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Opinion

Addressing Ageism in Long-Term Care: Strategies to Promote Resident- Centered Care

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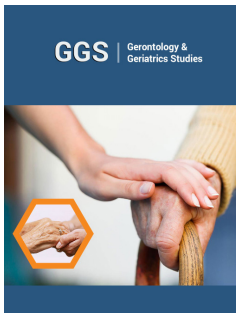

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Opinion

In nursing homes, where the average resident is 85 years old and 82% are age 65 and older, one might assume that staff are well-versed in preventing ageism [1]. Employees are trained to treat residents with dignity and respect, yet ageist attitudes and behaviors may persist in long-term care environments. In this opinion paper, I examine the theory of ageism, explore whether it exists in nursing homes through previous research and propose strategies to address it. The goal is to promote a more resident-centered environment that respects the values and preferences of older adults. The theory of ageism refers to "a systematic discrimination toward a group of people based on chronological age" [2]. Ageism is the stereotyping of and discriminating against individuals because they are old [3]. Ageism occurs in all facets of American culture from the media to business, to health care [3]. Examples of ageism can be found in the health-care environment; in acute-care and long-term care [4]. Ageist behaviors among health-care providers affect communication and access to health-care services [4]. In preindustrial society, age segregation was not part of American life and no age distinction occurred in farm work, social affairs, or community activities [5]. Toward the late 19th century, as America became more industrialized, age stratification became part of American culture affecting societal customs, including education, employment, welfare and retirement, in favor of the young [5]. As with weight bias, ageism is formed by believing and acting upon, the myths and stereotypes about aging that are accepted in American society. According to Robinson [3], the myths and stereotypes about aging form the attitudes and behaviors of people toward the elderly person. Acceptance that changes in health are part of old age may be partly responsible for ageism [4]. While older people may be denied medical treatment in some health-care environments, older people have improved access to medical treatments in other health-care environments because of their eligibility to Medicare [4]. In a study evaluating access and barriers to health care for 4,889 Medicare eligible men and women in four communities from 1989-1993, Fitzpatrick et al. [6] concluded that access problems existed because of physicians' lack of responsiveness to the needs of elderly patients as opposed to physical barriers such as cost or transportation. Fitzpatrick et al. [6] also concluded that persons at greatest risk for barriers to health care were low income, less educated females without insurance coverage beyond Medicare.

Self-perceived age discrimination was based on the physician's attitude toward the older patient in meeting the patient's health and personal needs [6]. Ageism is visible across healthcare environments, from acute care to long-term care settings [4]. In acute care, ageism often manifests through clinical decision-making, whereas in long-term care, it is shaped by the ongoing relationships and expectations between residents and staff. Many residents internalize the perception that, because they are old, they are frail, unable to care for themselves and belong in the nursing home, even when more viable options, such as

assisted living or aging in place, might better meet their needs. This self-reflective attitude can be reinforced by staff who justify the residents' living arrangements while failing to ensure care promotes the highest practicable level of well-being. When staff make decisions for residents or complete tasks that residents could manage independently, they unintentionally reduce functional capacity, foster dependence and perpetuate the stereotypes that older adults inherently require constant assistance. In addition to care practices, communication is another aspect where ageism can significantly affect the resident experience. A study conducted by Legace et al. [7] of 33 elders living in long-term care facilities in the province of Quebec found many of the elders interviewed perceived their communication with staff as ageist and that this interaction diminished their quality of life and well-being in the facility. Controlling and authoritative language and attitudes, infantile patterns of communication, not being listened to or completely ignored, were among the descriptions elders used to describe ageist communication among care providers. Interestingly, the study also found that many of these elders coping with ageist communication by accommodating the caregivers, further reinforcing the pattern of ageism within the facility.

A related study by Williams et al. [8] concluded that elderspeak (infantilizing communication), a form of ageism, was linked to resistiveness to care in nursing home residents with dementia. A secondary analysis of 80 video-recoding transcripts from a NIH-funded study of staff-resident communication during daily care activities supported the conclusion that elderspeak and language systematically diminishes the competence of the elder lead to withdrawal, depression, reduced self-esteem and continued dependency on staff, further promoting the stereotype of aging residents in nursing homes.

Strategies to reduce ageism in nursing homes:

A. Staff education and self-reflection: Incorporate ageism-awareness activities into mandatory continuing education programs. These activities should encourage staff to reflect on personal prejudices and stereotypes about older adults, including those living in nursing homes. Self-awareness is the first step toward changing behavior and promoting respectful, equitable care.

B. Resident empowerment: Engage residents in open conversations about their treatment and experiences. Educate them on the concept of ageism, their rights to respectful care and what constitutes staff- resident interactions. Empowering residents helps them advocate for themselves and reinforces a culture of respect.

C. Observation and accountability: Monitor staff-resident interactions to identify and address ageist behaviors or practices that could lead to discriminatory treatment. Peer observation programs can be especially effective, as they promote mutual accountability and encourage collaborative problem-solving to improve communication and care.

D. Policy integration: Embed ageism-related indicators into CMS quality measures and accreditation requirements. Holding facilities accountable for creating ageism-free environments ensures that respectful, person-centered care is a priority at the organizational level.

E. Adopting culture change models: Implement culture-change models that reframe nursing homes as home-like communities versus medical institutions. These approaches emphasize resident autonomy, choice, meaningful engagement and resident/person-centered care. Ageism in nursing homes can cause depression, withdrawal and diminished well-being. Our role as long-term care providers is to ensure that every resident's voice is heard, considered and respected. An ageism-free nursing home is one where residents are valued as individuals with unique histories, ongoing aspirations and the right to make decisions about their own lives. Addressing ageism is not only a matter of quality care, but also an ethical imperative that affirms dignity, autonomy and humanity for every older adult.

References

1. Centers for Disease Control and Prevention (2023) Table 4: Post-acute and long-term care user demographic and health-related characteristics: United States, 2020.
2. Parsons A (1993) Attitudes to the elderly. St Vincent's Nursing Monograph, p. 51.
3. Robinson B (1994) Ageism. University of California, Berkeley, School of Social Welfare.
4. Kane RL, Kane RA (2005) Ageism in healthcare and long-term care. Generations 29(3): 49-54.
5. Fleming KC, Evans JM, Chutka DS (2003) A cultural and economic history of old age in America. Mayo Clinic Proceedings, 78(7): 914-921.
6. Fitzpatrick AL, Powe NR, Cooper LS, Ives DG, Robbins JA, et al. (2004) Barriers to health care access among the elderly and who perceives them. American Journal of Public Health 94(10): 1788-1794.
7. Lagace M, Tanguay A, Lavallee ML, Laplante J, Robichaud S, et al. (2012) The silent impact of ageist communication in long-term care facilities: Elders' perspectives on quality of life and coping strategies. Journal of Aging Studies 26(3): 335-342.
8. Williams KN, Shaw C, Lee A, Kim S, Dinneen E, et al. (2017) Voicing ageism in nursing home dementia care. Journal of Gerontological Nursing 43(9): 16-20.