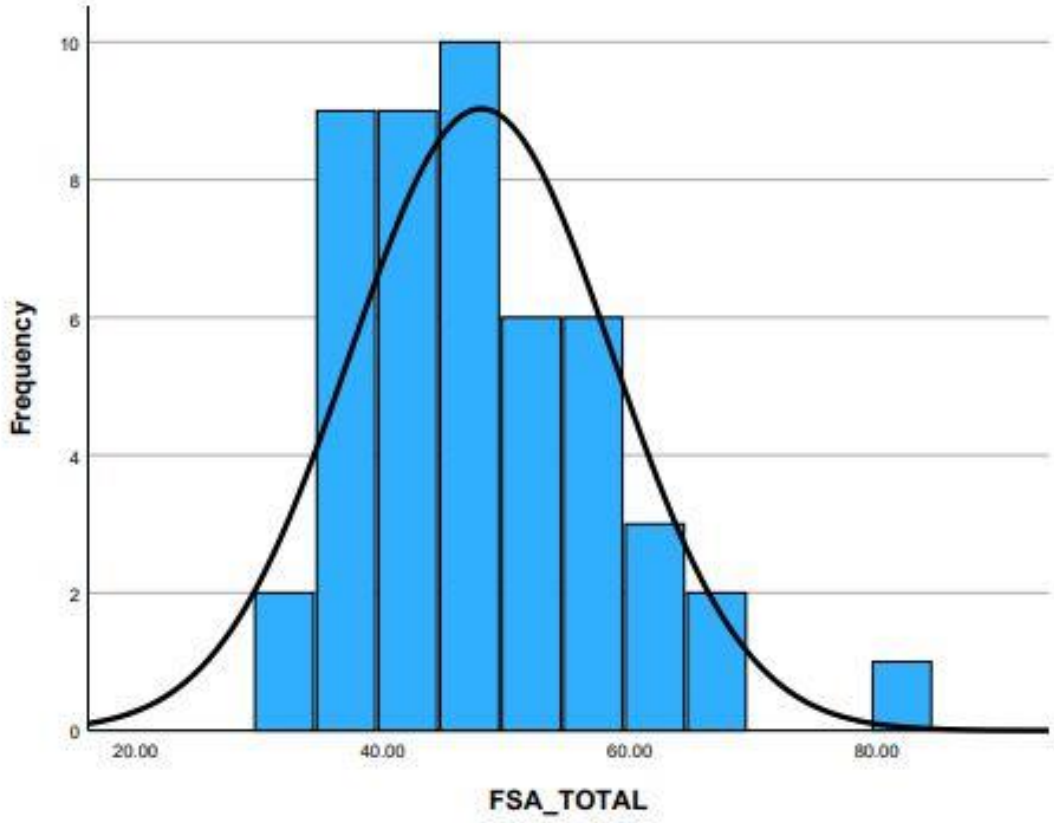
I am conducting a research study as part of a dissertation for my undergraduate degree. For my dissertation I am conducting a research study investigating the attitudes of healthcare support staff towards older adults. The study involves completing an anonymous survey asking questions on your opinions towards older adults. If you wish to participate, the link provided will lead you to the survey on Google Forms. If you know of anyone that would also be interested in participating, please do share it with your colleagues and friends.

(Survey Link).

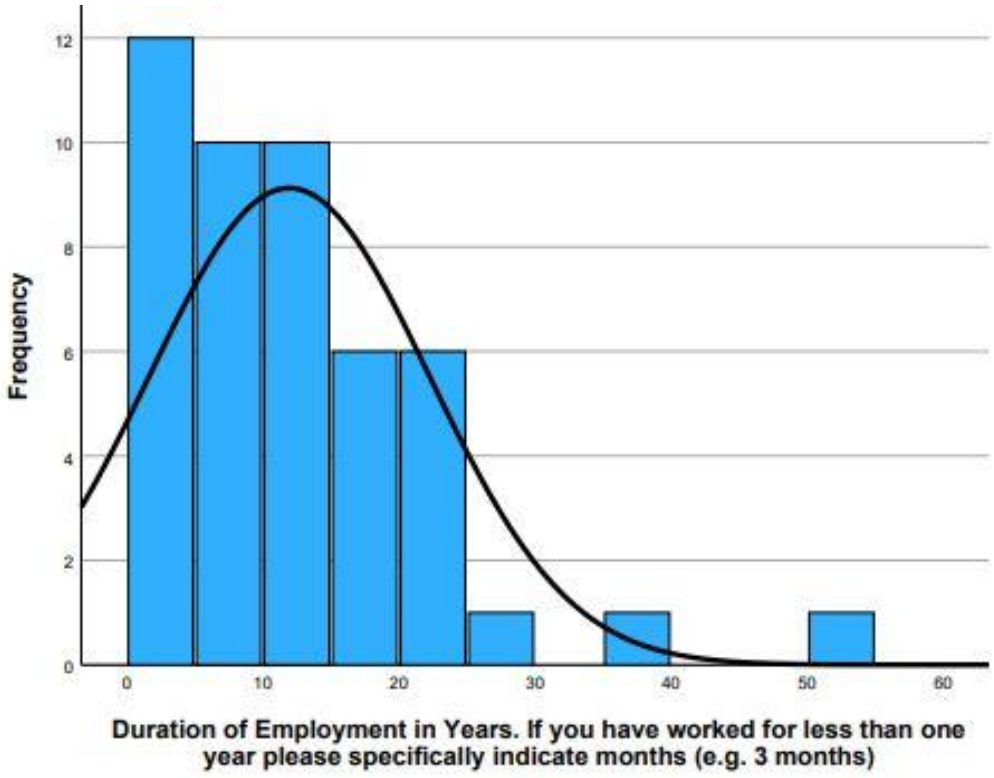
If you have any further enquiries regarding this study, contact me, Adam Breen by email: x22425146@student.ncirl.ie or the research supervisor Dr. Conor Nolan (conor.nolan@ncirl.ie)

Appendix G: Graphs displaying distribution of data

Appendix G.1: Distribution of FSA scores



Appendix G.2: Distribution of Duration of Employment



Appendix G.3: Distribution of Age