



The University of Sydney

Older Health Workers –

Enjoying work in the Hunter New England.

A project with rural nurses and allied health workers to identify key challenges and solutions for older workers.

Research Report

The Older Health Workers Project is a co-joint action research activity of the Australian Centre for Agricultural Health and Safety and the Hunter New England Area Health Service

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1. Executive Summary

Building and maintaining a sustainable health workforce is a key priority for Hunter New England Health and other Area Health Services in NSW. The rural health workforce is ageing; and is older than the urban health workforce. Within the rural clusters of the Hunter New England Area Health Service, around one quarter of allied health workers; and around one half of the rural nursing workforce is over 50 years of age. Sustainability of health services in rural areas will be dependent, at least in the short term, on nursing and allied health workers being willing, able and happy to work well beyond middle age.

This project aimed to explore older health workers experiences about the challenges of being an older worker in the rural health service setting. Specifically the objectives of the *Older Health Workers Project* were, to work with older nurses and allied health workers in rural areas, to:

- identify tasks and aspects of work that have become more difficult, take longer, or are avoided as a result of getting older
- identify the related personal physical and mental changes associated with these difficulties.
- identify and describe work systems amenable to adjustment, that might accommodate the changing needs of older health workers; as well as any personal action workers can take to improve general 'fitness for work'.
- develop recommendations for the Hunter New England Area Health Service to consider, in relation to changes that might be adopted more widely, toward sustaining an older rural health workforce.

A qualitative, **participatory action research methodology** was employed. A series of six workshops were held with rural nurses, allied health workers and clinical support staff, in rural communities serviced by Hunter New England Area Health Service. Small to medium size communities from six rural management clusters of the health service (HNEAHS) were selected, with populations between 5,000 and 30,000 people. Participants over 50 years were invited to attend through general staff notices, meetings, email networks and by word-of-mouth. Participants were mainly drawn from the Nursing and Allied Health professional groups in hospital and community health services. A small number of participants were drawn from other sectors, such as Aboriginal health, hotel and corporate services. Information was collated of information from work-sheets completed during small break-out groups and transcribed notes of workshop discussions. Theoretical sampling methods were used to review themes after each workshop, to help guide discussion in subsequent workshops. Participants were encouraged to share and implement ideas locally as appropriate. Draft results were sent back to participants for further comment. A Project Reference Group guided direction of the overall project, including formulation of recommendations.

Participants described **tasks that had become more challenging with age**; and these are reported within a range of contexts. Specific tasks in hospital wards that had become more difficult included reading drug labels and other print communications; administering medications; hearing patients and colleagues at the unit work- station; manual handling of patients and equipment; work in hot areas such as showers; constant hand washing; shift work and long periods of standing, walking or sitting. Delivery of babies (for midwives), patient exercises (for physiotherapists) and the performance of fine motor tasks by other health workers such as suturing and opening packages , were specific procedures described as being more difficult with age. For community health workers,

a number of difficulties were noted relating to use of vehicles and home visiting. Work with computers was a common and significant issue for older workers. Participation in meetings and conferences was also an issue, related to travel, availability and appropriateness of ongoing education and hearing during videoconferencing.

Participants reported ongoing fatigue related to physical and mental workload. **Personal challenges** faced as an older rural health workers included difficulty coping with change; emotional impacts associated with attachment, awareness of mortality, not meeting personal and organisational expectations, balancing work / family commitments; and staying engaged and positive in spite of difficulties.

Personal ageing factors believed by participants to contribute to specific challenges included:

- Deteriorating vision and hearing
- Musculo - skeletal changes affecting strength, dexterity, fine motor co-ordination, muscle tone, flexibility, stability, balance and manoeuvrability
- A sense of becoming slower, tiring more easily, increasing fatigue – with reduced energy levels, stamina, sleep disorders and slower recovery after stress
- Mental fatigue related to difficulties with memory, concentration and more time needed to assimilate new technology and changing roles
- A desire for greater work-life balance, and recognition of changing family demands
- A greater sense of one's own mortality, others ageing and the suffering of others
- Lowered tolerance for negative behaviours of others (eg. self-abuse, rudeness), accompanied by sensitivity to hints of "ageism"
- A sense of greater wisdom gained through experience and the positive contribution one can make as a result of this

Many of the challenges are amenable to interventions that would improve work and life for older health workers. Participants offered a number of suggestions for action at personal, work-supportive and policy levels. These were toward reducing the difficulties and 'tipping the balance' back in favour of a less demanding and more enjoyable work experience.

For example, work supportive solutions to difficulties working with computers, included ergonomic assessment of computer workstations; IT training and support pitched to the needs of older workers; and associated with this, time being allowed to adjust to change and assimilate new learnings. To overcome general fatigue and achieve better work-life balance, flexible work options such as part-time and job-sharing - and access to more leave when needed was desired. Participants also felt being valued in some tangible way by the health service, would be much appreciated.

Examples of policy level solutions suggested included review purchasing policies to find alternatives for (1) medications, where print size and colour is difficult to see; (2) packaging of health products for ease-of-opening. Involvement of workers in workplace design / re-design of facilities to ensure consideration of space and ergonomics was also suggested.

Findings are discussed in light of the literature on issues relating to older workers in general, older health workers and issues for workers in rural areas. In general, study findings support other research that suggests older workers have considerable capacity to manage and cope with job

demands – to a point where personal health, wellbeing and other realms of life take on more importance.

Two key **recommendations** have been made to Hunter New England Health:

1. Older health workers in Hunter New England should be invited to participate in development of *“a resource booklet for older rural health workers”* that draws attention to the physical and mental changes that impact on their work as they get older and outlines the practical suggestions they can make for making work easier, productive and safer. The booklet should be developed and owned by the health workers – eg titled *“Wisdom at Work”*.
2. Hunter New England Health should establish a small *“Task Force”*, comprising managers at local, cluster and area levels, older rural health workers, and an occupational therapist, to examine the research findings and develop supportive solutions for implementation by the area health service. This will include area policy and practice solutions, as well as recommendations for state-wide policy development.

In summary, older health workers in Hunter New England are an essential, committed and productive section of the rural health workforce. Those who participated in this study examining the impact of ageing on their work in the health service were thoughtful and articulate in describing these impacts, and were constructive in their suggestions for how changes could and should be made to make work more enjoyable, safer and productive. There was no sense of negativity, and all groups were keen to contribute to further progress the program. There was recognition that there are things that older workers can do personally to make themselves more fit for the work, and support for bringing in changes to systems of work that would not only benefit themselves, but the whole rural health workforce.

2. Introduction

Building and maintaining a sustainable health workforce is a key priority for health services in the NSW State Health Plan (1) and is the major strategic issue defined for action in the NSW Rural Health Plan (2). Similarly, the *Hunter New England Health Services Strategic Plan – Towards 2010* has a key focus on building a sustainable workforce, as one of its seven strategic directions (3).

Previous research has shown that along with an ageing general population, the health workforce is ageing, particularly in rural areas. The ageing of the health workforce, specifically focusing on general practitioners and nurses, has been well reported in the literature, with rural nurses being older than their city peers, but retiring at an older age than city nurses (4). In 2005, the average age of nurses in outer regional areas of Australia was 46.0 years, compared to 44.6 years in metropolitan areas (5).

The picture for the Allied Health workforce is less clear, with the term itself representing an umbrella for between 12 and 20 different professional groups. In general, the allied health workforce is younger than nursing, with 60% of the Australian allied health workforce being between 25-45 years of age (6). However, of the allied health professions, social workers and psychologists have higher proportions of older workers in their respective professions, with 40-45% over 45 years of age. Rural allied health workers are often older than their city counterparts, as well (7). Both the nursing and allied health workforces are predominantly female, at around 75% (6).

In September 2008, there were 5504 employees of Hunter New England Area Health Service in all professional categories, aged 50 years and over (including full-time, part-time and casual). This represented 36.6% of the total workforce. The nursing sector comprised 45.6% of the total Hunter New England Health workforce and Allied Health 8.4%. Those aged over 50 years comprised 38.3% of all nurses and 22.5% of allied health workers (8).

For the rural clusters of Hunter New England Health, a breakdown of workforce classifications in October 2009 indicated that the proportion of Allied Health workers that were over 50 years was close to the 2008 average of 22.5%, the exception being the Mehi cluster, with no Allied Health Workers over 50 years of age in October 2009. All rural clusters, however, had considerably higher proportions of nurses over 50 years of age. For the Tablelands cluster, 61.7% of the total nursing workforce were aged over 50 years. This was followed by the Lower North Coast cluster with 60.4%; the Upper Hunter (49.1%); Peel cluster (49%); Lower Hunter (47.7%); Mehi (46.8%) and McIntyre clusters (46.2%). This demonstrates the reality of the dependency of the Hunter New England Area Health Service on older nurses in the rural area— a reality likely to be shared by other rural Health Services in NSW and other Australian states (8).

The ageing health workforce, coupled with an ongoing difficulty in recruitment and retention of rural health workers, is a significant and looming issue, impacting upon provision of rural health services, as well as the health service's broader vision for "*Healthier communities: Excellence in healthcare.*" Sustainability of health services in rural areas will be dependent, at least in the short term, on nursing and allied health workers being willing, able and happy to work well beyond middle age. Ageing is associated with recognised physical and mental changes that impact on people's ability to function in the same way as when they were younger (9). The question is, are older health workers engaged in physically and mentally demanding work, facing challenges that differ from when they

were younger? In addition, are the issues being faced by 'rural' health workers, magnified for older workers? That is, are challenges for older health workers in rural areas exacerbated by more complex factors associated with workload, workforce and workplace relations that are non-age related, but for which negative effects may be greater for older workers?

Rural allied health workers

Within the literature relating to the rural allied health workforce little could be found on the particular experiences of older workers. Rather, the research focuses on categorical factors associated with recruitment and retention, which may (or may not) be worse for older workers. High vacancy rates in rural areas within the allied health professions may have more to do with retention than recruitment, with turnover rates in the public sector in the order of 42% within two years (10). However, like nursing, retention of allied health professionals is a complex interplay between personal, environmental and work related factors (11). Reportedly, many practitioners leave rural practice for personal reasons, such as family responsibilities, desire for change, travel and study (10) (12). Others cite variety of work, role responsibilities, social and community connections (including friendships and rural lifestyle), as important personal factors for retaining allied health professionals from dentistry, dietetics, occupational therapy, physiotherapy, psychology, social work and speech pathology in rural areas (11) (13) (14). However, older workers are perhaps more likely to have established community roots.

Professional difficulties associated with allied health professionals leaving work, are associated with organisational commitment and management practices. Although not necessarily unique to rural areas, lack of career structure and input in decision-making, job autonomy, organisational and professional support are often reported as lacking – leading to poor job satisfaction, stress, disillusionment and burnout (7) (10) (11) (14). Occupational therapists and social workers are reported to experience high levels of emotional exhaustion (15) (16). Alternatively, management support, supervision and teamwork were described as important for preventing high turnover of physiotherapists, occupational therapists and speech pathologists in rural Australia (15) (17).

Professional isolation and lack of collegial support are also significant issues for rural allied health workers. Allied health practitioners may be the only member of their specific profession within a small rural community, with colleagues hundreds of kilometres away. This can be exacerbated by limited access to professional development and continuing education (11) (18) (19). A review on the role of continuing education for Australian rural health professionals, concluded that professional development could be seen as 'glue' holding several aspects of employee satisfaction together, lifting staff morale through building confidence, competence and a sense of being a valued member of the team (19). Lack of support or access to professional development; professional isolation; difficulty obtaining relief cover; large caseloads; income and terms of employment; and excessive travel, continue to contribute to difficulties within retaining allied health professions in rural areas (10).

Rural nurses

Rural nursing is increasingly viewed as a nursing specialty, requiring a variety of advanced skills in an expanded clinical or 'advanced generalist' role (20). There is a significant literature around rural

nurse recruitment, retention, job satisfaction and workload - which will not be dealt with in detail here. However, rural nurses have been found to generally enjoy their work for its role diversity; small hospital sizes ; lack of complex organisational structures; interdisciplinary and community interaction and respect (20).

Nonetheless, rural and remote nurses, like their allied health colleagues, have reported higher levels of work stress than urban counterparts. This has been related to lack of replacement staff for leave, longer work hours, distance to continuing professional education workload, extended scope of practice, resourcing and management practices (21) (22). Role diversity requires adequate access to professional education to update and learn new skills necessary to maintain professional competence for rural practice. However, as for allied health, opportunity or access to further education is often reported to be lacking by rural nurses (20).

Other reported stresses include lack of financial and collegial recognition for their advanced generalist role. This sense of being devalued is exacerbated in small rural areas, by the need to undertake more non-nursing duties and excessive documentation, in response to the lack of administrative and hotel services staff. Rural nurses perceive this as a change in priority and focus from delivering quality patient care, to meeting organisational expectations (23).

It would appear rural nurses and allied health workers of all ages experience some difficulties and frustrations with role, organisational expectations and workload. But are the rural health workforce issues felt more strongly by older workers, who may have added challenges associated with the being older? How do older workers experience these broader issues - and what other difficulties might they experience on an individual level, on a day-to day basis? Importantly, what ideas do older health workers have, for addressing the challenges of being an older health worker in a rural setting; and how might health services support them in implementing solutions?

This project attempted to explore these issues by drawing on the ideas and experience of older health workers in rural communities serviced by the Hunter New England Area Health Service. A similar study involving workshops held with farmers across Australia, used interactive discussion techniques to engage older farmers in identifying tasks that were becoming more difficult with age; the physical or mental conditions that related to these challenges; and practical, innovative ways to help overcome these to make farm work more productive and enjoyable (24). A similar approach has been used in this research project.

The objectives of the *Older Health Workers Project* were, therefore, to work with older nurses and allied health workers in rural areas, to:

- identify tasks and aspects of work that have become more difficult, take longer, or are avoided as a result of getting older
- identify the related physical and mental changes of aging that are associated with these difficulties.
- identify and describe work systems amenable to adjustment, that will accommodate the changing needs of older health workers; as well as any personal action workers can take to improve general fitness for work.

- develop recommendations for the Hunter New England Area Health Service to consider, in relation to changes that might be adopted more widely, toward sustaining an older rural health workforce.

Project objectives were aligned with a number of objectives and initiatives of the *Hunter New England Health Services Strategic Plan – Towards 2010*, within *Strategic Direction 6: Build a sustainable health workforce* (3). These will be discussed in light of the project findings.

3. Methods

A qualitative, participatory action research methodology was used to achieve the objectives of the *Older Health Workers Project*. A series of workshops were held with rural nurses, allied health workers and clinical support staff in rural communities serviced by Hunter New England Area Health Service, following approval of the research protocol by the Hunter New England Human Research Ethics Committee (Reference 08/05/21/4.06).

Project Reference Group

A Project Reference Group was established prior to commencement of the workshops and deliberated on three occasions - once face-to-face and twice by teleconference. The Reference Group consisted of ten members, including the researchers, health service management, rural nurses and allied health workers currently working within the Hunter New England Area Health Service. Members were nominated by HNEAHS on the basis of particular areas of practice, location, responsibility or expertise relevant to the Project. After an initial brief, the Reference Group provided practical advice on the conduct and direction of the project, provided feedback after the initial workshop; reviewed the preliminary results and assisted in the formulation of recommendations to the HNEAHS Area Executive Team, which form part of this report.

Selection of communities for the workshops

Five communities were initially selected for the workshops, with the option for further communities pending workshop outcomes. That is, results from each workshop were progressively reviewed in line with theoretical sampling principles, until saturation of themes was obtained and no new information on the subject was arising from the workshops. Small to medium size communities were selected, with populations between 5,000 and 30,000 people. This was with a view to obtaining a 'rural perspective' from older health workers working in smaller, rural health services. Regional representation was also sought, with towns selected from six of the seven rural management clusters of the Hunter New England Area Health Service (HNEAHS).

Recruitment and consent of participants

For each workshop, a local contact such as the Health Service Manager or their representative was contacted to assist in arranging the workshop, including a venue, catering and helping to ensure health service staff knew about the workshop. The latter was done by placement and/or circulation of a general staff notices about the workshop at staff meetings, through staff email networks and by word-of-mouth.

The invitation to participate was directed toward workers over 50 years of age, although this was not a formal condition of participation. A copy of the generic notice of invitation is provided in the appendix. A proposed strategy to invite participants via a systematic notice on personnel payslips did not proceed due to the logistical difficulties with workshop lead times and inability to sufficiently localise messages. At the outset of each Workshop, participants were given a general explanation of the purpose of the research and a participant information sheet with further details (see Appendix). After opportunity for questions participants signed a formal consent form prior to involvement in workshop discussions.

Collation of information, feedback and opportunity for further action

Information shared through the workshops, was recorded primarily by means of work-sheets completed during small break-out groups supplemented by notes taken during the course of discussion. Themes were reviewed after each workshop, to help guide discussion in subsequent workshops, consistent with theoretical sampling principles and techniques. Participants were encouraged to share ideas for making work easier with colleagues after the workshop. It was agreed that confidentiality of 'who said what' was to be maintained. Participants were also encouraged to follow-through with these where relatively easy to implement locally or personally – and whilst the research was still in progress. This approach is consistent with participatory action research methods.

After collation of information from all the workshops, themes were sorted and organised in a sequence moving from (1) particular tasks and specific workplace settings, to (2) more general aspects of work and broader settings. Total separation of themes was not always possible with some responses being relevant or applicable to more than one theme. The combined results were forwarded back to those participants who had provided a contact address (ie. mail or email). Participants were invited to reflect on these and forward any further ideas for incorporation into the research findings. This cycle of feedback and incorporation of evolving ideas is also consistent with the principles of a participatory action research. Following this process, the Project Reference Group convened to consider the findings and develop recommendations for the Hunter New England Health Service.

4. Results

4.1 Sample characteristics

Six workshops were held, with an average of 13 participants in each (ranging from 3 – 27 participants). The workshops were conducted in the communities of Singleton, Inverell, Glen Innes, Narrabri, Gunnedah and Taree. These communities corresponded with the Lower Hunter, McIntyre, Tablelands, Peel and Lower Mid-North Coast clusters of the Hunter New England Area Health Service respectively. The location of each of community is highlighted in Figure 1 (indicated by arrows), in relation to facilities and area serviced by Hunter New England Area Health Service.

Overall, eighty participants aged 50 years and over took part in the Workshops, four of whom were male. Participants were mainly drawn from the Nursing and Allied Health professional groups, that were the focus of recruitment efforts. Fields of practice of participants from Allied Health included

radiography, occupational therapy, diversional therapy, physiotherapy, social work and psychology. Fields of practice for participants of the nursing sector included registered nurses and enrolled nurses from community health, aged care, general hospital wards, operating theatres, CSSD, midwifery, emergency departments and health service management.

A small number of participants were from other professional groupings as defined by HNEAHS workforce informatics (less than 10% overall). These were from ‘other professional, para-professional and clinical support staff’ (Aboriginal health), ‘corporate services’ (clerical administration) and ‘hotel services’ (catering). Whilst a range of professional fields was represented, the majority of participants worked regular office hours. Some shift workers were represented, however, with other participants having worked shift work in the recent past being able to contribute to discussions on issues for ‘shift workers’.

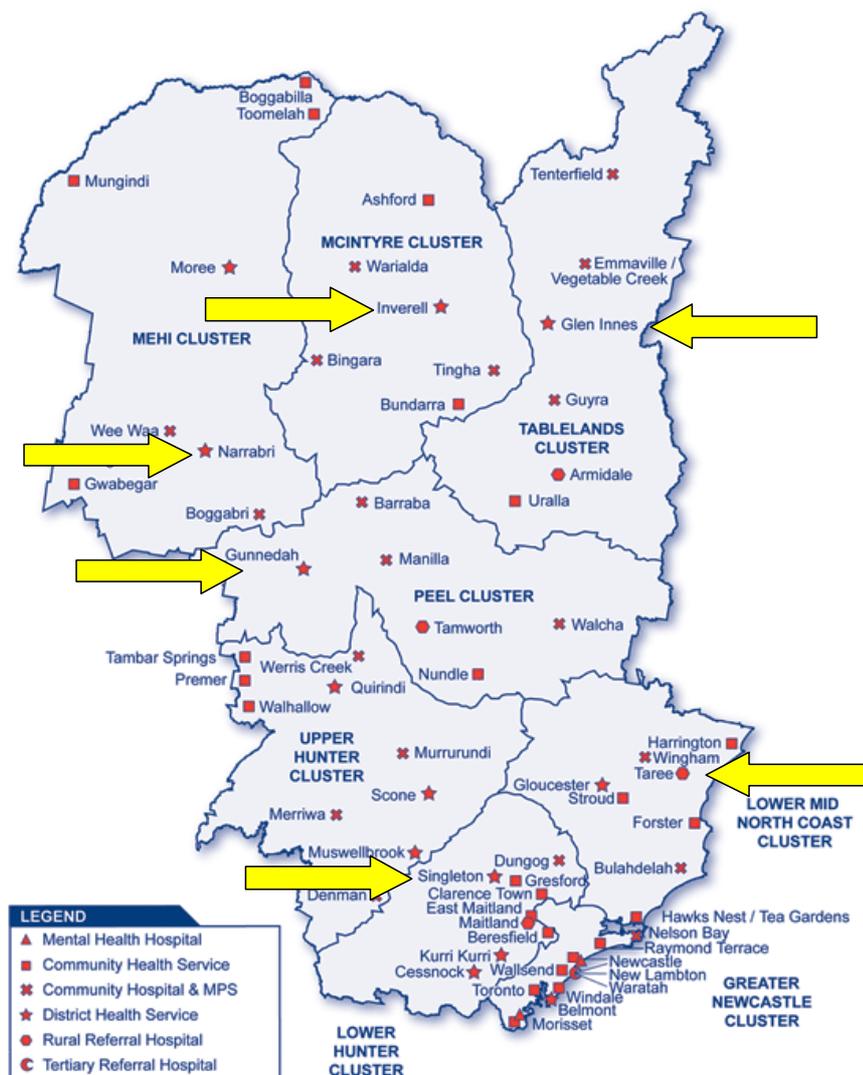


Figure 1. Location of *Older health Workers Project* Workshops, in relation to the facilities and region serviced by Hunter New England Area Health Service.

4.2 Tasks that have become harder, take longer or are avoided as workers have become older

The tasks that were listed and described by participants as being harder to undertake as they have become older have been organised in the first instance into the specified work settings, or contexts, within the work is carried out. The lists move from the specific to more general work settings, and then to the general challenges posed by work in the health system as an older worker. There is a degree of overlap in the way information is organised. Table 1 lists the tasks and challenges identified by older health workers as having become more demanding with age. Details describing the nature of the challenges, relevant personal ageing processes and work system factors that exacerbate the difficulties experienced are then outlined in more detail.

Table 1: Tasks reported by older health workers to have become more challenging with age

Work context	Tasks that have become more challenging
1. Work in hospital wards	<ol style="list-style-type: none"> 1. Reading drug labels and information sheets 2. Administering medications 3. Reading other print communications 4. Hearing at the ward work- station 5. Hearing patients 6. Manual handling - lifting and / or moving patients and equipment 7. Work showering patients and in hot areas 8. Constant hand washing 9. Shift work 10. Long periods of standing, walking or sitting
2. Undertaking specific procedures	<ol style="list-style-type: none"> 1. Midwifery – delivery of babies 2. Physio work – in particular patient exercises 3. Fine motor tasks – suturing, opening packages
3. Community health - work in the community	<ol style="list-style-type: none"> 1. Work involving vehicles 2. Work involving home visits
4. Work with computers	<ol style="list-style-type: none"> 1. Use of computers and technology
5. Participation in meetings and conferences	<ol style="list-style-type: none"> 1. Travel to meetings and conferences 2. Participation in ongoing education 3. Hearing speech in video and teleconferencing
6. Meeting workplace demands as an older worker – all settings	<ol style="list-style-type: none"> 1. Mental workload and fatigue 2. Meeting the general demands of the job as an older health worker
7. Personal challenges faced as an older rural health worker - general	<ol style="list-style-type: none"> 1. Coping with change 2. Emotional impacts of attachment, loss and awareness of own ageing and mortality 3. Emotional impacts of increased overall workload- but reduced clinical time, standards of care and not achieving personal goals 4. Emotional impacts of not meeting / fulfilling expectations of others 5. Balancing work / family life commitments 6. Staying engaged and positive in spite of difficulties

Work in hospital wards

Reading drug labels and information sheets

Deteriorating vision was the main reason given by participants, as to why reading drug labels had become more difficult with age.

This was exacerbated by other factors such as:

- Poor lighting at night and from environmentally friendly bulbs
- Fluorescent lighting – perceived as being ‘hard on the eyes’ by some participants
- Small size of print on medication labels, ampoules, foil imprints and drug information sheets
- Colour of print – eg. orange or red writing on ampoules used for injections
- ‘Clouded’ plastic sleeves enveloping IV flasks for sterility purposes, making print on the flask more difficult to read and identify, prior to being opened.
- Changes in light levels between environments
- Tendency to lose reading glasses, due to being on and off continually

Administering medications

Difficulties with administering medications were directly related to difficulty with cracking ampoules, administering IV medications and removing IV lines. Opening medication packaging, lids, jars, plastic overwrap, boxes with tape, seals, child proof packages and IV fluid bags, were all listed as being more difficult for older workers, than when they were younger.

Age-related factors specific to these tasks included:

- Reduced strength in hands and wrists
- Pain in hands and wrists
- Reduced fine motor co-ordination and dexterity
- Increased cramping of fingers

These difficulties were reported to be exacerbated further by:

- Smaller packaging
- Environmentally friendly gloves

Reading other print communications

Again, deteriorating vision was the main reason given by participants for this difficulty, exacerbated by similar factors as given for reading drug labels above. In addition, doctors’ hand-writing was considered more difficult to read when vision was already deteriorating. The small size of mobile phone keypads and text messages also was reportedly a problem - and computer work was generally believed to contribute to eye strain.

Hearing at the nurse-unit station

Hearing the conversation of colleagues at the ward station was described as a challenge with increasing hearing difficulty associated with ageing (some workers reportedly having noise-induced hearing loss). Health workers had difficulties hearing drug orders, other instructions, phone conversation and other ward staff. Some participants expressed anxiety about distinguishing or missing alarms, due to the high level of background noise at the ward station.

Factors reported to exacerbate the problem were:

- Accents of some medical officers of non-English speaking background
- High background noise level of general wards (eg 32 bed ward with open office)
- Distractions - constancy of phones ringing, others talking – making it difficult to focus or concentrate
- Where there's a crowd
- Speech of younger staff

Hearing patients in the ward

Hearing patients in wards was also reportedly more difficult due to age-related hearing difficulty. The difficulties were exacerbated by similar factors such as background noise, conversations and clatter.

Manual handling - lifting and / or moving patients and equipment

Physical work and manual handling tasks have become more difficult for workers as they are older. Specific ward tasks that have become more difficult include:

- Examining patients
- Dressing patients – putting on shoes and socks, adjusting clothes
- Holding limbs and draping surgical patients
- Pushing / pulling equipment (eg beds)
- Pushing / pulling patients on chairs
- Showering patients
- Toileting in difficult areas
- Transporting objects, records
- Squatting or kneeling - for procedures
- Picking things up off floor (eg getting slippers)
- Walking up and down steps
- Doing dressings
- Making beds
- Adjusting bed heights

The age-related factors for workers that contribute to making these tasks more difficult include:

- Musculo-skeletal changes affecting strength, muscle tone, flexibility, stability and balance
- Increased pain, stiffness (+/- osteoarthritis) in joints – hips, knees, hands, feet, neck and shoulders, back

Further, many reported that manoeuvring is generally more difficult when one is older – with the 'fuller' figures of both patients and staff.

Other factors exacerbating or contributing to the problems reported include:

- Poor manoeuvrability of some equipment, including poor maintenance
- Poor workplace ergonomics and design of facilities (old)
- Narrow bathrooms and doors - don't allow room for lifting aids
- No shelves or poor position of shelves
- Uncooperative patients
- All-in-one gowns, making it difficult to examine patients.

Showering patients and other work in hot areas

A number of female health workers reported discomfort associated with working in hot areas, in particular showering of patients in hot / enclosed bathroom areas. They reported intolerance of heat and heat sensitivity, believed to be brought about by menopause.

The problem has been reportedly exacerbated by:

- Lack of exhaust systems in many showers
- Sharing the ward space with younger colleagues and those who do not mind a hotter environment.

Constant hand washing

The need for constant hand-washing associated with ward work was well accepted. However, older workers reported experiencing painful, cracked skin associated with their drier, thinner skin compared to when they were younger. Some reported skin sensitivities and allergies associated with past chemical exposure (eg. operating theatres).

Shift work

Older ward staff reported increasing difficulty in dealing with shift work, particularly relating to 10 hour shifts, longer shifts, more shifts, double shifts, early shifts, and split shifts. With increasing age, workers commonly reported:

- Tiredness – especially after lunch
- Reduced stamina from physical demands on body
- Longer recovery - " takes 2 days to get over a double shift"
- Lack of sleep, disturbed sleep patterns - waking at 3am
- More anxious, worrying, not dealing with lack of sleep as well as before
- Strong work ethic of older workers - " If you were younger, you would just go off"

The problems were being exacerbated by:

- Being on call
- Inflexible work hours
- Lack of staff , "can't go off sick - no one to replace you"
- Unable to take time out to recover
- Insufficient rest times between rotations and being on call
- Do not accrue time in lieu

In general participants reported that as older workers they had become more resistant to shift changes. They like order and don't want work to impact on their private lives any more.

Long periods of standing, walking or sitting

There were some apparently conflicting difficulties associated with either standing or sitting for lengthy periods (eg, operating theatres and at desks doing data entry) but also with walking, standing and being on one's feet for long periods. It was felt that there has been unnecessary walking associated with layout of some units. With increasing age, health workers reported that it is harder to get mobile quickly after sitting due to stiffness and back problems; and that being on ones feet causes back pain and sore feet and joints more readily than when younger.

The problems are being exacerbated by:

- Poor design of computer work stations
- Design of facilities - long distances to medication rooms, utility rooms ie, the distance to get a Panadol™ or a 'pan' is... "too far and takes too long".
- "Running phones up and down - having to leave what you are doing"

Some specific hospital procedures

The following are some specific hospital and health service procedures reported to be more difficult for older health workers. The list is not exhaustive, and in particular, other work undertaken by allied health professionals has not been examined.

Midwifery

The physical work of delivery of babies was reported to be more difficult for older midwives. In particular, long periods of leaning over beds, bending, being on ones feet, and being on the floor with mothers, is more challenging due to back pain and joint stiffness.

The problems have been exacerbated by:

- Current options for birthing mothers - including birthing positions, birthing chairs.
- Presentations are now more complex, with more requirements

In the view of a number of older nurses: “I think (these are) reasons why some older nurses no longer practice midwifery”

Physiotherapy

While older allied health workers contributed significantly to the observations made in other sections, the only specific physiotherapy task reported to have become a greater challenge with age was related to assisting with patient exercises. Specifically the activities associated with bending and reaching over beds to do patient exercises is more difficult due to back pain and stiffness of older physiotherapists.

The problem is made worse in rural health settings where physiotherapists are more likely to be sole practitioners, having no immediate help with exercises.

Undertaking tasks requiring fine motor skills

Older health workers reported increasing difficulty with a number of fine motor tasks as they are getting older. These tasks include fine suturing, writing, opening things such as packages, lids, jars, plastic over-wrap, boxes with tape, dressing packs, seals, child proof packages, IV fluid bags

Age-related factors associated with these challenges include reduced strength in hands and wrists, reduction in fine motor co-ordination, reduced dexterity. The problems have been exacerbated by:

- Smaller packaging
- Environmentally friendly gloves

Community health - work in the community

Work involving vehicles

The following were commonly reported tasks involving vehicle use that have become more difficult with age include:

- General driving during the day
- Getting in and out of cars and/or the Day-care bus
- Carrying equipment to and from vehicles and homes (eg baby scales)
- Reversing

The following personal factors were associated with difficulties with vehicle use:

- Arthritis, sore joints, backaches - caused or exacerbated by vehicles and driving
- Less flexibility, manoeuvrability for getting in and out of cars
- Harder to turn around to look behind / harder to see out of cars

Community nurses noted that they have become more fatigued for report writing, after driving around during the day.

These difficulties are exacerbated by:

- The ergonomics of smaller and lower cars – described as “Hard to in and out of”, not comfortable, often with poor seating and lacking proper back support for travelling distances . “The Astras, as an example, are too low – you have to ‘roll out of them’”.
- On the other hand, the “Subaru Foresters are no good for getting wheelchairs in and out.”
- A green policy of smaller cars
- Day-care bus - jumping up and down, in and out of the bus
- Tight time frames (rushing)
- Car parking arrangements for health service cars
- General safety issues related to night and long-distance driving (eg. vision, fatigue, time allowed)

Work involving home visits

Work involving home visits have become more challenging for older community health nurses - in particular:

- Carrying equipment to / from vehicles and homes (eg baby scales)
- Moving around in cluttered houses - trip hazards

Greater difficulty is reportedly due to:

- Arthritis, sore joints, backaches - caused or exacerbated by vehicles and driving
- Mobility and stability on feet (with clutter)

Work with computers

Computers and use of information technology is seen by older health workers as a good and natural progression of service delivery - replacing written charts in emergency departments, operating theatres, community health etc, with most nursing records on computer. The benefits of the increasing use of computers and information technology in provision of improved patient care was accepted and embraced by all participants in the workshops.

However, many participants reported real difficulty, as older workers, with adoption of new technology. Indeed there was a view in several workshops that this has represented such a big change that its “a reason why some older workers won't come back (to nursing) because of the computer work – they're not computer literate. Yet some are the best nurses”.

“Some have even left because of the computers... or some can't work in ED ... because they can't use the computer.”
“Computerised records immediately affect those not confident on computers - can be a really good RN, but may not have the computer skills.”

Difficulties that were reported included:

- Physical aspects
 - Use of mouse – painful hands, carpal tunnel
 - Lack of keyboard dexterity
 - Difficulty seeing screens
 - Musculoskeletal problems sitting at computers for long periods for data entry
- Mental aspects-

- Difficult to rapidly begin use of new technology
- Difficulty in learning new programs and changes to programs
- Remembering passwords
- Interpretation of computerised results, and use of statistics

Reported age-related factors associated with these difficulties included:

- Being more tired at the end of the day, when computer work is required
- Musculoskeletal pain and stiffness – affecting neck and shoulders
- Stiffness when sitting for long periods
- Arthritic and other hand conditions affecting use of mouse
- Eye and vision problems, including headaches with bifocals, and difficulty seeing small font/print –writing too small in instructions (eg. CHIME)
- Historical-generational learning factors, for example:
 - “All new to us - so we are slower to pick it up”
 - Less education when younger and computers not part of early career training
 - We learn differently- we are more practical people
 - Not having computers at home, “not part of my life”, “not growing up with computers”

These problems reportedly have been are exacerbated by:

- Ergonomic factors:
 - Sitting more - less active
 - Posture and chairs for computer work - some computers being badly set up, on a bench
 - More clicking on the mouse required for newer programs (eg. CHIME)
- Availability of computers to do the work – not everyone has access to computers
- Systems and procedures – ‘more cumbersome than paperwork – a maintenance request takes longer than it does for the maintenance man to come and do the job’
- IT education provision
 - Not enough education given - "2hrs and there you go"
 - “IT trainers assume a skill level that is not necessarily so”
 - “‘Helpdesk’ is on the computer... but we need the help in hardcopy”
- Shift and casual work
 - “Harder for shift workers to adapt to computer”
 - Frequency of use – “how often you use it is a factor - if only once every 3 weeks, then its hard”
 - “In community health and emergency department it’s definitely harder for older casuals ... even remembering passwords... After coming back from leave, its changed again”
- General lack of support to assist older health workers become confident with new technology
 - “Made to feel inadequate, felt pushed aside by younger workers.”
 - “Go to the IT gurus... you can't get them. I work alone, no younger ones to .. help”
 - Tendency to avoid new technology due to difficulty with equipment

Participation in meetings and conferences

Participation in education and business meetings and conferences was reportedly more difficult for older rural health workers.

Travel to meetings and conferences

Travelling distances for meetings and conferences becomes a greater strain as health workers get older, particularly if distances are great and if night driving is involved.

" Once upon a time I could get in a car and drive to a meeting at the end of the day.
Now I can't do that."

Age-related factors associated with increased difficulty included:

- Less stamina or staying power for long distance driving
- Vision is not as good for night driving, and glare of lights and bright signs causes problems.

These problems have been exacerbated by:

- The poor ergonomic features of smaller and lower cars
 - Not comfortable, poor seating
 - No proper back support for travelling distances
- Green policy of using smaller cars

Participation in ongoing education

There were a number of important issues of concern for older rural health workers in ensuring their participation in ongoing education and training. These issues related to:

- Accessing available courses and education opportunities, and being overlooked for courses on the basis of age
- Challenges associated with learning new skills

Age-related factors reported to be associated with these difficulties, mainly related to learning new concepts and skills as an older person. The problems are being exacerbated by:

- Difficulty finding time to go and attend
- Finding the time to read about courses with "119 emails!"
- Locations are often hard to get to
 - Usually hours away - time to get there and back
 - Very early leaving and very late getting back
- Attitudes toward older workers participating or showing interest in courses
 - Offered to younger staff in preference
 - Being or feeling overlooked for courses .. "you'll be retiring soon" yet a belief it is more likely older workers will stay in one place for longer
 - Not being valued in wanting to do continuing education ... comments like "Why you would bother at your age"

On the other hand, it was recognised that some older health workers "flatly refuse to go... or change... or learn. This doggedness doesn't help those who want to!"

Hearing speech in video and teleconferencing

While video and tele-conferencing is seen by many as a good solution to communicating and learning at a distance, these pose problems for those older workers with hearing impairment associated with age or previous noise exposure.

Meeting workplace demands as an older worker – all settings

There are a number of common problems for older rural health workers that occur in all work settings or contexts, some of which have been reported above, but need to be recognised in their own right as issues for recognition.

Mental workload and fatigue

This problem manifests itself in terms of:

- Difficulty with keeping up with the paperwork that seems to keep growing
- Remembering things - reduced recall
 - Passwords
 - Names - getting clients names mixed up ... “usually comes to you after a while”
- Keeping up with emails and other required reading
- Keeping one’s mind on the task at hand
- Managing stress and burn-out

“There is so much paperwork - so many forms!. What its for, who to send it to .. Then it changes!”

Age related factors that were recognised as being associated with these difficulties included:

- Memory not being as good - need to write things down but can forget where the list is - ‘what did I come in here for (storeroom)?’
- Added stresses affecting cognitive function
- More difficult to concentrate for long periods and with distractions
- Mental fatigue leads to tiredness

These problems are being exacerbated by:

- The pace and constancy of change
- More ‘hats’ to wear – of importance in rural health services
- Variety of tasks and multi-tasking
- Information overload
 - Email - never getting to the end of it
 - Increased amount of reading within tasks
 - Too many meetings
- Stress and expectation to have “stuff in your head”
 - ‘new stuff’
 - Passwords (see computers)
- Expectation of clients that you should remember their names
- Pressure of meeting several demands at once
 - So many things all needing attention at once - phone calls, staff asking for items, patient wants you particularly. “When people want 5 things at once - trying to remember it all”
- Lack of enough staff to cover duties

These problems are reportedly have adverse longer-term impacts for many older workers who reported feeling “always stretched”; “physical and emotional stress”; “less happy, less tolerant” etc.

Meeting the general demands of the job as an older health worker

The overall demands of physical workload and mental stresses appear to compound for older health workers. The ageing processes that were reported to be associated with the problems of 'general work demand' included:

- Musculo-skeletal changes affecting physical strength and flexibility,
- Reduced stability
- General tiredness and fatigue – specially after lunch
- Difficulty focusing for long periods
- Reduced fitness and endurance
- Reduced energy levels
- Loss of weight (or gain)
- Slower physically - takes longer to do things - including routine tasks , can't walk as quickly
- Always stretched, physical and emotional stress, less happy, less tolerant (some more tolerant)
- Slower recovery time following stress and illness

The problems were seen to be exacerbated by:

- A sense that there is more to do, not enough time to do everything, or do it well
- More work to be done when we are less able to do it
- Health workers are not the healthiest people
- More complex work roles – routines and responsibilities have changed - admission / discharge procedures
- Patients (and the wider population) are older, heavier- and so are we
- Sicker, more dependent and debilitated patients than in the past

"It's just harder when things mount up at end of the day."

Personal challenges being faced as an older rural health worker

Workshop participants commonly reported personal challenges associated with continuing to work in the rural health services as older workers. These are not related to specific tasks, but many may have solutions that will attract workers to remain longer at work, and so should be included as key findings from the workshops.

Coping with change

At the time that workers are getting older and reporting less capacity to adapt to change, the nature of health work and the organisational arrangements around work is changing at an increasing pace. Sudden changes can create greater problems for older workers.

On a broader scale, role change has been a specific challenge. For example, "As Enrolled Nurses our job has totally changed - we didn't do paperwork, pills, reports etc previously, now it's expected"

Participants indicated that the age-related factors contributing to difficulties with change included:

- Subdued mental reflexes
- Need more time to assimilate (knowledge / change)
- Less /lack of adaptability

- Less tolerance for supposedly 'new things', for acronyms, for 'reinventing wheels'
"What goes around comes around, a revolving door of ideas, ... you've done it before and nothing ever came of it"

The problems were reportedly exacerbated by the following:

- "So many changes in health service over past 15 yrs"
- Constant change - before assimilating / adapting to the previous change - "a new system every year, you learn it, then it changes again"
- Change not always justified, or for the better
 - "(Systems...) often change to something that doesn't work as well (eg. 8 codes to 15)."
 - "It sometimes seems change is brought in for change sake, like cost centre codes changing 3 times within a very short time)"
- Change is often associated with increased paperwork requirements or new computer programs, and these are difficult for older health workers
- Experience of older workers not valued – "people don't ask us (about the change) - opportunity not provided for comment"
- Casual workers - not always working - don't know about changes

Again, it was recognised by participants that some flatly refuse to change or learn, and this makes it more difficult for others who want to give it a go and learn and adjust to new requirements.

Emotional impacts of attachment, loss and awareness of own ageing and mortality

There are some very specific problems for older workers in the health industry and some that are specific to working in rural communities over a period of time. These include:

- Dealing with emotional stress after episodes in acute care
- Deaths of older people, who are often well-known to self – either as patients who have been cared for over a long period, or as friend or relatives in rural communities.
- Feelings of loss and grief associated with colleagues leaving
- Coming to work with younger colleagues who are not familiar with the shared history

The age-related factors associated with these difficulties were reported as:

- Being increasingly confronted by the ageing process in clients, colleagues
- Dealing with ageing in clients and own ageing / mortality
- Slower recovery from physical and emotional stress
- Difficulty sleeping

"The death of older people affects us more as we age ourselves – they're closer to our own age now"

These issues are exacerbated by:

- Patients are becoming peers - "now you know them, they're not just a patient" (bonds formed over any years)
- No debriefing available

Emotional impacts of not achieving personal professional goals – high workloads, reduced clinical time and lower standards of care

The impact of not achieving personal professional standards was reported by many participants. It was observed that the physical stresses that had been reported have associated emotional components. Whether the impacts have been derived from the ageing process, or the increased

demands of the job, there was commonly reported a sense of change - from provision of total patient care to something less, with lower standards of care being delivered.

“It’s not the work you do, it’s the work you cannot do that is frustrating and emotionally distressing and results in less job satisfaction.”

The age-related factors contributing to these problems for older health workers included:

- Self-awareness that things take longer - and that also creates a higher workload
- Slower recovery from physical and emotional stress
- “Stresses are compounded because you are older - no longer have the hormones and adrenaline rush, but have a menopausal effect”
- “You know you can do it, but you get tired, stretch yourself and are less happy, less tolerant”

Problems are exacerbated by:

- Its hard to say no to physical work required (ethic)
- Lack of time to achieve high standards of care
 - “Awareness of not completely achieving the standard of care that should be done. There’s guilt, frustration from experience of better care days. Guilt, frustration, not taking pride and poor job satisfaction, because it’s a standard you don't have time to achieve... and younger ones don't know any better to take up the task of better standards of care”
 - Less patient time and reduced client contact due to more computer entry / notes
 - “CHIME / Oracle / Proac - all take time away from patient care”
 - “ Less (time now)than when we (only) wrote notes – a doubling up, as we write field notes, then computer notes”
 - A lack of understanding by higher executives / management of the encroachment of administrative work on clinical time
- Declining work conditions over the years - shared offices, technology, work cultural changes

Emotional impacts of not meeting or fulfilling expectations of others

Older workers reported emotional impacts of not being able to meet the expectations of care and service of others, including expectations of patients, the organisation (relating to workload) and of peers. There were also emotional stresses associated with supporting other staff and being the ‘stable’ staff member. As stated previously, participants recognised that as they have aged they are generally less able to cope with stress and changing roles.

The problem has been exacerbated by higher *patient expectations* and needs:

- Higher needs - greater problems associated with increasingly overweight patients with chronic disease and palliative care patients
- Higher expectations -
 - Of recovery and recovery time “fix it”
 - A "Macca's Medicine" service delivery model - clients ‘want it now’ and are more often intolerant or rude”.
 - “In our way of dealing with it (we respond) ‘there's a queue, but you will be treated the same’. Then we are accused as being ‘grumpy old so and sos’ (by demanding clients)”

High *organisational expectations* include:

- Workload is too excessive to deliver quality patient care - and it’s frustrating. For example,
 - “We can't get done in a day what you want or are expected to do”

- “Not enough time to get things done - so much more to do now“
- “Not understanding we need more help, but the resource is not there”
- Increased emails and reading time required
- Required to learn and absorb 'vast' amounts of knowledge to perform job
- Stress of increasing time needed to perform / document non-clinical tasks – but expected to be completed ASAP
- Documentation driven by fear and/or risk of litigation - considerable time involved writing up clinical notes, reviewing correctness
- Pressure to take work home
- Workforce issues:
 - Recruitment
 - “In rural areas, it’s getting harder and harder - we have to start thinking where we are going to get our workforce. There's a mass exodus and there's nothing coming in. We need a different view of health work”.
 - The recruitment process is exhausting
 - Contractual arrangements instead of secure positions – creating uncertainty
 - ‘Reconnect’ - “A lot of those returning to work through 'Reconnect' have a miniscule time to adjust, are then thrown into situations beyond their training, then drown and leave. Then the younger ones think older workers are 'old farts’”
- Supporting newer staff
 - “Others revolve, rotate around you and you have to take on more of the support / responsibility role”.
 - “Staff expect a lot of support from you - yet see less clients”
 - “Undercooked new graduates - need a lot of support”
 - “Students are more demanding”

Balancing work with family life commitments

Older health workers reported increasing difficulty associated with juggling work and family commitments and need more time to fulfil all commitments. Further, many reported no time for themselves – recognising the need for attention to health and fitness.

Age –related factors of relevance to meeting these needs include:

- Recognition of the importance of one’s own health issues, including the need for health appointments, often with specialists
- Coping with many facets of life and keeping mind on the job
- Less energy to do these tasks as get older
- Wisdom with age – recognition of the greater importance of balancing work and family life

Many older health workers reported generational challenges related to:

- An increased carer role in family
 - Ageing parents
 - Growing children and their children – looking after grandchildren
 - Looking after spouse, older parents, adult children during sickness or disability
 - ‘Home things’ - going home to do more physical work

“At our age, we have children growing up, with their children, and elderly parents... the main carer”

“As you get older, you need to help support the family more, responsibility falls on you as the carer role... but the expectation is still to come to work.... A guilt feeling”

“When finished work, still carrying the bricks - caring for our own sick elderly”

Meeting carer responsibilities was made more difficult or exacerbated by:

- Other shift workers in family
- Split days off
- Distances to travel to see family
- Marital issues

Staying engaged and positive in spite of difficulties – attitudes

Older health worker participants were keen to remain engaged and make a positive contribution to delivery of good health care in their community. Personal changes occurring due to ageing that were reported as relevant to maintaining a positive outlook included:

ON THE ONE HAND:

- Being less capable of dealing with the increased physical /emotional workload posed by demanding patients
- Tolerance is often lower for rude people - "You get to an age where you say - hang on, you can't speak to me like that." "I'm less tolerant and so are patients - intolerance is much more common."

IN CONTRAST:

- "I've become more tolerant", and
- Wisdom has been gained through experience
 - "As you get older, you realise you can't fix things... you can only do so much"
 - "We have a way of thinking, because its our experience" ... "we know how things work best"
 - "We have the greatest organisational wisdom – but its not valued..."
 - "Easier to be more cynical when older, as seen it all before and things don't change"
 - "Older, wiser, notice it more"

There was a general understanding within groups around a "psychology of ageism". Many reported:

- A heightened sensitivity to snickering, patronising tones, being more sensitive to criticism getting older - "Its easy to feel devalued as we get older... we need to work around that."
- But also, an interest in working through common issues - to work out solutions.

However, these age-related sensitivities were exacerbated or challenged by a number of factors that contributed to feelings of inadequacy or negativity. Many, but not all workers, reported real difficulties in maintaining tolerance for (1) the attitudes and behaviours of patients; and (2) the attitudes and behaviours of the organisation and younger workers.

- Attitudes and behaviours of patients
- Increased stress and physical risk posed to workers by patients who:
 - Are rude and/or aggressive
 - Have lifestyle and / or dependency illnesses - eg. drug and alcohol issues
 - "We see more self - abuse, which is very hard to handle"
 - "Those who won't help themselves or get onto something to get to the next stage, ... (but) ... expect us to do everything for them"
 - Display destructive or undermining behaviours
- Attitudes and behaviours of organisation:

- Organisation's 'revolving door of new ideas'
 - "Reliving the same thing, never any outcome ... keeps coming around, going around ... all in circles... So, we tend to step back, not get involved ... then work gets boring"
 - "Why didn't they just come and ask me?"
 - "We withdraw a bit when they come up with another new/old idea. It's called self-preservation"

- Organisation's indifference to workers' initiative
 - "Sometimes when we come up with good ideas, we are told 'there's no money', so you think 'why bother' and withdraw and get cynical"
 - Wisdom, experience and skills of older workers not valued - though usually been with the organisation for many years
 - Older workers not encouraged to contribute... seen as "hospital trained nurses with skills, not knowledge"

- Negative attitudes to ageing –
 - Assumptions that "... because we are older , we don't have family commitments
 - Won't need to go on a course because "...you'll be retiring soon"

- Attitudes and behaviours of younger workers:

- Interpersonal communication with younger staff can be difficult, including the language and sayings used

- Perceived difference in the work ethic of younger people –
 - "Younger workers don't do the whole job, do the bits they like and leave the rest"
 - " Younger staff see 1/2 the client base and don't expect to see more"
 - Younger ones (seemingly) less compassionate and less committed
 - No longer have a hierarchical system, (so).... " 1st year students don't know how to do anything... then they go off to do an assignment"
 - "Young workers don't go into clinical work... channel off into project management".
 - " If you point something out to them, they accuse you of bullying"
 - "Some of the younger ones have this saying that ticks me off... it is... 'she's just an AIN' or ... 'just an EN'. These are the ones who have been (here) for years.."

- Lack of respect for knowledge and skills
 - A perception that "oldies don't know much"
 - "I had and have respect for older people, whereas, the respect isn't really there for us from younger workers - not respectful of older workers."

ON THE OTHER HAND, some participants described examples of good working relations between generations

- "Not in our team, we work well and communicate well"
- "Beware of generalising - there are exceptions" – and - "some older RNs don't respect some of the skills EN's are now using, either".

4.3 Potential solutions and effective interventions

At each workshop, there was opportunity for the group to consider possible solutions for just a few of the problems that they had identified and described. There was a universal interest and readiness to consider practical solutions that would make work easier and more efficient, and a common theme that emerged was the interest in regaining some of the sense of value for the contribution that is being made by older workers in the rural health services. There was a recognition of the role that Hunter New England Health played in initiating the *Older Health Worker Project* and a wish to be engaged into the future in identification and development of solutions – not just to ‘keep the workforce’ but to ensure high levels of morale for the older sector of the rural health workforce.

Solutions that were considered by participants fell into three categories:

1. **Personal solutions** – things that older health workers can be encouraged to do to make them more fit for the work they are doing; and that will make work easier and more enjoyable
 2. **Work-supportive solutions** – these being changes that could be made by the Area Health service, or often by the local health service, that would make tasks easier and work more fulfilling for older health workers
 3. **Policy-level changes** – that may require higher level changes in, for example, purchasing policy, building standards etc.
11. These were tabulated and sent back to participants for further input /comment . For example – in relation to the problem “*Reading drug labels and information sheets*” described above, the following solutions were suggested:

Table 2. Solutions suggested by participants for difficulties ‘*Reading drug labels and information sheets*’

Personal solutions	Work-supportive solutions	Policy changes suggested
<p>Most importantly - acknowledge impact of ageing process on sight</p> <ul style="list-style-type: none"> • Discuss with optometrist - ?bifocals, graduated lenses • Be ready to ask for assistance • Chains for glasses • Develop routines – where you put glasses, or a cheap extra pair where reading required 	<ul style="list-style-type: none"> • Magnifying glass - drug trolley, emergency trolley, drug cupboard, clinical room (any infection control issues could be worked out) • Lights – if enviro-friendly bulbs, then need more / better placement • Clean lights - maintenance 	<ul style="list-style-type: none"> • Print on medications needs to be bigger, black • Colour and size of print on vials needs attention – unsafe at present.

Solutions suggested by participants for “*Work with computers*”, is shown in Table 3. Compared to the previous example, which had a balance of personal work-supportive and policy-level solutions proposed, it is noted that most solutions suggested by participants for working with computers were workplace-support related. No policy-level solutions were proposed, although it could be argued that some of the work-supportive solutions would require system-wide support.

The general suggestions following Table 3, have been made for meeting some of the difficulties described in the workshops. These will be included as part of further work in developing and promoting solutions for individual health workers, local health services and the Hunter New England Area Health Service more widely.

Table 3. Solutions suggested by participants, related to 4.3 'Work with computers'

Personal solutions	Work-supportive solutions	Policy changes suggested
<p>Action to develop skills:</p> <ul style="list-style-type: none"> • Learn and use keystrokes where possible • Day staff can go to TAFE computer course, (but harder for shift workers) 	<ul style="list-style-type: none"> • All computer workstations need an ergonomic assessment - set up properly with a workstation and stool • IT training and support needs to be pitched at older workers, such as: <ul style="list-style-type: none"> - 'someone your own age to teach you' - ED computer – (staff)willing to have a go, but need added support - Need more time to be taught properly, learn, absorb and for follow-up - "straight forward instructions for 'what I need to know' only' - Language needs to be clear about terminology and acronyms - Older people could do with ongoing training or small groups - "Hardcopy help" - More one-on -one training • Help could come from community volunteers? - "people who are volunteers have all these skills (incl. Computers skills) that are wasted". We need to change the view about what volunteers have to offer. Not just canteen work. 	

Examples of personal solutions

As mentioned within Table 2, personal solutions suggested for overcoming sensory difficulties in hospital and community health settings, included acknowledging the impact of the ageing process on sight and hearing. Participants suggested having sight and hearing regularly checked; and considering the need for and use of bifocals, graduated lenses or hearing aids. Simple measures such as using chains for glasses, developing routines for where glasses are put or utilising a cheap extra pair where reading is required, were also suggested. Asking a speaker to repeat speech and confirming it by repeating it back to them, was another practical suggestion, as was asking for assistance if needed.

Personal solutions for overcoming problems associated with dexterity and mobility, included keeping scissors handy; and the use of lifts and handrails where available, to ease the difficulties associated with negotiating stairs. Looking at the comfort and ergonomics of activities was regarded important – to 'set things up things to make life easier'. Examples included using tongs to reach slippers; or chairs and stools for attending to dressings. Problems associated with long periods of sitting and data entry could be assisted by getting up and walk around regularly, if doing data entry. For community health, it was recommended that mobile phones should be switched off whilst driving /on the road as a safety measure.

For travel to meetings and participation in ongoing education, travelling in stages was recommended wherever possible, with regular breaks. Participants suggested it was better to share the driving if possible – and to only drive within one’s level of comfort and capability, to reduce stress and tiredness. To help deal with physical and mental workload and fatigue, diligent note-taking, being selective in one’s commitments, pacing oneself, taking short rest breaks, maintaining regular exercise and for some, losing weight was recommended.

Participants acknowledged that change was usually good and a necessary part of the job, where the benefit of the change being introduced was provided and given the time to adapt at their own pace. Participants also acknowledged the need to respect the ageing process in themselves and others, and the need to work around age-related sensitivities.

Examples of work supportive solutions

Work-supportive solutions for sensory difficulties suggested by participants included provision of magnifying glasses on drug trolleys, emergency trolley, drug cupboards and the clinical room. Inadequate lighting needs to be addressed. Vision could also be assisted by increasing the default font size of text on computer screens and reports at program set-up.

For dexterity and mobility, non-slip grips for lids and child proof caps could be considered for medication trolleys and clinic rooms. Patient handling systems needed to be reviewed in some localities, taking into account the physical needs of older health workers (eg.team nursing). Participants felt the need for ongoing education around manual handling - thinking about it continually. Participants suggested that ‘No lift’ policies needed to be better implemented - with responsibility to use lifters by all staff required. More utility trolleys to transport things were also a practical suggestion.

Workplace design and ergonomics were regarded as important considerations, even by simply reviewing seating, adjusting the work area and provision of footstools. It was also suggested the unit manager / leader carry a mobile phone to limit unnecessary walking. Participants suggested vehicles needed to have adjustable seating; and that station wagons were much better for handling wheelchairs than small cars. Reversing indicators installed in cars were also suggested to assist with difficulties reversing.

Work-supportive solutions included considering teleconferencing rather than travel; and for workplaces to allow time-out from normal duties for driving during work hours. Travel rewards were also suggested, such as ‘discounted’ and ‘designated coffee shops’ and ‘motel quality’ accommodation, rather than ‘nurses homes’.

As in Table 2, participants felt in-services needed to cater for all degrees of skill and all ages – including consideration of the distances some participants had to travel to attend. Conference presenters and organisers may also need to consider the needs of hearing impaired older workers (eg. hearing loops) as this was a proposed difficulty expressed with use of teleconferencing facilities by workshop participants.

Practical work-supportive solutions to reduce physical and mental fatigue included suggestions for bigger pockets in uniforms - for pens, notes, lists, scissors etc. Meetings could be changed to allow for greater social networking and staff support (with food and drink provided); or alternatively, have less meetings or bigger gaps between them.

Some participants described how some facilities allowed use of the hospital gym by staff, to help improve physical fitness. Expanding on this, it was suggested hospital gyms could be more widely available for 'Lunchtime fitness programs' and/or "Tai Chi" ; and for personal exercise after work. It was also suggested some incentive might be provided to have a full medical check-up.

For adapting to change, participants felt that the benefit of any change needed to be demonstrated by management and staff needed adequate time to adapt to / assimilate the change.

The two most commonly reported suggestions for dealing with physical and mental fatigue, work-life balance and for remaining positive, were in relation to:

- Flexible work options.

Flexible work options included more part-time options, such as 3-days/week, job-sharing, and/or shorter shifts. Participants also felt if they were able to take more time off when needed to attend to family matters or recover from stresses (ie. family leave, leave without pay), this would be a definite advantage. These might involve a combination of work-supportive and policy-level solutions

- Being valued by the health service

Being valued and respected in some tangible and practical ways by the health service, was an important theme within the workshops. Participants suggested the Area Health Service might consider in the first instance, establishment of an older health worker 'advocacy' group - that is accepted and encouraged by management, otherwise there was a sense that it wouldn't happen or be effective. Other actions suggested by participants, might fall within the role or scope of such a group, in collaboration with the Area Health Service.

Possible activities for an Older Health Workers Advocacy group:

- Consider of an annual "Older Worker's Forum" (to) recognise, value and in a practical way, promote older workers wisdom
- Support older workers in the job interviewing process – especially when applying for a job they are already doing.

Participants described how an older worker who may never have had an interview before – but can do the job... yet a younger worker may get it with 'less clinical skills'. Care needs to be taken in selection of interview panels. Participants suggested it was essential to make sure a clinical person from the older person's own sphere is present on any panel.

- Consider a system of 'small rewards' and 'benefits' to recognise and value the positive contribution of older health workers over many years of service (eg. presentation, car space, discounts)

It was also suggested that 'not feeling valued', could be addressed through positive efforts to create a workplace culture that fosters "teamwork and inclusiveness"; and values the contribution of all members of the team. An understanding by management of the affects and impacts of not "being valued", may be an important step in addressing these workplace cultural issues.

Policy level solutions

Policy level solutions were less frequently raised, as these were less likely to be achieved at a local or area level. However, some suggestions have potential for consideration and uptake system-wide. For instance, problems with seeing red / orange medication print on glass vials, could be overcome with a review in purchasing policy – whereby alternative products with black and/or larger print is considered wherever possible. Review of packaging at purchase-point for ease of access by health workers is also possible with policy support.

Workplace ergonomic assessments and consultation with workers in the design and re-design of facilities, is likely to ensure better use of space; and allowance of more space for manoeuvring of patients and equipment. This action is likely to require policy-level commitment and prioritisation.

Whilst a financial incentive was also suggested as a policy –level solution to compensate for long years of dedicated and ongoing service, there was little discussion on the topic, as it was felt these were hard to address at health service level (due to set salary scales). However, financial incentives and "fringe benefits" to compensate for long years of dedicated and ongoing service, were cited by a significant number of participants when asked to anonymously 'jot down' one or two things that would keep them working longer.

5. Discussion

Some of the impacts of ageing upon older workers described by participants are reported elsewhere in the literature; whilst others have not been described previously. Solutions to these challenges are discussed where these have potential for significantly improving the experience of being an *older-health-worker* in a rural area shall then be discussed.

5.1 General impacts of 'ageing' and 'health' for older health workers

In summary, the main changes associated with ageing that impact upon the experience of work identified by participants in this study were:

- Deteriorating vision and hearing
- Musculo - skeletal changes affecting strength, dexterity, fine motor co-ordination, muscle tone, flexibility, stability, balance and manoeuvrability
- Heat and skin sensitivities
- A sense of becoming slower, tiring more easily, increasing fatigue – with reduced energy levels, stamina, sleep disorders and slower recovery after stress
- Mental fatigue related to difficulties with memory, concentration and more time needed to assimilate new technology and changing roles

- A need for greater work-life balance, and recognition of changing family demands
- A greater sense of one's own mortality, others ageing and the suffering of others
- Lowered tolerance for negative behaviours of others (eg. self-abuse, rudeness), accompanied by sensitivity to hints of "ageism"
- A sense of greater wisdom gained through experience and the positive contribution one can make as a result of this

Physiological changes associated with ageing reported in the occupational health literature that are consistent with the above difficulties include reduction in aerobic power, muscular strength and endurance, reaction speed, acuity of special senses, difficulties with thermoregulation and concerns regarding an increased risk of chronic illness (9) (25). Problems with sleep and rotating shifts are common because ageing affects circadian adaptation to night work - particularly for those over 40 years of age (26) (27).

In relation to health and injury concerns in older workers, back-pain /strain; other musculo-skeletal pain; and mood disorders such as anxiety, depression and work-related stress; have also been reported as common health and injury problems with older health workers (28) (29). However, it is also generally recognised that those with higher job satisfaction, control over practice and lower job demands have better health; and that older nurses can have better physical and mental health than age-gender matched national norms (28) (30). This is because the level of fitness required to perform health work, is likely to convey some personal health benefits - likely to be related to a 'healthy worker effect' (31). Conversely, recent research suggests the 'healthy worker effect' may be to some extent, negated or compromised by 'work-family' conflict, where hours worked are excessive (32). This would fit with workshop participants' description of fatigue, chronic pain and desire to have more time off to attend to family matters.

In the absence of major health problems, however, little relationship has been found between ageing and the work performance per se - with most older adults retaining both their physical and mental capabilities well into their seventies (9) (33) (34) (35) (36) (37). However, personal health and fitness can be highly variable amongst older adults - and this is more likely to affect physical strength and likelihood of injury than ageing per se (9) (33).

Personal health problems may, in fact, be the "straw that breaks the camel's back" for many older workers, in their decision to leave or continue working. Poor health has been strongly associated with labour force exit (38) (39) (40) (41). Hansson (et al) suggests that older workers seem to exhibit considerable capacity to manage and cope with job demands and absorbing difficulties; but at some point become "overwhelmed" and find themselves at increased risk of health consequences, injury and disability (42). This sense of coping "up to a point" was also expressed by participants of the current study.

5.2 Practical difficulties for older health workers

Challenges and difficulties mentioned by participants in this study, were quite specific to the health work practice from which participants were drawn.

Physical work demands

Physical difficulties reported by participants included seeing fine print on medications, screens and documentation; fine motor tasks associated with minor procedures, opening packaging and administering medications; hearing patients and colleagues; manual handling tasks and showering of patients; shiftwork; excessive walking or maintaining awkward postures for long periods – including delivery of babies and performing physiotherapy exercises. Workers in the community also described difficulties with postures and access to vehicles and patient's homes when visiting.

Participants commonly described musculo-skeletal pain and stiffness, due to a combination of ageing and past occupational impacts - such as excessive walking and manual –handling. These are cumulative over time and exacerbated by other physical ageing changes (28) (43); which are likely to contribute to a reported desire of older health workers to shift toward less physically demanding positions as they get older (44) (45) (46) (29). Compared to health workers in urban areas, however, there may be less opportunities in small rural health services for lateral movement of older workers into less physically demanding positions. It may be possible, therefore that older health workers in rural areas, keep providing direct physical care longer than they wish to, to the detriment of their enjoyment of work and physical health. However, physical work with patients should not be confused with a desire to spend less 'time' with patients , which participants valued and felt was being eroded by administrative tasks.

Other physical demands such as difficulties with opening packages, ampoules and administering medications, were commonly reported by participants and related to deteriorating vision and declining fine motor dexterity. This finding was not found elsewhere in the literature.

Ongoing stress and fatigue

Older health workers in this study, commonly reported tiredness and emotional stress – partly related to long or rotating shifts. A number of studies and reviews have reported that the physical demands of the job, rotating shifts , overtime and inflexible scheduling are associated with chronic fatigue and increasing the personal health concerns of older nurses (25) (47). Alternatively, older nurses working part time have been shown to have better physical health and emotional well-being, than full time counterparts (28). Some workshop participants attributed fatigue and low energy levels to a menopausal effect, which has also been reported by Fitzgerald (25). The discomfort felt by some participants in shower areas and in sharing heated space with younger colleagues, may also be related to menopause and the declining thermoregulation experienced by older workers (9).

Computers and information technology

Difficulty working with computers and information technology was a major practical issue raised by participants in the workshops. These included difficulties with physical aspects, such as reading screens, using keyboards and mouse and discomfort with poorly designed workstations. However, most discussion surrounded difficulties with learning new programs, remembering passwords, a sense of insufficient training and an expectation from younger colleagues and management that older health workers should be able to 'pick things up' easily - without an understanding that many older workers were not brought up with computers and do not use them in other spheres of life. There was also a sense of frustration with the style of in-service education - aimed at a much

younger, more computer literate generation. Lack of confidence was a common barrier which participants felt was partly related to infrequent use of computers.

Other research has noted the influence of age, levels of computer-specific education and confidence, on the attitudes of health workers toward clinical use of computers (48) (49) (50) (51). The importance of user-centred design, consideration of the views of users, addressing user-needs and appropriate training have also been described elsewhere (52) (53). Health services need to ensure new information systems have recognisable benefits for clinical staff and not significantly increase their workload. For instance, assumptions that electronic systems will have time efficiency gains are not always correct. A systematic review of 23 studies highlighted that goals for decreased documentation time with introduction of electronic health record systems, are not likely to be realized (54).

These studies support the concerns of workshop participants, in relation to use of computers and technology. In particular, lack of experience and confidence with computers; sometimes inappropriate training and workplace expectations; and fears of an increased workload without perceived benefits. Whilst it may be argued that these are 'teething problems' associated with supporting two systems (paper and electronic), in light of an ageing health workforce, factors that improve levels of confidence and the clinical acceptability of new computer systems deserve further attention if moves to integrate electronic health records as proposed for roll-out in NSW Health are to be achieved within the recommended timeframe. (55)

Travel to meetings and participation in ongoing education

One of the difficulties associated with rural health practice, includes the time, cost and distances involved in travel to meetings, conferences and professional development education. This is the case for workers of all ages, but is likely to be worse for older workers due to difficulties with fatigue, sleeplessness and night driving. Whilst video and teleconferencing may be an alternative option, some participants expressed difficulty with hearing this form of media. Participants also noted that access to ongoing education is difficult for some. Comments included reference to 'ageist' attitudes, where older workers were not informed about courses or they were not offered to older workers. Some managers are reported to be reluctant to train workers 'close to retirement' for a range of reasons and use of certain practices to avoid doing so (56). Conversely, participants in the workshops were keen to keep skills updated, a finding supported by a number of studies cited by Letvak (28).

5.3 Broader challenges for older health workers

Coping with change

Workshop participants expressed a frustration with both small and large organisational changes – However, there was also an acknowledgement that some change was good and necessary, and some of the 'age-related reluctance' to embrace change, was more to do with their own acquired 'organisational wisdom' as to what has worked in the past and will not work this time around. The cynicism toward some changes described as 'change for change sake' was because of the added stress this brought, with no perceived benefit. It was also related to the sense of powerlessness or

not having one's opinion heard or valued. Feelings of disempowerment have been associated with susceptibility to burnout and ill-health in a number of studies reported by Gabrielle (et al) (29).

On a larger scale, Hegney (et al) (20) suggests that work stress amongst rural nurses is being provoked by a climate of change and restructuring that has seen financial constraints and role changes for which nurses are not prepared or consulted. Role changes, not being valued and frustration with organisational expectations felt by other rural health workers, may be worse for older workers, who also report difficulties adapting to change due to ageing and generational factors - especially when this leads to reduced clinical time with patients and lower standards of care being provided than when they were younger.

Emotional impacts of workload, expectations and not achieving personal goals

Older health workers as a generation, have been described as courteous, committed, hard-working, knowledgeable, intuitive, skilled decision makers, possessing a deep-rooted understanding of patient needs – and offering experience and wisdom that takes years to develop (25) (43) (57). These generational values, however, can come at a cost, with an emotional burden apparent when older workers are under the chronic stressful circumstances described by workshop participants.

Heavy patient loads lessen time spent with patients, detracting from one of the most important attributes of work for older health workers; and increasing the emotional exhaustion that also leads to job dissatisfaction (58) (59) (60). Participants expressed the sense that when extra stressors were added to the work demand (eg. workloads, documentation, computers) it all “added-up”; and took time away from providing quality care.

Feelings of guilt, frustration, fear of making errors, and general weariness have been reported as some of the consequences of not fulfilling one's own role expectations and standards of care (25). It has also been suggested these affects are likely to be greater for older workers, because of the value placed upon providing quality care - which helps define their self-worth (58) (61).

Growing sense of mortality, the suffering of others and 'compassion fatigue'

Sense of community and rural lifestyle are among the most important reasons cited by nurses and allied health workers, for continuing to work in rural areas (11) (13) (62). This includes the greater likelihood of knowing and being known by those being cared for. Workshop participants described the emotional difficulties associated with not only coming to terms with their own mortality, but in looking after patients their own age – especially if it is someone they know well, and/ or if the person dies. This is also more likely to be the case in a small rural community. From what participants described, the grief and emotional impact for older workers of 'losing someone you know' is not insignificant.

Compassion fatigue, a form of secondary traumatic stress, has been described as the 'cost of caring for others in emotional pain' (63). Those under chronic stress in health-work may be prone to compassion fatigue - initiated when exposed to an acute event of suffering in others (64). Considering that many health workers in this study felt they were more empathetic now than when they were younger; and given the rural context of their work where they are more likely to know those who are suffering, 'compassion fatigue' may be part of the fatigue experience of participants.

Work-life balance and the extended carer role

In-depth interviews with older Australian nurses conducted by Gabrielle et al (29), found that prominent factors leading older nurses to review their work-life balance, included poor working conditions, existence of chronic pain, ageing and personal issues. Coping strategies included doing less physical work (mentioned earlier), working either less or more regular hours and having specific time-out to rest when off-duty. These coping strategies were also mentioned by workshop participants, who also expressed a desire to take more time-out to look after themselves.

Prominent among 'personal' issues mentioned by participants of this study were the complex responsibilities associated with an extended primary carer role. This included care for elderly parents, growing teens and grand-parenting; and has been described in other studies (65) (66). Financial concerns have also been shown to be associated with the extended carer role (25) – although this issue was not raised by participants in these workshops. However, participants felt that management did not often understand the need for more time-off or more regular shifts, to enable them to fulfil their carer role. In small rural health services with a small workforce, this problem may be exacerbated, as there are less workers to share undesirable shifts.

Interpersonal relationships and feeling un-appreciated

Collegial relationships with other members of the health care team are known to reduce job stress and foster decisions to stay in the workplace (25). In this study, workshop participants expressed some difficulties relating to younger staff members; and that at times management did not understand or value the perspectives of older health workers. The latter was also described by Gabrielle et al (29) where similarly, older nurses felt they were 'uncared for', 'unappreciated' or 'devalued' in their workplace. Moseley et al (67) also cites a number of studies where older nurses feel negatively perceived by younger colleagues and management.

Participants also expressed a growing intolerance as they have become older, for perceived rudeness in patients and colleagues – and self-abusive behaviours in patients. Rudeness and self-abusive behaviours are in contrast with the generational values of this group described earlier. That is, older health workers themselves are generally self-motivated, courteous and patient with others – however, when confronted by lack of courtesy, patience, and a willingness to help one's self behaviours in others older health workers who are already under stress, find such behaviours very difficult to deal with.

A review of literature relating to attitudes of health workers toward drug and alcohol misuse in patients, confirm that older health workers generally had lower tolerance for substance misuse (68). However, the picture is mixed. Negative attitudes of health care workers toward obese patients has also been documented elsewhere, but some indicate older workers have greater tolerance toward obesity in patients, than younger workers (69) (70).

Optimism in spite of difficulties

There was an underlying optimism displayed by older health workers in the workshops, that should be emphasized. Participants displayed a humour in their sharing of ideas, despite the difficulties they described. Older health workers, it would seem, continue to practice because they like their profession; and believe their maturity and wisdom give them a valuable perspective.

The workshops support other findings that suggest older health workers “continue to care”, despite intergenerational conflicts with younger colleagues and less respect from patients (29) (58). Older health workers are generally confident in their abilities and capable of meeting workplace demands in spite of difficulties – until the point where their personal health and well-being is compromised beyond ‘acceptable limits’. Gabrielle (et al) (29) noted that poor working conditions and lack of supportive workplace relationships, combined with ageing concerns, influenced nurses to make changes for the sake of their own health. There are a number of modifiable factors proposed in both the literature and by participants themselves, on ways to tip this imbalance back in favour of a more enjoyable, less demanding workplace; and a happier and healthier older health workforce.

5.4 Potential solutions

There was no systematic research undertaken in this study into solutions for all challenges reported as impacting on work in the rural health services. However, it is clear from consideration of some of the solutions that were suggested that there will be value for older health workers, their patients and the health service, in undertaking a systematic program to address the reported problems. Indeed, most of the reported problems DO have solutions that would appear to be effective, and these relate to supporting 1) development of personal health and fitness, and 2) modification of work tasks and systems. These two tasks should involve older workers themselves in association with specialists in personal health and wellbeing of older people for the first task, and with health service managers for the second.

Some of the solutions offered by participants in this study that resonate with others described in the literature include:

Promoting physical wellbeing

Employee wellness and exercise programs, have been shown to improve the general fitness and health of older workers. Positive physical gains for frequent participants of older worker wellness programs include improvements in aerobic power, heat tolerance and a sense of improved self-efficacy and mood state with reductions in anxiety and depression. Programs can also encourage healthy lifestyle, such as reductions in smoking and alcohol consumption (9).

Use of health service gyms were suggested by participants in this study, for the purposes of staff health and fitness; and were likewise described as an innovative strategy to improve wellbeing in a Summit on retaining older rural nurses in Minnesota (67).

Recognition and respect for older health workers

A review of factors influencing retention amongst older nurses conducted by Moseley (et al) (67) suggests that respect and recognition of the achievements of older staff is one of the most important factors contributing to job satisfaction and intention to leave amongst older health workers. Creating an organisational culture that recognises and respects older workers, including their generational values, expectations, knowledge, experience and perspectives, may therefore be a useful solution – and was one proposed by workshop participants. Strategies suggested in the literature for doing this include managers acting as role models and encouraging positive behaviours; recognition through public acknowledgement (eg. letters, certificates, presentations); valuing expertise through provision of challenges (eg. mentor, preceptor, committee); or

encouraging older health workers to write articles or give presentations on their own area of expertise (25) (67).

Avenues for recognising experience and complexity of rural practice through creation of senior positions and rural practice certification has also been suggested (43) (55) (71). However, appreciating older nurses and viewing them as a valuable resource, may require an attitudinal change within nursing management and the workplace (29). Health care organisations that value the contribution of their workers and view the organisational wisdom of its older workers as an asset, may well reap the benefits by way of improved workforce retention and service delivery.

Modifying work procedures can also help reduce the physical demands upon older health workers. Examples offered include rotation of older health workers through lighter duties; and diligent attention to manual / mechanical lifting procedures (9) (67) (71). Some rural facilities prevent lost time and effort leaving a task to communicate with staff, by making use of “walkie talkies” (71). In a similar vein, participants of the workshops suggested use of mobile phones by unit managers, to reduce the walking required to answer and transfer phones.

Involvement of older health workers in worksite safety inspections and committees, as part of an occupational health and safety program, can also help ensure the needs of older health workers are being met (67). This is also a practical way to demonstrate that the experience and opinion of older workers is valued.

General management factors

Management styles in general, can significantly impact job satisfaction and enjoyment of work for all age groups. In summary, however, positive personal characteristics of managers described by health workers in the literature, include a general ability to listen; being responsive to needs; a nurturing leadership style; supportive attitude; being a presence in the unit and having the ability to resolve issues. Older nurses in particular, prefer managers who are professional, demonstrate integrity, empower workers and who have good relationships with workers on a personal, face-to-face basis (67) (71).

Organisations that empower their workers through management styles that foster autonomy, responsibility and inclusive decision-making, are also likely to offer the recognition and respect that older health workers value. This includes greater control over practice and shared responsibility for development of policies and procedures (67) (71). Teamwork and a sense of belonging is also important to older health workers - which can be fostered by management and through attention to the role of social gatherings and positive interpersonal relationships. This was also mentioned by workshop participants. As mentioned earlier, older health workers enjoy work more where there is a perception the organisation cares and values its workers (43) (67) (71).

Some of these strategies have overlap with those described by other rural health workers, reported by Hegney et al (62). These also relate to teamwork, including recognition and positive relationships with colleagues and management; maintaining clinical skills (including opportunities for ongoing education); and supportive organisational structures - which included resourcing and provision of adequate staff facilities, IT education, balanced caseloads, quality care and an understanding of the multiple roles rural health workers in small communities outside of work.

Education and professional development

A number of studies support the notion that opportunity for ongoing education is both desired by and desirable for older health workers (71). Professional development support may include provision of regular updates and support to conferences and education programs (67). However, attention to the learning styles of older workers is important, as stated by workshop participants and in the literature (9) (33). In particular, it is reported that older workers tend to prefer active participation and self-paced learning systems, to formal classes with younger workers (9). It is suggested this is because older workers are goal-oriented and like to see practical, clear objectives with immediate links to their current work. Older workers also learn experientially, preferring to use problem-solving approaches and the opportunity to share experiences and opinions. Older adult learners also need to be treated with respect, without fear of judgement by younger colleagues (33).

Workplace design and ergonomic features

Consideration of physical workplace design and how this impacts upon older health workers was suggested by participants and has also been raised by others. Workplace ergonomic assessments, such as by an Occupational Therapist, could include assessments of the height of tables, comfort of chairs, lighting and non-slip surfaces. Design adjustments might involve remodelling of patient rooms for easy access of equipment; and decentralised nursing stations so that supplies are closer. Alternatively, use of small portable utility trolleys and supply carts, can reduce lifting, carrying and unnecessary walking to and from storage and supply rooms (25) (67) (71).

Installation and placement of air-conditioning systems and lifts has also been suggested; whilst improved flooring and electrical outlets placed higher on walls, can prevent stooping and trip hazards. (9) (71). Mechanical patient handling equipment, tilt beds and bedside commodes are available in many rural health services, but it has been suggested that these need to be more readily available for use by older health workers - especially with obese patients (25) (71).

In relation to vision and hearing needs, better lighting options, enlarged computer screens for easier reading and attention to glare on computer screens and monitors, have also been recommended in other studies; as well as attention to acoustics within units through use of insulating floor coverings and noise treatment measures (25) (71).

Flexible work options and benefits

One of the most important and frequently reported ways to encourage older health workers to remain an active part of the health workforce, is to provide flexible work options, such as flexible scheduling, job sharing, part-time and shorter shifts (25) (43) (46) (58) (67) (71). It has also been suggested that older nurses should be given shift preferences, on the understanding that they have 'paid their dues' with working less desirable shifts when they were younger (58) (67).

Working less hours was frequently mentioned by participants of this study, as a primary solution to the problems of chronic fatigue and the need to attain better work-life balance. Participants suggested this could be in the way of reduced hours (as above); or in the form of 'fringe benefits' such as more time off when needed. This might be in the form of more leave without pay, or better access to sick leave and family leave.

Greater financial reimbursement that recognises experience and role complexity of senior rural nurses and allied health workers, is another ‘benefit’ for consideration raised in the literature (67) (71). Within nursing, creation of ‘senior nurse’ positions as recommended by some, may go some way toward realising this (43) (55) (71). Whilst ‘better pay’ was mentioned as a desirable solution to compensate for ‘years of hard work’, it was felt such changes were difficult due to systemised salary scales; and being a whole issue in itself, was largely outside the scope of the workshops.

Barriers mentioned by participants to implementing some of the suggested changes, were lack of replacement staff and a perception there was a general lack of financial resources. However, workplace ergonomic assessments, flexible work options, ‘fringe benefits’ and training programs, are likely to lessen the physical and mental fatigue that limits older workers enjoyment of work – a motivation that rates more highly for older workers than pay scales alone (33).

5.5 Work supportive and system-wide solutions not emphasized elsewhere

Whilst it is not expected that all the practical difficulties and personal solutions offered by workshop participants would appear in the research literature (eg. chains for glasses), some work supportive and potentially system-wide solutions were suggested, that were not found elsewhere.

Review of purchasing policies

Problems with sight, hearing and fine-motor dexterity, for example, were a common experience for older health workers – for which a range of personal suggestions were offered. However, amongst the most notable work-supportive solutions with potential for system wide application, was to review purchasing policies regarding (1) ‘easier to read’ alternatives to the small, red-orange print that appears on some commonly used IV/IM medication ampoules; and (2) ‘easier to open’ alternatives to some of the small, difficult to open packaging of health products.

Travel and use of vehicles

Workplace design and ergonomic solutions were also prominent amongst solutions offered by participants and these have been discussed in relation to the literature. However, participants also suggested work vehicles needed to be part of such assessments; with attention to adjustable seating, ease of access and space to handle/carry cumbersome equipment, such as wheelchairs. This might also include a review of purchasing policy, with regard to suitable vehicles.

Solutions to difficulties associated with travel to meetings and ongoing education not mentioned elsewhere, included allowance for long distance driving during work hours (ie. time-out from normal duties for travel). Travel rewards such as discounted, designated coffee stops/shops and ‘motel quality’ accommodation instead of ‘nurses homes’, were amongst other practical, work supportive solutions not mentioned in the literature.

Participants also felt in-services needed to consider the distances some participants had to travel to attend; and that presenters and organisers also need to consider the needs of hearing impaired older workers (eg. hearing loops). Teleconferencing rather than travel was suggested, although not without its own issues relating to hearing difficulties. Participants also suggested ‘less frequent’

meetings to reduce travel – and that meetings could be changed to allow for greater social networking and staff support (with food and drink provided).

Older Health Workers “Advocacy groups” and “Forums”

Being valued and respected in practical ways by the health service, were major suggestions for dealing with the physical and mental fatigue, change, emotional impacts of work, balancing work-life commitments and remaining positive, that have been discussed in light of findings elsewhere. However, to address this, participants of the workshops suggested establishment of an older health worker 'advocacy' group, support for workers in the job interviewing process and an annual "Older Worker's Forum.

6. Recommendations

This small study has drawn to attention the practical issues confronting the older rural health workforce in Hunter New England Area Health Service. It is expected that the results would not be confined to this rural health service in New South Wales or Australia. Whilst a few solutions have been put forward by participants in personal, work-supportive and policy spheres, the following major recommendations are made as the way forward for developing a robust and effective response to the findings.

Major recommendations

1. Older health workers in Hunter New England should be invited to participate in development of *“a resource booklet for older rural health workers”* that draws attention to the physical and mental changes that impact on their work as they get older and outlines the practical suggestions they can make for making work easier, productive and safer. The booklet should be developed and owned by the health workers – eg titled *“Wisdom at Work”*.
2. Hunter New England Health should establish a small *“Task Force”*, comprising managers at local, cluster and area levels, older rural health workers, and an occupational therapist, to examine the research findings and develop supportive solutions for implementation by the area health service. This will include area policy and practice solutions, as well as recommendations for state-wide policy development.

These recommendations are entirely consistent with objectives and planned activities of the *Hunter New England Strategic Plan Towards 2010. Strategic Direction 6: Build a sustainable health workforce*. Addressing the current shortfall in the supply of health professionals is a key priority for the Health Service, which also strives toward a health system that values its workforce as a vital resource and toward treating staff fairly and with respect (3).

7. Conclusion

Older health workers in rural areas are a committed and productive section of the workforce. However, they appear to be presented with a “double-wammy” of challenges, associated with being both an older worker – and being a rural health worker. In most instances, older health workers are meeting these challenges in spite of specific difficulties arising in the workplace. The experiences of workshop participants and findings within the wider literature would indicate these challenges are being borne at a considerable physical and emotional cost to the health and well-being of older workers. However, there appears to come a point where work demand factors ‘cost’ too much in terms of personal health and well-being of older workers, likely to be coupled with a shift in the importance of other realms of life, which take on more importance for older workers.

Many of the challenges are amenable to interventions that would improve work and life for older health workers. Participants offered a number of suggestions for action at personal, work-supportive and policy levels. These were toward reducing the difficulties and ‘tipping the balance’ back in favour of a less demanding and more enjoyable work experience.

Both the general and specific recommendations are consistent with Hunter New England Area Health Service priorities for workforce sustainability, that which provides an existing framework from which recommendations might be launched. Implementation of the two specific recommendations by Hunter New England Health will be the beginning of a process that will improve the experience of work for older health workers in rural areas – both for those within Hunter New England Health Service and beyond.

Importantly, the workshop process itself points toward a way of engaging older health workers in matters that concern them. Any actions that health services and managers can take to consult and value the opinions of its older workers would benefit not only older workers, but the sustainability of the health service workforce.

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