

ORIGINAL RESEARCH:
EMPIRICAL RESEARCH - QUALITATIVE

Age stereotypes towards younger and older colleagues in registered nurses and supervisors in a university hospital: A generic qualitative study

Madeleine Helaß¹  | Anja Greinacher¹ | Sebastian Götz¹ | Andreas Müller² | Harald Gündel³ | Florian Junne⁴ | Christoph Nikendei¹ | Imad Maatouk^{1,5}

¹Department of General Internal Medicine and Psychosomatics, University Hospital Heidelberg, Heidelberg, Germany

²Institute of Psychology, Work and Organizational Psychology, University of Duisburg-Essen, Essen, Germany

³Clinic of Psychosomatic Medicine and Psychotherapy, University Hospital Ulm, Ulm, Germany

⁴Department of Psychosomatic Medicine and Psychotherapy, University Magdeburg, Magdeburg, Germany

⁵Section of Psychosomatic Medicine, Psychotherapy and Psychooncology, Department of Internal Medicine II, Julius-Maximilian University Würzburg, Würzburg, Germany

Correspondence

Imad Maatouk, Centre for Psychosocial Medicine at the University Hospital Heidelberg, Department of General Internal Medicine and Psychosomatics, University Hospital Heidelberg, Im Neuenheimer Feld 410, 69120 Heidelberg, Germany.

Email: imad.maatouk@med.uni-heidelberg.de

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Abstract

Aim: This study aimed to identify and compare age stereotypes of registered nurses and supervisors in clinical inpatient settings.

Design: Generic qualitative study using half-standardized interviews.

Method: Nineteen face-to-face interviews and five focus groups (N = 50) were conducted with nurses of varying levels at a hospital of maximum medical care in Germany between August and November 2018 and were subjected to structured qualitative content analysis.

Results: Reflecting the ageing process and cooperation in mixed-age teams, nursing staff and supervisors defined similar age stereotypes towards older and younger nurses reminiscent of common generational labels 'Baby Boomers' and Generations X. Their evaluation created an inconsistent and contradictory pattern differing to the respective work context and goals. Age stereotypes were described as both potentially beneficial and detrimental for the individual and the cooperation in the team. If a successfully implemented diversity management focuses age stereotypes, negative assumptions can be reduced and cooperation in mixed-age teams can be considered beneficial.

Conclusion: Diversity management as measures against age stereotypes and for mutual acceptance and understanding should include staff from various hierarchical levels of the inpatient setting.

KEYWORDS

age stereotypes, nurses, older employees, qualitative approaches, supervisors, younger employees

1 | INTRODUCTION

In the course of the demographic changes in modern society, research on ageing is receiving greater attention from the perspective of health and organizational psychology. The relevance of the topic is particularly prominent in the healthcare system, which has to come to terms with a 7.9 million global shortfall of registered nurses by 2030 with large variations in developed and developing countries (WHO, 2017).

Ageing nurses are exposed to age stereotyping and ageism, which are stressors and risk factors that occur intraindividually, in the nursing team and across hierarchical levels, which can affect job satisfaction and teamwork and lead to health problems for nurses in the future (Weber et al., 2020). Finally, this can lead to turnover and intentions to resign of older nurses (Walker et al., 2018). Thus, age stereotypes could indirectly contribute to the worsening of the precarious personnel situation in nursing worldwide.

Age stereotypes have so far only been considered individually among nurses or supervisors (or employers). The question of whether and to what extent the age stereotypes of nurses and supervisors differ has not yet been sufficiently clarified and will be answered by the present study.

2 | BACKGROUND

Age stereotypes are defined as 'generalized beliefs about the qualities and characteristics about people of a particular age' (Finkelstein et al., 2015, p. 26). Against the background of the wide age range of the nursing profession, stereotypes enable the reduction of this complexity. Conversely, age stereotypes negate intra- and interindividual differences and changes over time.

The vast majority of previous studies on age stereotypes included not only positive age stereotypes towards older employees, describing them as honest, trustworthy and loyal, but also deficit-oriented stereotypes, including poor performance, resistance to change and lower ability to learn, in addition to the shorter job tenure (Harris et al., 2017). Due to negative age stereotypes, older employees are meant to be more costly for companies and can make investment not worthwhile because of a low payback (Posthuma & Campion, 2009).

Negative age stereotypes towards older workers operating through the conscious awareness (Desmette & Gaillard, 2008) may cause biases and affective and attitudinal prejudices (Posthuma & Campion, 2009). Recent experimental studies confirm the existence and stability of age stereotypes. By measuring attitudes not explicitly, for example in self-report, but implicitly via the Implicit Association Test, it could be shown that younger workers are preferred to older workers by students, older adults and workers (Kleissner & Jahn, 2020b). Another point worth considering is discrimination through colleagues as a behavioural consequence of negative age stereotyping (Nelson, 2005). If older employees perceive themselves as the target of negative age stereotypes (stereotype threat) (Schmader et al., 2008), they may try to avoid confirming or even refuting these

Impact

What problem did the study address?

- Age stereotypes towards younger and older nurses and their relation with cooperation in mixed-age teams

What were the main findings?

- Supervisors and nursing staff have similar age stereotypes.
- Negative age stereotypes in nursing teams could be associated with more conflicts.

Where and on whom will the research have an impact?

- Hospital nursing staff: Raising awareness of age stereotypes and their importance for team cooperation, work performance and job satisfaction
- Supervisors and nursing staff in daily cooperation: Designing the working environment to exploit the benefits and reduce the risk of potential generational conflicts
- Developers and providers of nursing management trainings: Considering age stereotypes in further trainings

stereotypes; for example if they assume that they are considered slow by colleagues or supervisors, they work faster to refute this assumption. However, working faster leads to greater exhaustion, leading in turn to slower work. There is a certain risk that older employees confirm the stereotype by trying to avoid to confirm it, in the sense of a self-fulfilling prophecy. Thus, negative age stereotypes of colleagues can be seen as additional external stressors for older nurses in addition to high work demands of the profession and have negative effects on work engagement, learning, development and promotion intentions and positive effects on intentions to resign by older employees (Weber et al., 2019).

Age stereotypes do not only occur among nurses, but also among supervisors. Thus, age discrimination or negative age stereotypes can directly lead to discriminatory personnel decisions of supervisors (Avolio & Barrett, 1987; Gringart et al., 2005). Because supervisors are meaningful role models for employees, age-stereotyping supervisors can indirectly lead to negative age stereotypes in teams (spillover effect) and to poorer teamwork performance (Kunze et al., 2013).

Most of the prior studies have focused on age stereotypes related to older workers and their influence or impact on health-related or work-related factors (Weber et al., 2020). Although some indications exist, so far, empirical evidence showing that age stereotypes influence cooperation processes (Schloegel et al., 2016) or work quality is lacking. Furthermore, knowledge about whether

and to what extent age stereotypes of supervisors differ from those of nurses due to different areas of responsibility and experience, as well as networks in and outside the hospital, is limited. Therefore, this study was designed as a first step to fill this research gap by identifying and comparing age stereotypes towards older nurses by registered nurses and supervisors.

3 | THE STUDY

3.1 | Aims

This study aims to assess positive and negative age stereotypes of registered nurses and the cooperation in age-diverse teams. Furthermore, the common and distinctive factors of stereotypes between registered nurses without managerial position (staff nurses) and employees in a supervising managerial position (nurse managers and ward nurses) are explored.

3.2 | Design

To investigate the question, we followed the generic qualitative approach (Percy et al., 2015). This study was conducted in the sub-project 'Healthy aging in the nursing profession' (Gesund Altern im Pflegeberuf), which was part of the project 'Mental health in the hospital workplace' (Seelische Gesundheit am Arbeitsplatz Krankenhaus, SEEGEN) (Mulfinger et al., 2019) funded by the General Ministry of Research and Education. Interviews and focus groups were conducted in a university hospital of maximum medical care with surgical, conservative and mental health departments in Germany.

3.3 | Participants

The sample consisted of registered nurses, ward nurses and nurse managers of a German university hospital.¹ In this study ward nurses and nurse managers were grouped into 'supervisors'. All registered nurses and supervisors were invited to participate in the study. Recruitment was conducted in nurses' team meetings on all wards. For the nurses who could not be addressed directly, flyers and posters were displayed and the information was sent per mail. In case of interest, the respective persons were subsequently addressed by one of the two recruiters (MH or SG) to arrange an appointment.

Based on theoretical sampling (Coyne, 1997), participants were initially openly selected. With the start of the data evaluation, further participants were specifically selected according to sociodemographic criteria (Campbell et al., 2020) until the participants were

almost equally distributed in terms of gender and hierarchical level and varied as much as possible in terms of age, professional experience and departments (Etikan et al., 2016). Individuals had to be at least 18 years old and work in a patient-centered or management position. The exclusion criteria included current or prolonged incapacity to work amongst others due to parental leave, medical leave or sabbatical longer than 4 weeks. A total of 50 participants participated in the study: 19 participants (nine registered nurses, five ward nurses and five nurse managers) participated in the face-to-face interviews and 31 participants joined the focus groups. Focus groups were grouped according to hierarchical levels resulting in two focus groups of registered nurses, two of ward nurses and one of nurse managers. One participant cancelled the interview appointment with no statement of reason.

3.4 | Data collection

Interviews and focus groups were conducted using German language between August and November 2018 in the offices of the research team or managers. A semi-structured interview guide for face-to-face-interviews and focus groups based on literature comprised 12 questions on age images and nurses' cooperation (see Appendix A). The interview guide has been pilot-tested for functionality and comprehensibility using four participants from different hierarchy level, age and gender. Then the interview guide was iteratively adapted. All surveys were conducted by MH (female, first profession registered nurse, psychotherapist) and SG (male, registered nurse) under the guidance and supervision of IM. A previous training of both interviewers, lasting several months, took place in a colloquium for qualitative social research by several experts from the university. Except for one researcher, most of the team was familiar with a large part of the sample. The participants were informed about the aims of the project and the task of the interviewer. Audio recordings from interviews and focus groups were made and transcribed verbatim. The participants received no remuneration; the interviews and focus groups were conducted during working hours. Each participant was offered the opportunity to receive a summary of the results after study completion.

3.4.1 | Face-to-face interviews

The interviews had a mean duration of 25 min (range 20–40 min).

3.4.2 | Focus groups

Hierarchical-level-grouped focus groups were led by one moderator (MH or SG), who directly asked questions and encouraged participants to respond to one another's comments (Kitzinger, 1994). The focus groups had a mean duration of 29 min (range 25–41 min).

¹While registered nurses have no managerial position, German ward nurses and nurse managers are registered nurses with management responsibility, ward nurses for one ward and nurse managers for departments or a group of wards. Nurse managers are superior to ward nurses, who are superior to registered nurses.

3.5 | Ethical consideration

The study protocol, study information and informed consent were reviewed and approved by the Ethics Committee of Heidelberg University (S-005/2018). The study was registered with the German Register for Clinical Studies (DRKS00013482). The participants were informed about the study in a telephone or personal contact and any questions that arose were clarified. The written study information and informed consent were subsequently given or sent to the participants and they were asked to bring them signed to the date of the interview and the focus groups.

3.6 | Data analysis

The verbatim transcriptions of face-to-face interviews and focus groups were pooled and evaluated by two researchers (MH and SG) using qualitative content analysis according to Mayring (2004) using MAXQDA Analytics Pro 2018 (VERBI, 2017). The analysis was inductive based on the data material. Semantic units from words, sentences or paragraphs in the transcripts were labelled with codes, which were compared with identify similarities and differences, and then grouped as more abstract (sub) categories. The primary focus of the analysis was to identify the main attitudes of the participants and the emergence of core variables. After analysing the most detailed 10 interviews, which varied in terms of survey method (face-to-face or focus group interview), hierarchy level, age and gender, a core concept of categories became clear. Then, starting selective coding with further interviews, the characteristics of each category were differentiated and verified. With the category system completed, the first 10 transcripts were re-examined and semantic units re-categorized where necessary. The process of data codification and categorization was continuously discussed by the research team, until consensus and data saturation (Fusch & Ness, 2015) was reached.

For each (sub) category, the similarities and common factors of the generational beliefs of registered nurses and supervisors are described first; then, the differences and distinctive factors are listed. The translation from German language was analogously done. For ease of reading, older employees are abbreviated as OE and younger employees as YE, supervisors (ward nurses and nursing managers) as SU and registered nurses who have no managerial position as RN.

3.7 | Validity and reliability/rigour

To increase the rigour of qualitative studies in terms of credibility, dependability, confirmability, authenticity and transferability, several recommendations of Lincoln and Guba (1985, 1986) and the consolidated criteria for reported qualitative research (COREQ) were followed in this study. To improve credibility, which includes the truthful interpretation of original data, and to promote confirmability (how findings support collected data), we prepared detailed notes

and self-reflections on experiences and biases towards the research subject and discussed them among the research team (Kynge et al., 2019). The purposive sampling design increased credibility through 'member-checking' (Guba, 1981) and enhanced the trustworthiness and rigour of the data (Campbell et al., 2020).

Moreover, participants were selected appropriately to the research subject, sample size was chosen appropriately. The distribution in terms of gender and leadership position as well as age range in the hierarchy groups was approximately the same and data saturation was reached and transferability enriched. Dependability as the assessment of the quality of the integrated process of data collection, was ensured by independent coding and being in dialogue with some co-researchers about whole analysis process. To improve both criteria, interviews were audio recorded and transcribed. Authenticity as the truthful representation of the interviews was achieved by using various quotes from several participants to illustrate the connections between original data and findings. To guarantee transferability, meaning the applicability of findings to other fields and contexts, a clear description of the sampling techniques, inclusion criteria and participants' main characteristics was provided.

The authors' reflection is an integral part of qualitative studies, covering the research process from the definition of the research object to the interpretation of the results. Through continuous self-observation during the research process, individual attitudes, experiences and motives of the researchers, could be self-reflected, discussed in the team and with field respondents of the colloquium until consensus was reached (Kynge et al., 2019).

4 | FINDINGS

4.1 | Participants

Out of 3090 contacted nurses with and without management positions, $N = 50$ participants from nine departments took part in the study (response rate 1.62%). The sample was predominantly female ($n = 26$, 52%) with an average age of 47.39 years ($SD = 10.89$; range 22–63 years; $Md = 51$). The mean professional experience was 20.10 years ($SD = 12.16$; range 1–40 years; $Md = 20$). Table 1 shows the sociodemographic factors of the participants.

4.2 | Findings of the content analysis

The qualitative analysis identified 294 single codes from the group of employees described. Five categories were inductively formed out of single codes: positive stereotypes and benefits of diversity (C1), negative stereotypes and disadvantages of diversity (C2), benefits of diversity and successful cooperation (C3), generation conflict (C4) and diversity management (C5). The number of codes is found in the brackets at the end of the heading. Although only age stereotypes towards older employees were asked, a balanced discussion of age stereotypes towards older and younger nurses exists; therefore, both were evaluated and described in two subcategories

TABLE 1 Sociodemographic data

	Interviews				Focus groups				Total
	RN n (%)	WN n (%)	NM n (%)	Total n (%)	RN n (%)	WN n (%)	NM n (%)	Total n (%)	
	9 (48)	5 (26)	5 (26)	19 (38)	14 (45)	13 (42)	4 (21)	31 (62)	50 (100)
Gender									
Male	4 (44)	3 (60)	2 (40)		8 (57)	5 (38)	2 (50)		24 (48)
Female	5 (56)	2 (40)	3 (60)		6 (43)	8 (62)	2 (50)		26 (52)
	RN	WN	NM	Total	RN	WN	NM	Total	
				19 (38)				30 (60)	49 (98) ^a
Age (years)									
M	38.00	46.20	52.20	43.89	50.14	49.83	51.33	50.14	47.39
SD	11.83	7.19	6.10	10.95	12.48	8.17	8.14	12.48	10.89
Range	23–57	35–52	42–58	23–58	22–63	34–59	42–57	22–63	22–63
Median	38	39	54	46	55	48	55	55	51
Professional experience (years)									
M	17.33	15.60	24.20	18.68	26.90	12.92	20.67	21.00	20.10
SD	12.08	8.17	12.15	11.16	13.07	7.45	9.02	12.86	12.16
Range	4–38	3–25	3–32	3–38	3–40	1–30	12–30	1–40	1–40
Median	20	15	30	20	31	14	20	19	20

Note: M = mean, SD = standard deviation, RN = registered nurses (no managerial position), WN = ward nurses (registered nurses with management responsibility for one ward, superior to registered nurses), NM = nurse managers (superior to ward nurses and responsible for departments or a group of wards).

^aAge and professional experience were collected from 49 participants; one focus group participant did not give any information (n = 30).

(age groups) of categories 1 and 2 (Table 2). Table 3 presents the list of illustrative quotations for each category.

4.2.1 | C1 Positive stereotypes of employees and benefits of diversity (84)

Category 1 summarizes positive stereotypes towards older and young employees and benefits for diversity.

4.2.2 | C1.1 Older employees (53)

Common factors: The professional experience, routines and reliability of OE were frequently named. OE were said to have intuition, core competencies in patient observation, de-escalation, and a good overview of the work area. OE were also consulted for advice by SU, for example on management decisions. Thus, OE would have a lower vulnerability to stress-related phenomena due to professional experience, personal maturity and composure.

Distinctive factors: Some SU saw OE as more competent in dealing with physicians and colleagues and more flexible in adapting to environmental changes. SU considered OE to be mediators and informal leaders of the team. According to the RN, the calm and serenity of the OE gave the team a sense of security. OE would have a

broader responsibility and a higher workload and were held in higher esteem in the team and SU. Conflicts were resolved by OE directly with those affected without involving SU.

4.2.3 | C1.2 Younger employees (21)

Common factors: YE would represent new impulses, enthusiasm, the questioning of habits and innovation. Some RN and SU shared their experience of serenity, calmness and feeling relaxed working with YE.

Distinctive factors: SU considered YE as having expectations of their performance that are more appropriate to the situation and requirement and presumed YE as a necessary condition for change. RN characterized YE as fast, effective, inquisitive, motivated and dynamic. Their knowledge seemed to be up to date. RN reported that YE would have a good ability to differentiate, for example prioritization of tasks or identify and meet the most important current needs of the patient.

4.2.4 | C2 Negative stereotypes and disadvantages of diversity (99)

Category 2 covers negative stereotypes towards older and young employees and disadvantages of diversity.

TABLE 2 Categories extracted from the interviews

Key domains	Definition	Subdomains
Category 1 Positive stereotypes and benefits	C1 Positive attitudes towards and cognitive interpretations of the perception of an age group (including causal theories) and perceived effects on work performance and working atmosphere	C1.1 towards OE C1.2 towards YE
Category 2 Negative stereotypes and disadvantages	C2 Negative attitudes towards and cognitive interpretations of the perception of an age group (including causal theories) and perceived effects on work performance and working atmosphere	C2.1 towards OE C2.2 towards YE
Category 3 Diversity and cooperation	C3 Evaluation of the cooperation of YE and OE, positive, rewarding aspects and opportunities of diversity and successful cooperation Both age groups are put into context/relationship; the advantages of individual age groups are listed in C1	
Category 4 Generation conflict	C4 Causes/triggers of disagreements between the age groups and reasons for not wanting to work together; difficulties in working together	
Category 5 Diversity management	C5 Theoretically meaningful (suggestions for improvement, wishes) and actually implemented methods to improve cooperation between age groups or work in mixed-age teams to improve the esprit de corps and reduce stereotypes	

4.2.5 | C2.1 Older employees (55)

Common factors: OE were described as rigid and inflexible; changes and innovations would be fended off by fear. OE would see the job as a vocation and would give it priority over private life and personal health. Physical limitations with older age might lead to a slower pace of work and less stamina. OE tend to complete assigned tasks out of a high sense of duty (overcommitment), even if this leads to high workload and overtime.

Distinctive factors: OE were described by SU to have a low stress tolerance, which led to a high stress level among OE. According to the SU, the severity of illness of OE is high, making it a reason for inability to work. SU believe that OE tend to stay away from work because of more serious illnesses such as herniated discs, severe flu. According to SU, a cold as a minor illness is not a reason for OE to stay home sick. RN considered OE to be frustrated by the contradiction between the demands of one's own work and the actual work requirements and restrictions (e.g. limited implementation possibilities).

4.2.6 | C2.2 Younger employees (44)

Common factors: YE place great emphasis on leisure, family and friends. They seem to be characterized by egocentricity and good ability to distinguish themselves, resulting in less support for colleagues. YE were meant to compete with colleagues in their need to represent their own interests. YE would have a high intent to leave the department, institution or profession at all. For YE, careers should run without much effort.

Distinctive factors: According to RN, a lack of reflective ability, critical faculties and team spirit among YE made cooperation more difficult. They would rarely take advice, since they wish to make their own experiences. RN described YE as poorly trained and less experienced. They lack professional distance to patients. They also have low motivation to perform and have higher absenteeism due to illness.

4.2.7 | C3 Benefits of diversity and successful cooperation (43)

Category 3 encompasses the effects of beneficial diversity on the cooperation of different ages.

Common factors: OE and YE predominantly benefit from each other in terms of team functionality, patient outcomes and personal development. Although some disturbances (see C4 Generation conflict) are present, differences were accepted and the disadvantages of each age group were compensated in the team. Moreover, work processes ran more smoothly in mixed-age teams than those in homogeneous teams with only one age cohort.

Distinctive factors: SU reported that an exchange of experience and knowledge transfer between OE and YE is present, as well as good to above-average professional cooperation. Mixed-age teams enable the review of their own value system and allow employees' personal development through high-performance ageing models. SU described a family-like distribution of roles, in which YE are trained and supported by OE. RNs also highlighted that mixed-age teams also facilitate and improve contact and work with patients and relatives of different ages.

4.2.8 | C4 Generation conflict (40)

Working in mixed-age teams causes and triggers difficulties and can be responsible for conflicts between generations.

TABLE 3 Illustrative quotes for each (sub-)category

Category	(Sub-)category: Common Factors	Group	(Sub-)category: Distinctive Factors
Category 1 Positive stereotypes and benefits	<p>The advantage of getting older is that you have experienced so much that you hardly ever get into a real stress situation. Because, one has already experienced and mastered so many stressful situations and knows that it will continue again and again. I am someone who seldom gets into hot water. I usually remain very calm. [L_SU_2]</p> <p>When making decisions about individual processes, you also listen to the experiences of long-serving employees. Maybe we are in a process at management level where we want to decide something that may have been decided before, some things are repeated. Then, of course, we rely on the experience of long-term employees or older employees and then decide against it.</p> <p>I: So it's like a small consulting job: B: Yes, exactly, so that's what you get. [L_SU_13]</p> <p>We have one nurse who focuses on 'de-escalation'. Fortunately, we don't have physical violence there either. But 'de-escalating verbally'. She goes to the door and says: 'Hello, I'm [Name], what's going on?' And then she talks to every relative and everybody is peaceful and happy. And we think, thank God, let her do it, then they won't ring every 5 minutes. Or we have one who was in ICU too, and she just sees immediately when a patient deteriorates and then says to the physician, 'here'. And she is always right. So they all have a core competence that is of course very much appreciated by the others. [L_SU_14]</p> <p>They [YE] see it in a more relaxed way, they approach it in a more relaxed way, so at least they are always more relaxed on the outside. [FG_SU_3]</p> <p>I: And in terms of respect and appreciation? 3: Yes, this has also already been incorporated. If I now look at myself personally, I have no reason to complain about it in any way. Yes, that is just Papa Smurf, who is there when things get difficult, regardless of whether the physicians see a problem, the nursing colleagues see a problem or the psychologists. There is of course a respect that is primarily based on experience. [FG_RN_3]</p> <p>Older colleagues have a lot more experience and can assess situations differently, and above all you notice that in communication with the patients. They have simply internalized the routines so that everything works out. [L_RN_14]</p> <p>[...] the burden is also greater for those who have more experience, because some of the work that would otherwise have been spread over several shoulders is then left to them. [L_RN_17]</p> <p>I always find the younger staff generally more inquisitive, more motivated. [L_RN_11]</p>	SU	<p>And, yes, the young colleagues are more likely to bring the ideas from school with them or they are interested in developing themselves further and then, I would say, bring new momentum to the team. [L_SU_4]</p> <p>This team is really lacking two or three young people, maybe even freshly registered people, who are then also ready to want a change. Because in a team that has of course been working in this constellation for ages and has a certain average age, people don't necessarily want a change. (FG_SU_1)</p> <p>I have a staff member in mind who is 57 years old, when the ward round is in the room, 'hm, everything's fine' and when they're outside, 'okay', he says, 'now I'll carry on as usual, because no one will be interested in an hour' and I'll say, 'everything's fine the way it is and that's it'. And yes, sometimes physicians make jibes. The older ones are really more jaded due to the experience they have had and no longer perceive things in the same way. [FG_SU_3]</p>
		RN	<p>I think that younger colleagues are more dynamic [FG_RN_2]</p> <p>'Younger people like to have new ideas, don't necessarily let themselves be offered everything or perhaps question things more quickly, which I think is good.' [L_RN_18]</p>

(Continued)

TABLE 3 Continued

Category	(Sub-)category: Common Factors	Group	(Sub-)category: Distinctive Factors
Category 2 Negative stereotypes and disadvantages	<p>And I have patients who need a lot of care or who are confused, who need much more attention and much more care and therefore much more work. And a young employee, he or she finds it easier to change and adapt at the same pace as older employees. That does not mean that the older employee is no longer able to work under pressure. However, I do believe that older employees are much more able to cope with the ups and downs and especially these peaks, where you have to be much faster, and bring them to the edge of their performance more quickly than a young employee. They do it well. That is not the question. And they are also resilient. But I think their performance and adaptability of performance is lower. [FG_SU_2]</p> <p>I also have some [OE] that still fight back today. They only do what is absolutely necessary on the computer. [FG_SU_1]</p> <p>But there are also a lot of older people who have fears when they come in somewhere fresh and have no idea whatsoever and then stand there like freshly graduated. [FG_SU_3]</p> <p>That has really changed. I would also totally underline that. We [OE] had a duty plan, we lived our lives according to it. And with them [YE] it's rather the other way round. So, you make the schedule you want and then it's more in line with your life. [FG_SU_2]</p> <p>There are also some nursing staff who, I would say, have developed clear constraints over the years. They really live it up at work. They live them out at work in various forms. These constraints are unhealthy for the nursing staff and also partly for the patients, because they partly destroy themselves. The older nurses on some wards, there are not many of them, but they really wear themselves out for the job. They do everything. They also stay an hour longer every day and stay clear, not only because they are overworked to the maximum, but also because they live out, let's say, their compulsions. I could give you many examples. [FG_RN_2]</p> <p>So I have the impression that not all, but some older nurses really do see it as their vocation to serve. [FG_RN_1]</p>	SU	<p>The sensitivity to stress, when many stimuli hit us at the same time, is something I notice in myself and also in others... that it is more difficult to deal with it as we get older. A few years ago, I thought it was great when I was standing at the reception desk and five emergency physicians came at the same time and I thought, 'Ah, yes, now this is what I'm particularly good at: Keeping calm and sorting everything out'. I slowly notice that I think, 'oh no, that's almost a bit more for me right now'. That's what I've experienced with all my other colleagues, that certain positions have become more difficult for them as they've gotten older. And I notice that about myself, too. [L_SU_14]</p> <p>The younger generations are not able to accept criticism. I also have the feeling that all of this is being bad-mouthed and it is mostly just a question of 'why did it not work, what was the problem' and then it is taken as criticism and immediately shot back. [FG_SU_1]</p> <p>Yes, I do not know if sometimes it is already so competitive, if sometimes it is, independent of competition... I think it is rather this 'I will show you! What you can do, I can do it for a long time'. So more such competition, jealousies, show who has it better, who gets things done faster or does not need so much support. [L_RN_8]</p> <p>So there are [younger] people with whom this is difficult, who may not be able to deal with it themselves either, and conflicts may try to be resolved at a hierarchically equal level, for example at senior physician level or at nursing management level. Not everyone addresses the people it affects. This may be due to the fact that the young people do not yet have a real standing and are often not seen and then the criticism, from which one could learn, is not addressed directly to the person concerned, but first to the ward management and from the ward management to the person concerned. [L_RN_17]</p>
Category 3 Diversity and cooperation	<p>There is a lot of satisfaction from older employees with young people who still bring a lot of commitment. A commitment and enthusiasm that you may no longer have yourself [OE] and that you may otherwise have to work at every day when you are older. [L_SU_15]</p> <p>I also think it's important that the team is mixed, that everyone can learn something from everyone else, can benefit from it, it's like an extended family in principle, there's a certain balance, as if you only have young people with a hundred thousand ideas, everyone wants something different and you don't get anywhere, or - this is a bit of an exaggeration - only older employees who don't feel like doing anything at all. And so, everyone can benefit from everyone else. [FG_SU_1]</p> <p>And of course, these are all things where you can learn from. And that is then fun. And that is fun for both sides. Of course, someone who has been in the ward for 4 weeks is happy if, after 20 years, he can show an old hand something that is not psychiatric. And that works too. [L_RN_7]</p>	SU	<p>In a mixed team with different age groups, I have significantly more people who may be running different areas in the portfolio. And if I only work with people who actually think, 'okay, 15 more years, then I will have my retirement', then I will not get very far. But if I have young people with me, who push it more, then I will make a lot more progress, but I also need the older ones, who of course take on the role of mother or father for the younger ones. And who also do this social work more. how do you manage to do all this cleverly? [FG_SU_1]</p> <p>On the one hand, it is good when there is someone from all age groups, because all age groups of patients are there. That you have a 'mirror image'. And that people also know what problems the patients have, where the others might say, that could be my child. [L_RN_19]</p>

(Continued)

TABLE 3 Continued

Category	(Sub-)category: Common Factors	Group	(Sub-)category: Distinctive Factors
Category 4 Generation conflict	<p>Then it may not be so important to the younger ones that the patient is not completely washed, but only face and genital area and for that he is medically well cared for [I_SU_1].</p> <p>That's a different way of thinking. The young people then say, 'Oh God, the old are annoying, because the material in the room should be replenished. It should be done; it should be cleaned'. Maybe that's not so important for them, because they say, 'Hey, the patient is lying well in bed, he's still alive, then everything's good. [...] So when a handover is made and now the documentation is being gone through and things are not filled in, then the older colleague is more likely to be able to say, 'Hey, what's this, half of this is missing, why didn't you fill it in' and so on, 'what was going on there' or 'why wasn't this done, was there an emergency'. And when young and young do the shift handover, it's best not to talk about it at all. That's just the way it is'. [FG_SU_3]</p> <p>So, I would say that the colleagues my age / So they are all around 40 years old actually feel the same way as I do, it's really a generational problem. And the young feel overwhelmed by us because we want too much from them. And they are no longer prepared to give that. [I_RN_12]</p> <p>There are often negative moods on the ward and then someone comes and then it is passed on directly to the person, although they come motivated, so very young and still want to learn something and so the first three sentences and then the year is already over: I would see that as a difficulty. So, a 17-year-old, an 18-year-old, depending on when you graduate from school or when you go to secondary school at 16, or something like that, comes into a team that is completely negative and only complains, and we nurses are so good at complaining, and then I imagine it's difficult. You have to do that and squat in some place and then you also get told, 'yeah, oh shit, another one I have to train. Do you at least know how to do one plus one?' or something. I imagine that would be difficult. [FG_RN_2]</p>	SU	<p>Of course, there are heated discussions, but somehow, we find a middle ground and say, "hey, no, we'll try it out this way". It's always a give and take. [I_SU_11]</p> <p>It often happens that, especially with the older ones, I get feedback that they feel excluded when it comes to private conversations among the younger ones, who then also meet privately, where the person then notices and is not invited to these private meetings or for whatever reason, that there is a feeling of exclusion. [I_SU_13]</p> <p>One problem with our hierarchy is that the team was very entrenched. The management and 15 people have now left and it was very difficult to get into the team as a newcomer, especially as a youngster. There is really a dominance from above or hierarchical from the age. And at the beginning I made suggestions, 'why do not we do it this way or that way'. That was simply crushed with comments like 'after a year I wouldn't have dared to do that'. It was very, very difficult. [FG_RN_2]</p> <p>I: Are there also advantages to working together? So, of young and old? RN: No. I: There are no advantages? RN: No. Sorry. [I_RN_12]</p>
Category 5 Diversity management	<p>I believe in understanding each other. The understanding and the qualities that each generation, both young and old, have to work out and work on in order to be able to participate from one another [I_SU_4].</p> <p>For example, I always make sure that the team composition, the shift composition, is always very mixed. Because I think that makes a lot of difference, that you don't have only the old in one shift and only the young in the other shift, but I always think it's the mixture that makes it. [...] That people talk openly with each other and that everyone's arguments are perhaps expressed constructively. What do the young think and what do the old think? How do they see the situation now? Because everyone has a slightly different view. [I_SU_11]</p> <p>A balanced mixture is best in a team, even during the shift. [I_RN_1]</p> <p>And, for example, that older staff members perhaps no longer have to work physically or always on it, but can also perhaps simply pass on their knowledge in other wards. In lectures or such training sessions for half a day, where certain situations should simply be discussed. I would find that very helpful. [I_RN_11]</p>	SU RN	<p>So, you always have to make sure that the long-serving or older employees are integrated into everything and are also challenged and further promoted and not say: 'he's already about to retire' or 'he's already experienced everything anyway'. You can continue to actively shape things and involve someone [OE]. I think that also increases motivation. [I_SU_13]</p> <p>I also think that understanding between young and old is extremely important. [I_SU_11]</p> <p>I mean, if someone [YE] thinks after three months in intensive care: 'Oh, now I'm going to anesthesia, there's not so much work'. Then you can't expect so much understanding from us, because we have a much longer training period. We want staff with a background who have first worked in intensive care, i.e. intensive care, for two, three or four years and then come to anesthesia. But when someone from a normal ward comes to anesthesia, that's unbelievable. That makes the training incredibly long. And, yes, it takes longer and makes our work more difficult. [...] I would like the working path to be like it used to be: first work your way up and then go into the functional services. And not right after the exams. [I_RN_12]</p> <p>RN: I would definitely improve it by organizing the induction differently for many. The newcomers are usually young. And that's difficult when a young person is training a young person. I: Ah, you think it's better if the older ones train the younger ones. The experienced. RN: Mhm (agreeing). [I_RN_16]</p>

Notes: FG, focus group; I, interview; RN, registered nurse; SU, supervisor, YE, young employees; OE, older employees.

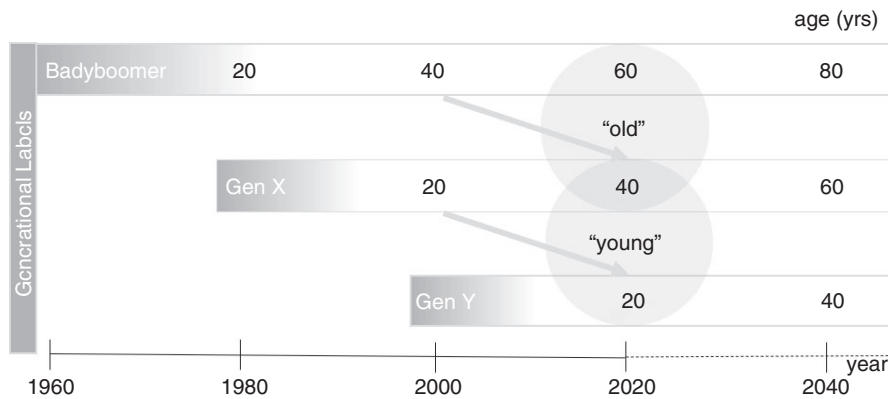


FIGURE 1 Schematic representation of age and generation labels

Common factors: Different expectations and values with regard to working methods, communication and demeanour at work (toward patients and colleagues) between OE and YE, as well as the way of life of both, were mentioned. For example YE focus on medical care (medical activities carried out on a doctor's prescription, such as administering infusions, medicines, changing dressings.), while OE focus on nursing care (personal hygiene, excretion, nutrition, prophylaxis (prevention) and support with communication and daily living skills).

The lack of equal treatment of OE and YE in the planning of work shifts (e.g. YE are more likely to be assigned to weekend and night services), financial benefits (e.g. monetary gratuity by the employer for new/young employees when they join the hospital), vacation days (e.g. YE are planned for service on Christmas Eve), and work distribution (e.g. if OE are not able to do physically demanding work, YE take on this additional work or OE take care on difficult patients who can be a potential safety problem for YE) would lead to feelings of injustice and frustration manifesting in frequent discussions and conflicts, for example about YE's innovative spirit. OE's high expectations cannot be fulfilled by YE. Therefore, a reaction of excessive demands, withdrawal and reactance resulted. Although OE and YE benefit from each other from a professional point of view, they do not like working together because of the predominantly conflictual cooperation with the high need for discussion and clarification.

Distinctive factors: SU described a possible higher workload of YE because they consider the limitations of OE and compensate for these. YE might tend to keep to themselves, making OE feel excluded. Solving conflicts between OE and YE requires a lot of time and energy. SU saw conflicts between different generations as solvable; most RN do not. RN ascribed low performance motivation to YE; OE would have to compensate for this and would feel a higher workload. YE seem to be dominated by OE and are slowed down in implementing innovative ideas. RN suspected that conflicts arise from the different working methods of both age groups.

4.2.9 | C5 Diversity Management (38)

Category 5 deals with actual or suspected approaches, measures and solutions that improve cooperation in mixed-age teams and overcome obstacles.

Common factors: Mixed-age teams are described as advantageous for nursing. Implementing age- and life-phase-oriented workplace designs is necessary to use the respective strengths. For example OE might take over educational activities that include further training, lectures and case discussions. In these contexts, they could develop their potential and thus strengthen their position in the team. To bridge the differences and promote a more relaxed interaction between the age groups, talking openly about divergent opinions and presenting arguments in a constructive and comprehensible way were recommended. Therefore, mixed-age work shifts can reduce fear of contact.

Distinctive factors: SU would like OE to be open to new ideas and more willing to change to gain a successful diversity management that is next to introducing measures to improve different age groups working together as well as adaption of workplaces to the respective age groups, it is important that the employees accept these measures. According to RN, YE should first gain experience on the nursing wards and then be deployed on the special wards (e.g. ICU). YE should be better trained ideally by an older and more experienced colleague. RN propose relief measures for OE, including exemption from night shifts and working fewer hours for the same salary. RN made clear that the institution (i.e. hospital), represented by SU, is responsible for the health of the employees.

Age stereotypes towards older and younger nurses seemed similar to the common generational labels Generation 1968/ 'Baby Boomers' and Generation X. In this context, the attributes 'older' reflect characteristics of the Baby Boomers and 'Younger' of Generation X, although these have not applied for 20 years and 'older' corresponds to Generation X and 'younger' to Generation Y (see Figure 1).

5 | DISCUSSION

This study aimed to assess age stereotypes towards older employees in the nursing profession from the viewpoint of RN and SU in inpatient settings. Although age stereotypes towards older colleagues were primarily sought, following Snape and Redman's (2003) suggestion, age stereotypes towards younger nurses were also reported and evaluated. This may be due to the fact that the one-sided

reporting triggered cognitive dissonance to the disadvantage of older colleagues, which is relativized and balanced by emphasizing the stereotypes towards younger nurses. Focusing only on older nursing staff in the question of appropriate diversity management neglects an age group that is just as relevant for ensuring adequate and efficient inpatient care.

RN and SU described age stereotypes as reminiscent of common generational labels, for example 'Baby Boomers' and Generations X, differing to their respective work context. RN focused on stereotyping in everyday work; SU focused not only on the interdisciplinary cooperation of the RN, but also on the support of their work as managers and the extent of the goals they have set in stereotypes. The participants concluded that, precisely, these age stereotypes can influence cooperation and cause conflicts. Some solutions of diversity management are successful and improve work-related outcomes in mixed-age teams.

In our study, older nurses were seen as competent, loyal, idealistic and perfectionist, but less adaptable and willing to change. They were valued for experience, loyalty and reliability by the participants of our study. This is in line with findings from a recently published work from Kleissner and Jahn (2020a). Older nursing staff was also described as focused on the job, afraid of making mistakes and overcommitted, as Posthuma and Campion (2009) described before. Owing to the idea that OE have good strategies for dealing with work-related stress, the participants in our study assumed that older nurses were more resilient to work-related stress, as Wakim (2014) described earlier. These stereotypes towards older nurses fit the generational label 'Baby Boomer' by describing them as hard working, resistant to change (Perry et al., 2013), believing in sacrifice to achieve success and valuing company commitment (Jorgensen, 2003).

The participants in our study described younger employees in the nursing profession as having a pragmatic and result-oriented working style and would prefer to independently and autonomously work. This is in concordance with the existing literature, which states that younger employees ascribed work as less important than private life and leisure (Huber & Schubert, 2019). Younger employees would strive for a high-quality life and personal fulfillment (Apostolidis & Polifroni, 2006). For these reasons, younger nurses in our study are attributed a lower rate of career advancement to leadership roles. This contradicts previous studies (Flinkman & Salanterä, 2015), which have indicated that career options are important to young nurses and that the lack of them is a reason for resignation (Kerzman et al., 2020).

Assigning the characteristics of young nurses to a generational label, Generations X, which 'values autonomy and independence, does not believe in paying dues, is reluctant to take on leadership role and believes in balanced work-life-objective' (Jorgensen, 2003, p. 42; Perry et al., 2013) comes closest. Although research on generational labels in nursing profession is still rather limited, first mixed-methods systematic reviews show that general generational labels about job attitudes, emotion-related job aspects and practice and leadership aspects also apply to nurses (Stevanin et al., 2018).

Since we did not provide a definition 'younger' and 'older' in our survey, this is done on the basis of a theoretical derivation. The majority of registered nurses is currently between 20 and 60 years old and the active workforce in nursing profession is 16–67 years, though '40 years old appeared to be an acceptable cut-off to distinguish between younger and older' nurses (Ng & Feldman, 2012, p. 824).

Assuming an age segregation at the age of 40 years, younger nurses (40 years and younger) correspond to Generation Y (20–40 years), and older nurses (older than 40 years) correspond to Generations X (41–60 years). But interestingly, the participants in our study attributed the characteristics of the next older generation to young and old nurses: for young nurses were predominantly named attributes of Generation X and older nurses were given Baby Boomer labels. Generation labels, that nurses have accepted as valid when starting their careers are still assumed to be valid by them 20 years later. From our viewpoint, this can be seen, on the one hand, as an indication of the temporal stability of age stereotypes. On the other hand, this finding gives cause to question the generation model once again due to lack of empirical evidence (Teclaw et al., 2014).

Our second finding is that supervisors report similar age stereotypes just as non-supervisors in hospital nursing profession, differing only in the focus of the respective work and responsibility area. While nurses report age stereotypes relating to their daily care routine, supervisors report stereotypes involving interdisciplinary cooperation and support of their work as managers. Different groups of people (nursing colleagues, supervisors, etc.) have sometimes contradictory expectations; for example, YE are assumed by supervisors to have realistic performance requirements and a good ability to differentiate, resulting in a lower willingness to work overtime and take over work from colleagues. Conversely, this behaviour of young nurses is declared to be lacking performance orientation and laziness by nursing colleagues. The results indicate that respondents evaluate age groups according to the extent to which their expectations of work performance are met by nursing colleagues.

Current literature presumes that older employees in the nursing profession are still faced with discrimination (Kumar & Srivastava, 2018). For subjects of discrimination, negative age stereotypes may lead to decreased 'self-efficacy, job satisfaction, performance as well as learning, development or increased retirement intentions of older nurses' (Weber et al., 2019). Latest research shows that supervisors and colleagues can influence the impact of age stereotypes on work engagement and intention to stay (Yeung et al., 2021).

However, in our study, younger nurses are also subject to age-related discrimination, since the individual differences between nurses of the younger generation are not perceived, reverse age discrimination in the nursing profession, that is discrimination against younger nurses from older individuals exists (Raymer et al., 2017).

Third, in our study, the cooperation between younger and older registered nurses was described as predominantly conflictual because of age stereotypes about different organizational commitment, and relationship management in the team. The participants

in our study described different work values in terms of prioritization of work (YE: medical care, OE: nursing care), commitment to work (acceptance of unfinished tasks and workload limits) and organization (e.g. presentism). In our study, conflict resolution was a controversial issue. Supervisors see conflicts between different generations as solvable; most nurses do not. Some nurses and supervisors therefore deduce that both age groups do not like to work together, despite that working together is beneficial in terms of patient care, staff and patient safety and gaining experience and knowledge for both. These findings correspond to the separation aspect of age diversity (Harrison & Klein, 2007), which is related to self-categorization and social identity theories. Self-categorization theory (Turner et al., 1987) has suggested a categorization of individuals belonging to a specific group (in-group) contrasting themselves to others (out-group) and depends on 'the extent to which the attribute [author's note: age] is meaningful in order to distinguish between individuals in a given situation' (Meyer, 2017, p. 5). Social identity theory has suggested that perceiving an individual belonging to an out-group can lead to intergroup bias; this means that an in-group member can be evaluated more favourably than an out-group member (Turner & Tajfel, 1986). In relation to working groups, this means that the intergroup bias may lead to lower group cohesion, less trust and more frequent conflicts (Van Knippenberg & Schippers, 2007).

Some participants in our study considered the cooperation to be beneficial to professional development, patient care and daily workflow, demanding mutual acceptance of the weaknesses of both age groups. Nurses consider the relief of older employees and better training of young employees as a prerequisite for good cooperation. To prevent the emergence of age stereotypes and reduce the existing age stereotypes, diversity management plays a decisive role in creating more innovation, productivity and corporate citizenship. As Wegge et al., (2012) described before, both groups, nurses and supervisors, agree that sufficient diversity management includes the planning of mixed-age services and the adaptation of the workplace to the individual needs of the age group to master the '3Cs': communication, commitment and compensation (Hendricks & Cope, 2013). Beyond mixed-age work shifts, mixed-stereotyping employees are recommendable because exposure to members that disconfirm the age stereotypes can reduce this categorization (Liebermann et al., 2013), according to contact theory (Allport, 1954), and the mere exposure effect (Zajonc, 1968). A correction of attitudes, for example stereotypes is only possible if repeated experiences with nursing colleagues who contradict this age stereotypes (triggering cognitive dissonance) are integrated into one's attitude construct until these new attitudes stabilize (resulting in cognitive consonance).

There is a need to implement trainings to reduce age discrimination and to systematically examine their effectiveness. Trainings should invite participants to self-reflect on their own ageing but also to reflect on the experience made when starting their career as nurses. This would allow a change of perspective and improve mutual understanding.

The results also have implications for policy. In the future, caution should be exercised with the use of generational labels as they

lack empirical evidence and encourage prejudice and stereotyping by age. Nationwide campaigns against age discrimination and laws to protect young and old employees at the workplace were implemented. Protection against age discrimination should also be included in the hospital policies and staff management. An adjustment of the workplace hospital should be oriented towards the individual needs, strengths and weaknesses of each employee, regardless of their age.

In addition to promoting positive contacts for reframing and re-attributing age stereotypes (Casad & Bryant, 2016) towards younger and older nurses, the measures for reducing age stereotypes and creating an age-diverse friendly workplace recommended by Kleissner and Jahn (2020a) are of particular importance. A summary of various studies by the authors reflects the following key points in the fight against age stereotypes: raising awareness of existing age stereotypes (Schloegel et al., 2016), promoting an open discourse on age stereotypes (Ng & Feldman, 2012) and creating a working environment that reduces the occurrence of age stereotypes (Roberson & Kulik, 2007). In addition to the recommendations of Kleissner and Jahn (2020a), participation of supervisors in measures fighting against age stereotypes seems necessary, as age stereotypes are also present at the management level. As significant role models in hospitals, supervisors can set a good example by avoiding differentiation of nurses by age, communicating positive age stereotypes and implementing diversity-friendly human resources policies. Furthermore, by cultivating a diversity-friendly management style, diversity in teams can be seen as an opportunity for further development and professionalization of nursing and social support in the team (Velando-Soriano et al., 2020).

5.1 | Limitations

This study has several limitations to consider. We tried to reach all nurses by advertising in ward meetings, but also by flyers, posters and contacting them by e-mail. However, it is not possible to exclude the opportunity that nurses who had a particular desire to talk about these topics, that is presumably nurses who had already dealt with the topic, signed up to participate in the study. Of the addressed participants, only 1.62% took part in the survey, which could affect generalisability. The duration of the focus groups was short, so there is an opportunity that not all relevant aspects could be discussed. Furthermore, data collection in the focus groups might have been biased due to the lack of anonymity. The presence of employees belonging to certain age groups might have enforced potential bias. Although participants from different departments of the respective hospital were interviewed until a data saturation has been reached, the generalizability needs to be seen with caution because of the specific setting of the university hospital. It could be problematic for the interpretation that the supervisor position is confounded with age and that the supervisors therefore evaluate their in-group. Furthermore, the participants only distinguished between old and young without naming a specific age cut-off. Since stereotypes are

not only held against older people, but also against younger people, where the age line between the generations lies should be examined more closely in the future. A social desirability bias is possible since participants were familiar with the issue of age diversity and diversity management through various educational and public relation programs in the workplace and public realm. Therefore, it must be assumed that the results merely reflect the publicly accepted attitude and age stereotypes seem to be more dominant, and more significant rather than that is known for certain.

Quantitative and empirical studies should be applied to verify age stereotypes of nurses and supervisors. Since we conducted the study at a maximum care hospital, a comparison with hospitals of other care levels would be necessary to verify the validity of the data. Longitudinal studies of different age cohorts and their comparison are still necessary to verify generational stereotypes. A possible rejection of the concept of generation would have the consequence that the thinking of staff in categories such as 'old' and 'young' and the attribution of characteristics to age would be reduced in the future.

6 | CONCLUSION

Based on our knowledge, this is the first study that concerns age stereotypes at different levels of the nursing hierarchy. It reveals important results, clearly reflecting the existence of age stereotypes towards younger and older nursing staff in inpatient setting.

Despite many negative stereotypes, positive age stereotypes point to the strengths of age groups. To reduce negative age stereotypes and support strengths, diversity management should specifically promote positive contacts at the hospital workplace and enable new experiences with the other age group. Reducing these reservations, improving cooperation through appropriate diversity management, and promoting new experience with the out-group nurses in everyday life are possible. Supervisors should be role models for diversity-friendly leadership by emphasising the individual strengths of each employee and involving employees of all ages in creating an age-friendly work environment.

Trainings to reduce age discrimination should encourage participants to self-reflect their own ageing process and professional biography that is reflecting the experiences since starting their nursing career. With regard to hospital policies generational labels should be used carefully, not to discriminate by age and try to set up individual appropriate workplaces.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE [<http://www.icmje.org/recommendations/>]):

- Substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- Drafting the article or revising it critically for important intellectual content.

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ORCID

Madeleine Heläß  <https://orcid.org/0000-0002-1755-2069>

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APPENDIX A

INTERVIEW PROTOCOL

Age stereotypes

1. How do you experience working with older colleagues?

- What are the differences between young and old employees?
- What are the advantages of working together?
- What are the disadvantages of cooperation?
- What works particularly well?
- What could be improved?

2. How do colleagues experience working together with older employees of other age groups?

- How would your colleague describe the cooperation with older nurses?
- What works particularly well?
- What could be improved?
- What do you see as the advantages of cooperation?
- What are the disadvantages of cooperation?

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