

DEPARTMENT OF NEUROBIOLOGY, CARE SCIENCES
AND SOCIETY,
Karolinska Institutet, Stockholm, Sweden

Work in Eldercare - Staying or Leaving

**Caregivers' experiences of work and support during
organizational changes**

Birgitta Fläckman



**Karolinska
Institutet**

Stockholm 2008

All previously published papers were reproduced with permission from the publisher.

Published by Universitetstryckeriet, Uppsala
Box 513, SE-751 20 Uppsala, Sweden.
© Birgitta Fläckman, 2008

ISBN 978-91-7409-049-9

In eternal loving memory of my father and mother, Harald and Agnes Asplund

TABLE OF CONTENT

INTRODUCTION	1
BACKGROUND	1
Caregivers' working life and working condition in nursing homes	1
Changes in the working life	2
Support for improving care and increasing job satisfaction	3
RATIONALE FOR THE STUDIES	5
AIMS OF THE THESIS	5
METHODS	6
Design	6
Settings	7
Sample	9
Data collection	10
Interviews	11
Self-assessments	11
Creativity and Innovative Climate Questionnaire (CCQ)	11
Maslach Burnout Inventory (MBI)	12
Analyses	13
Qualitative content analyses	13
Statistical analyses	14
Ethical consideration	14
RESULT	15
Study I,	15
NH I	15
NH II	16
NH III	16
Study II	17
Value of caring milieu	17
Value of knowledge	18
Study III	18
Experiences of pride and satisfaction	18
Experiences of having professional competence	19

Experiences of losing control	19
Experiences of decreasing influence	19
Study IV	20
METHODOLOGICAL CONSIDERATION	20
Pre-understanding	24
REFLECTION OF THE RESULTS	24
Working in eldercare during organizational changes	25
Being a caregiver during organizational changes	27
Caregivers' experiences of support	29
Support through education and clinical supervision	29
The supporting leadership	30
Work in eldercare – staying or leaving	31
IMPLICATIONS FOR ELDERCARE PRACTICE	33
POPULÄRVETENSKAPLIG SAMMANFATTNING (SUMMERY IN SWEDISH)	34
TACK	40
REFERENCES	42
PAPER I-IV	
DISSERTATION FROM THE DEPARTMENT OF NEUROBIOLOGY, CARE SCIENCES AND SOCIETY 1993-2008	

ABSTRACT

The overall aim of the present thesis was to reveal nursing home (NH) caregivers' work experiences when receiving support through education and clinical supervision over a two-year period, while the workplace was undergoing organizational changes. The studies (I-IV) combine qualitative and quantitative methods in a longitudinal two-year follow-up project in three Swedish NHs (NH I - III), in which support was given to the staff at NH I-II. NH III was included as a comparison. The thesis is based on interviews (I-IV) and self-assessment questionnaires (I), which were conducted at three occasions: at start, after 12 and 24 months at the respective NHs. As a result of political decisions, NH I was informed of organizational changes and pending financial cutbacks shortly after opening. The other NHs were informed at around 12 months. The numbers of caregivers willing to participate at start were 32, 21 and 22 at the respective NHs. No new participants were included to replace dropouts. Descriptive statistics (I) and qualitative content analyses (I-IV) were used. Study I focused on the organizational climate and the prevalence of burnout symptoms in the three NHs. The result from NH I revealed an improvement over time as opposed to NH II, which showed negative progression at 12 months, despite support. This corresponded to the time at which they received information about financial cutbacks. The improvement based on the interviews at NH I was not as distinct as that based on the self-assessment scores. The support given seemed to have helped the caregivers at NH I, but was not able to alter the situation at NH II. The development based on self-assessments at NH III was more constant throughout the study. Results from interviews at NH II and III were more in accordance with the scores. In Study II, the caregivers' work experiences at NH II, while receiving support through education and clinical supervision, showed that they valued the caring milieu and their own knowledge. The value of knowledge was related to their different backgrounds and to the knowledge gained through the support, and it seemed to be one factor underlying participants' continued willingness to stay. In Study III, caregivers' experiences and reflections on working at NH III, while under threat of organizational changes and termination notice, showed a transition from 'having a professional identity and self-confidence' to 'being a professional in a threatening situation caused by someone else'. Finally they were 'struggling to adapt to a changed working environment as a person and a professional'. The caregivers experienced a loss of pride and satisfaction. Included in Study II and III were interviews from those caregivers who had been interviewed on all three occasions. Study IV focused on what had caused caregivers at the three NHs to decide to leave their employment during the study period. Caregivers' decisions to leave work could be encompassed in one main category: 'Unmet expectations'. Their experiences were lack of encouragement, trust and professional development. Also reported were feelings of insecurity, different opinions on the care delivered, being disregarded and betrayed, followed by thoughts of leaving work and pursuing other opportunities. It can be concluded that the changes at all three NHs seemed to have over-shadowed attempts to improve working conditions. Successful changes require a vision that justifies them. High-level decision-makers and managers ought to be conscious of the factors that facilitate or impede similar transitions. They should also focus on supporting caregivers during change processes, as the literature shows a risk for decreasing quality of care.

Keywords: Nursing home, caregivers' experiences and expectations, organizational climate, burnout, education and clinical supervision, cutbacks and organizational changes, termination notice, transition, nursing workforce

ORIGINAL PAPERS

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals.

I. Fläckman B., Skovdahl K., Fagerberg I., Kihlgren M. & Kihlgren A. Organizational climate and burnout in relation to changes in organization - caregivers' self-assessments and experiences at nursing homes. Submitted

II. Fläckman B., Fagerberg I., Häggström E., Kihlgren A. & Kihlgren M. (2007). Despite shattered expectation a willingness to care for elders remains with education and clinical supervision. *Scandinavian Journal of Caring Sciences* 21, 379-389.

III. Fläckman B., Hansebo G., Kihlgren M. & Kihlgren A. Struggling to adapt: caring for older persons while under threat of organizational change and termination notice. Resubmitted.

IV. Fläckman B., Sørli V. & Kihlgren M. (2008). Unmet expectation: why nursing home staff leave care work. *Journal of Older People Nursing* 3, 55-62.

The papers have been printed with the kind permission of the respective journals.

INTRODUCTION

In recent years, the conditions surrounding the care of elders in Sweden have been a common topic. Caregivers deal with older adults with multiple diagnoses who often present complex problems and require advanced nursing care (Aminzadeh & Dalzell 2002, Wimo et al. 2002). Financial cutbacks are a reality and have resulted in reductions in hospital beds and in the number of nursing homes (NHs). Older people with the greatest needs are prioritized (National Board of Health and Welfare 2008), the consequence being an increased workload in today's Swedish NHs. Organizational changes, in turn, may result in decreased quality of nursing care at NHs (National Board of Health and Welfare 2004). In acute care, periods of personnel reduction and ongoing reorganization have contributed to feelings of a 'waste of human resources' and 'competence drain' in caregivers (Hertting et al. 2004). Little is known about caregivers' experiences of the consequences of cutbacks and changes in an eldercare context. Staff turnover and sick leave are well known, and furthermore, difficulties in recruiting and retaining personnel with a formal education constitute a great problem (SALAR 2006). Current organizational theory and empirical evidence suggest that a supportive workplace promotes satisfaction and retention of workers (Riggs & Rantz 2001). Some reports have shown positive effects of support through education and clinical supervision on patients (Kihlgren 1992) and on staff, as well as on the quality of care (Edberg 1999, Hansebo & Kihlgren 2004), but there is a lack of knowledge about effects over a longer period.

BACKGROUND

Caregivers' working life and working conditions in nursing homes

The increased workload seen in today's Swedish NHs has been discussed by several authors (Gurner & Thorslund 2003, Häggström et al. 2005, Skovdahl et al. in press). Demographically, the age group 80 years and older has increased by 87% between 1980 and 2007 (263,000 to 590,962) (Statistics Sweden, 2007). Despite this growth, there has been a reduction in places for older people in the healthcare system, and older people with the greatest needs are prioritized (National Board of Health and Welfare, 2008). In 1998, 118,700 persons lived in nursing homes (NH), and by 2006, these numbers had decreased to 98,600 (National Board of Health and Welfare 2008). In addition, the hospitals considerably reduced their number of beds by 55% (from 58,000 to 26,000) between 1992 and 2006 as well as the

length of each hospital stay (Statistics Sweden 2007). As older people often present complex problems and require higher levels of nursing care (Aminzadeh & Dalziel 2002, Wimo et al. 2001), the consequence today is a considerably increased workload in Swedish NHs (Gustafsson & Szebehely 2005).

Among those working in eldercare, licensed practical nurses (LPNs) and nurse's aides (NAs) make up the largest group, with registered nurses (RNs) numbering only a few (National Board of Health and Welfare 2008). Physicians, usually a general practitioner from primary healthcare at the county council, function as consultants (Ministry of Health and Social Affairs 2007, SALAR 2006). The NH manager, whose role is strictly administrative, is often educated in and experienced with social care (Åberg et al. 2004). The caregivers provide care that is complex and personal. LPNs and NAs perform services for older people according to the Social Service Act (SoL) (SFS 2001: 453) and on delegation from RNs (SOSFS 1997: 14), who perform healthcare according to Health and Medical Service Act (HSL) (SFS 1982: 763). RNs and physicians are health and medical staff and are guided by the Act on Professional Activity (SFS 1998:531) in the health and medical area.

One of the most critical issues in care of older people is the shortage of healthcare professionals. A lack of well-educated personnel and difficulties in retaining personnel are well-known facts that have an immense impact. This is compounded by an insufficient number of young people who choose educational programmes and work in eldercare. Furthermore, there are problems with personnel turnover and absences due to illness (Karsh et al. 2005, National Board of Health and Welfare 2008). Different factors have been said to influence these situations, for instance institutional factors, such as continuing changes in the organizational structure of NHs and scarcity of resources, such as staffing, and instability in leadership (Brannon et al. 2002, Kash et al. 2006, Castle 2005). As people live longer nowadays despite diseases, they consume an increasing amount of various forms of healthcare. At the same time, the financial resources in society are decreasing, necessitating efficient use of healthcare resources (National Board of Health and Welfare 2008).

Changes in the working life

Organizations worldwide are undergoing rapid and often far-reaching changes. The changes and conditions surrounding eldercare have long been and remain an ongoing problem. Reductions in places in NHs have been caused by financial cutbacks due to budget limitations (National Board of Health and Welfare, 2004). Research on organizational downsizing has shown that growing work demands may lead to health risk problems among personnel

(Kivimäki et al. 2000, Westerlund et al. 2004). Changes in working life create job insecurity and have been noted as contributing to work-related stress reactions. A decrease in psychological well-being and job satisfaction is reported, as well as higher degrees of psychosomatic complaints and physical strains (De Witte 1999). Regarding working under threat of cutbacks and termination notice, life is influenced to a high degree by increasing stress levels (Brenner 1988).

Research shows that both leaders and employees are confronted with the consequences of such changes in organizations. The effects of organizational changes (Lind Nilsson 2003) and the organizational climate (Ekvall 1996) are to a fairly large extent in the hands of the manager. The psychological effects of restructuring are linked with perceptions of low information and participation (Brown et al. 2006). National Board of Health and Welfare (2004) also highlighted that organizational changes may lead to hasty decisions and sometimes to unplanned cutbacks, which may lead to insecurity for older persons, increased demands on their relatives and caregivers, and worsened quality of care.

Support for improving care and increasing job satisfaction

The importance of sufficient staffing, time and knowledge in nursing care has been pointed out, and these factors have a major impact on quality of care for patients (Kayser-Jones et al. 2003, Wetle et al. 2005) and job satisfaction for personnel (Stone et al. 2006, Sung et al. 2005). Robertson et al. (1999) maintained that there is a connection between a sense of pleasure in one's work and continuous education among nurses in geriatric care. Some effects of staff support through education and clinical supervision on patients have been reported (Kihlgren, 1992) as well as on staff and on the quality of care (Edberg 1999, Hansebo & Kihlgren 2004), but there has been little work done on the effects of support in eldercare over a longer period. A 4-year follow-up study, however, has been reported on by Arvidsson et al. (2001) in the area of psychiatric care. Clinical group supervision was shown to give individual nurses the opportunity to take a step back and reflect upon their daily practice, to learn from others by sharing experiences and thus to gain personal knowledge about themselves and their professional development.

The concept of clinical supervision is sometimes difficult to clarify due to the variations in nursing practice (Lyth 2000). Lyth's definition in his concept analysis is as follows: Clinical supervision is a support mechanism for practising professionalism within which they can share clinical, organizational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and

skills. This process will lead to increased awareness of other concepts, including accountability and reflective practice (Lyth 2000, p.728). Supervision also promotes increased self-assurance and greater ability to enter into an authentic relationship with the patient, as well as developing more responsibility for the provision of care (Berggren & Severinsson 2000, Hansebo & Kihlgren 2004).

Based on current organizational theory and empirical evidence, Riggs and Rantz (2001) also suggested that a supportive workplace promotes satisfaction and retention of workers. Staff turnover and sick leave in eldercare in Sweden have constituted a great problem for many years, but are decreasing, according to SALAR (2006). Research on caregivers' experiences of the working situation in NHs reveals variations. Researchers have reported that RNs and NAs found long-term care to be a very satisfying area to work in (Moyle et al. 2003). NAs who stay in long-term care mention a real sense of connection, or family, with a subset of residents and co-workers (Secrest 2005). Another report shows that employees in eldercare experienced the care work as meaningful, and were of the opinion that they had the competence they needed to do their job. This increased their opportunities to have control over their work (Josephson & Wingård 2002). On the contrary, other studies have shown that LPNs and NAs are more displeased with their work conditions than are other working groups (Gustafsson & Szebehely 2005). The situations of NAs and LPNs are generally described as work with low wages and poor benefits, resulting in illness absenteeism, high turnover rates and inadequate staffing. This, in turn, may lead to poor care quality and high personnel costs (Gurner & Thorslund 2003).

Previous studies have shown that an adequate number of well-trained nurses and a stable nursing staff were essential to the quality of care (McAiney 1998, Schnelle et al. 2004). Furthermore, lack of staff continuity in nursing homes was often stressed as a problem in a study by Hov (2007), as it could lead to misinterpretation and misunderstanding that increased the patients' suffering. Little research has been done on what causes NH staff to decide to leave their employment. The same concerns knowledge about the effects of education and continuous support, particularly during periods of change in working conditions. With this in mind, it is important to conduct further research to increase our knowledge of these issues, so that we can meet the needs of the increasing number of older people who are dependent on healthcare in community settings.

RATIONALE FOR THE STUDIES

The literature review shows that community eldercare in Sweden is characterized by an increasing number of older people with multiple disease history, and difficulties in recruiting and retaining staff. Organizational changes have become a part of everyday life, but little attention has been given to caregivers' experiences of how this influences them and their caring work during periods of threat of overloading and notice of termination. Furthermore, few studies can be found that elucidate what causes nursing home staff to stay or leave work while working under such circumstances. Studies have shown positive effects of support through education and clinical supervision, but there is a lack of knowledge of effects over a longer period, also when combined with organizational changes. Accordingly, it seemed necessary to further investigate caregivers' experiences of their work during organizational changes, in spite of any support given.

AIMS OF THE THESIS

The overall aim of the present thesis was to reveal nursing home caregivers' work experiences when receiving support through education and clinical supervision for two years, while the workplace was undergoing organizational changes.

The specific aims for the studies in the thesis were:

- I.** To investigate the organizational climate and the prevalence of burnout symptoms among caregivers, over time in three nursing homes undergoing organizational changes.
- II.** To describe nursing home caregivers' work experiences while receiving education and clinical supervision for two years.
- III.** To illuminate caregivers' experiences of and reflection on working in eldercare while under threat of organizational change and termination notice.
- IV.** To illuminate what had caused nursing home caregivers to decide to leave their employment in eldercare.

METHODS

Design

The present thesis consists of four studies (**I-IV**), involving caregivers within the municipal eldercare system. The studies are part of a two-year longitudinal project in three Swedish nursing homes (NH I-NH III), in which support through education and clinical supervision was given to the staff at NH I-II. During the course of the project, administrative reorganization and personnel reduction were instituted at all three of the NHs, as a result of political decisions, but at different times. An overview of the research project with support and information on financial cutbacks is presented in Figure 1.

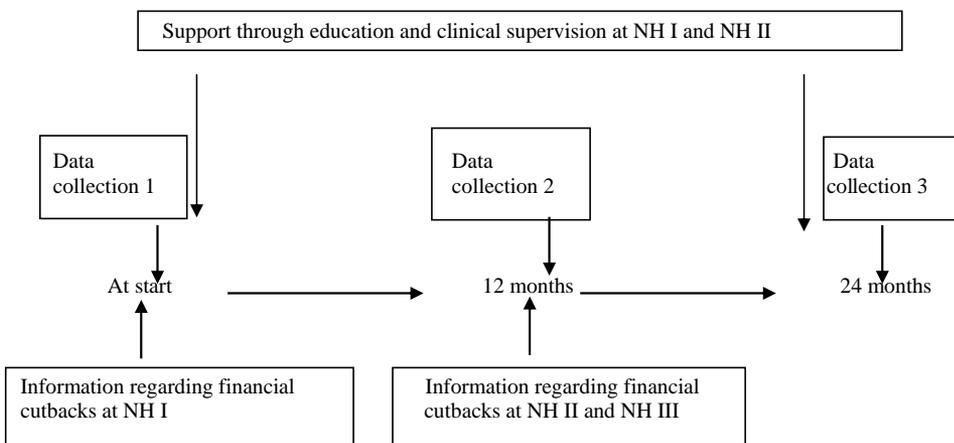


Figure 1. Design of the main project and time frame for information regarding financial cutbacks at the respective nursing homes, NH I, NH II and NH III

Table 1 shows an overview of the respective studies: a quantitative approach (**I**) with self-assessment questionnaires and a qualitative approach with caregiver interviews (**I-IV**).

Table 1. Overview of studies I-IV

Study	Focus	Sample	Data collection	Analysis method
I	Caregivers' self-assessment of organizational climate and burnout while receiving support during two years	Sample see Table 2-3	The Creativity and Innovative Climate Questionnaire (CCQ) x 3 and Maslach Burnout Inventory (MBI) x 3 (at start, after 12 months and after 24 months)	Descriptive statistics
	Caregivers' work experiences based on CCQ and MBI	5 caregivers from each NH I-III	Interviews x 3 (at start, after 12 months and after 24 months) (n=45)	Qualitative content analysis
II	Caregivers' work experiences while receiving support during two years	7 caregivers from NH II	Interviews x 3 (at start, after 12 months and after 24 months) (n=21)	Qualitative content analysis
III	Caregivers' work experiences during threat of organizational changes and notice of termination	11 caregivers at NH III	Interviews x 3 (at start, after 12 months and after 24 months) (n=33)	Qualitative content analysis
IV	Caregivers' decision to leave their employment	18 caregivers from NH I - NH III who decided to leave work	Interviews in connection with leaving work; 9 close to study start and 9 within a year (n=18)	Qualitative content analysis

Settings

NH I was situated in a city with a population over 100,000. NH II and NH III were located in a community with 20,000 inhabitants. NH I and NH II were both new facilities with 40 residents each, and NH III, which had existed for 10 years, had 52 residents at the outset of the study. The residents from the three NHs had multiple diagnoses and a majority had dementia diseases, some of them in severe stages with demanding and psychiatric symptoms. Each of the three NHs had one RN mostly, and the total ratio, including LPNs and NAs, was 1.0 staff member per bed (including night staff), which was to cover all the shifts. Caregivers' work included cleaning the ward as well as washing the residents' clothes. The RN was responsible for nursing care, dispensing medication and determining whether a doctor should be consulted, but did not take part in daily nursing care.

The two-year support through education and clinical supervision started after collecting the initial data at NHs I and II. Caregivers from NH I and NH II were able to request the educational topics and could give their input regarding the education and clinical supervision. A voluntary training program was offered and conducted by physicians and nurse specialists

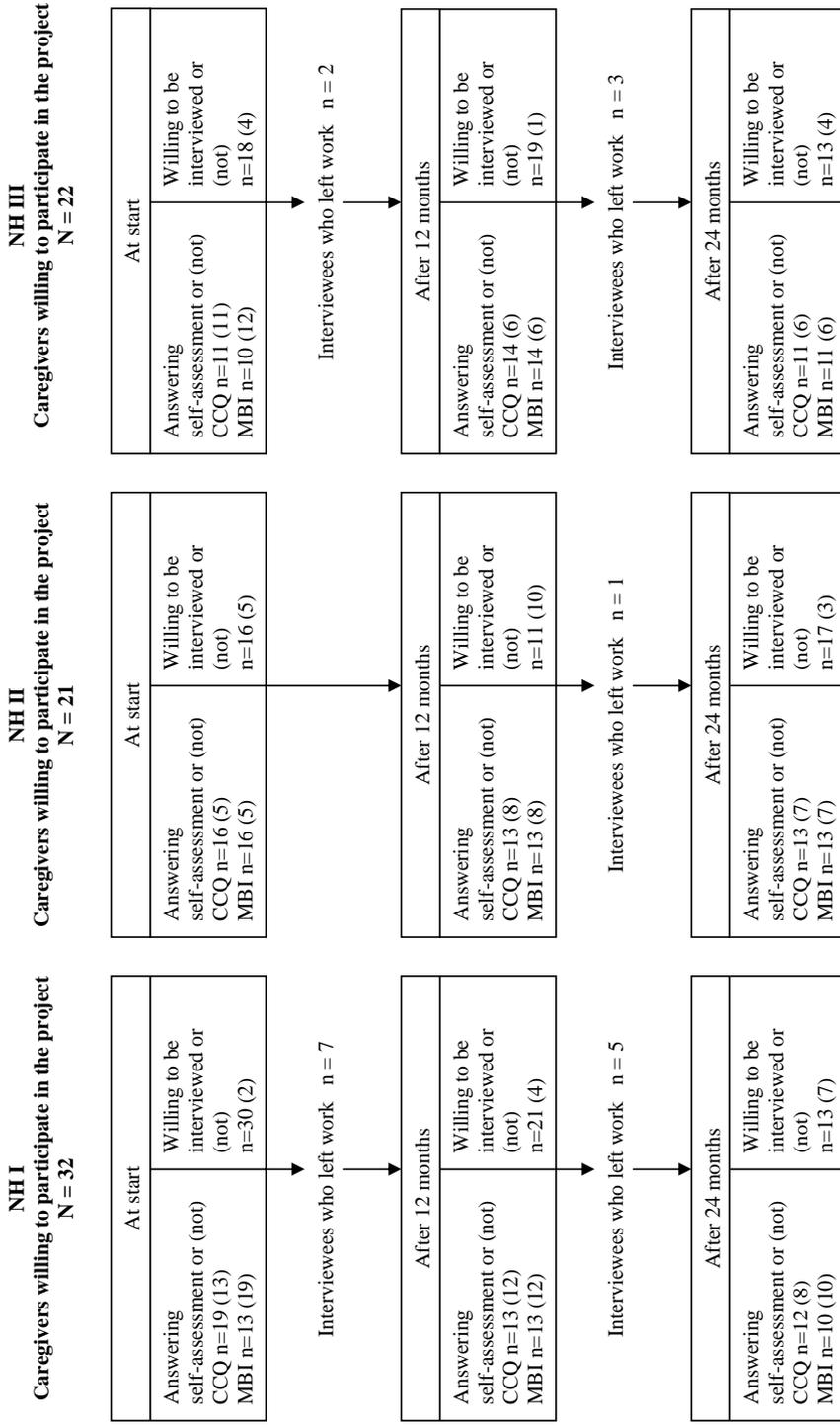


Figure 2. Caregivers who volunteered to participate, drop outs, and those who participated at start, after 12 months and after 24 months.

during the two years. Caregivers sought more knowledge about diseases and care of persons with stroke, Parkinson's disease and dementia, as well as additional training in communication, seeking literature, team cooperation, conflict management as well as lectures on how to deliver 'integrity promoting care' (Kihlgren 1992 pp. 32-33). In order to establish individual resident care plans, training was given in using The Resident Assessment Instrument (RAI/MDS) (Hansebo et al. 1993). The clinical supervision was offered once a month and was provided by two nurses from the same research centre with the same orientation and background. This support included their participation in and observation of bedside care as well as being available to answer questions about individual residents.

Financial cutbacks at NH I began to be known shortly after opening, in spite of promises of ample staffing. At NH II and NH III, rumours of the cutbacks and some changes began around 12 months after the start of the project (Figure I). Reduction in the number of employees and a simultaneous increase in the number of residents were carried out. When, for instance, personnel were on sick leave, they were not replaced and tasks were therefore transferred to others, adding to their workload.

Sample

All caregivers at NH I-III were verbally informed about the aim of the project. Caregivers who volunteered to participate, dropouts, and those who participated are presented in Figure 2. At NH I, all caregivers who gave their informed consent to participate were included. All caregivers at NH II and NH III gave their consent to participate, but in order to achieve a manageable number of participants to interview, every second caregiver was randomly selected from the payroll list to participate. Most caregivers had prior experience of working with older people. The majority had more than 10 years' experiences in eldercare. The included caregivers ranged in age from 18-64, of them 2/3 were between 35-64. The caregivers from NH I-III, who were interviewed and who answered the self-assessments (I), were not always the same each time. For example, a caregiver could have answered only the first and the third assessments or only one of the assessments on one occasion. Only those who were included in the project from the start participated. Caregivers dropped out due to illness, personnel turnover, inability to respond for personal reasons, and others declined without giving a reason (Figure 2). The interviewed caregivers in Study I (5 from each NH) were selected by drawing five interviews from each interview occasion in the main project. The caregivers who performed the self-assessments (I) are presented in Tables 2-3.

Table 2. Descriptions of the caregivers (Study I) at NH I-III and their response rate on CCQ

	NH I			NH II			NH III		
	At start n=19	12 months n=13	24 months n=12	At start n=16	12 months n=13	24 months n=13	At start n=11	12 months n=14	24 months n=11
Caregivers									
RNs and LPNs	1	1	0	0	0	0	0	0	0
NAs and SS	15	11	11	7	6	7	2	1	2
Female/male	2/0	1/0	1/0	8/1	6/1	6/0	9/0	13/0	9
Age (years)	17/1	12/1	10/2	15/1	12/1	11/2	11/0	14/0	11/0
18-34	5	2	2	4		2	2	2	1
35-44	8	7	7	8	7	6		1	1
45-54	2	2	2	2	3	3	4	5	4
55-64	3	2	1	2	3	2	5	6	5
Day/night shift	16/2	12/1	9/3	13/3	13/0	12/1	11/0	12/2	10/1
Years of healthcare experience	< 1	1							
1-10	2	2	2	5	3	4	2	1	2
> 10	15	11	10	11	10	9	9	13	9
Missing data	1								

Table 3. Descriptions of the caregivers (Study I) from NH I-III and their response rate on MBI

	NH I			NH II			NH III		
	At start n=13	12 months n=13	24 months n=10	At start n=16	12 months n=13	24 months n=13	At start n=10	12 months n=14	24 months n=11
Caregivers									
RNs and LPNs	0/10	1/11	1/9	0/7	0/6	0/6	0/2	0/2	0/2
NAs and SS	2/0	1/0	0/0	8/1	6/1	6/1	8/0	12/0	9/0
Female/male	12/0	12/0	8/2	15/1	12/1	11/2	10/0	14/0	11/0
Age (years)	18-34	4	3	2	4	3	2	1	2
35-44	4	6	6	8	5	6		1	1
45-54	1	2	2	2	3	3	4	6	4
55-64	3	2		2	2	2	5	5	5
Day/night shift	10/2	12/1	8/2	13/3	12/1	12/1	10/0	2/2	10/1
Years of healthcare experience	< 1	1							
1-10	2	2	2	5	2	4	1	2	2
> 10	9	11	8	11	11	9	9	12	9
Missing data	1								

In Study **II** and **III**, only those caregivers at NH II and NH III who had been interviewed on all three occasions were included.

In Study **II**, four LPNs and three NAs (n=7) from NH II participated.

In Study **III**, two LPNs, two NAs and seven with no formal education (n=11) participated.

In Study **IV**, fourteen LPNs and four NAs (n=18) at the three NHs, who decided to leave their employment during the study period, agreed to be interviewed.

Data collection

The interviews and self-assessments on which the present thesis is built were conducted at three occasions: at start, after 12 and 24 months at the respective NHs (I-III), except for the

interviews in Study **IV**, which were performed when the caregivers had decided to leave work. In connection with interviews (**I-IV**), the self-assessment questionnaires (**I**) were distributed. The questionnaires were then sent by the caregivers themselves in pre-paid stamped envelopes to the research team.

Interviews

The interviews (**I-IV**) took place in a setting chosen by the interviewees where there would be no interruptions. The interviews started by asking the caregivers about their expectations of working in the NH and how they felt about taking care of older people, the joys and difficulties involved with the work and how they envisioned the future. Study **IV** also focused on their decision to leave their employment. The interviewees were instructed to narrate freely using their own choice of words. To clarify and develop the content of the narratives, questions such as 'please tell me more about this situation' or 'can you tell me more about how you felt regarding that situation' were asked (cf. Mishler 1986). The interviews lasted 30-60 minutes, were tape-recorded with the participants' permission and transcribed verbatim by an experienced secretary.

Self-assessments

Creativity and Innovative Climate Questionnaire (CCQ)

In order to measure the creative climate at the three NHs (Study **I**), the CCQ self-assessment instrument (Ekvall 1996) was used for measuring an organization's degree of creativity and innovativeness. The CCQ has been used earlier in Sweden (Boström et al. 2006, Mattiasson & Andersson 1995, Lövgren et al. 2002, Norberg et al. 2002). The CCQ consists of 50 statements covering the following ten dimensions (Table 4) with five items each. The responses range from absolutely not applicable (0) to applicable to some extent (1), fairly applicable (2) and highly applicable (3). The points for these five statements are added up and then divided by the number of statements. The dimensions were developed through several large-factor analytic studies. The stability, internal consistency and reliability have been tested and are considered high (Ekvall 1996). The instrument is described as being an organizational rather than an individual measure, as the changes are measured at the organizational level (Ekvall 1996). The mean value in each dimension can vary from strong and dynamic, 3.0, to that of an extremely weak and stagnating organization, 0.0. The scales are not reciprocally calibrated, for example the value 2.0 in one dimension is not necessarily higher than 1.5 in

another. Comparison can only be made dimension by dimension. Cronbach's alpha reliability coefficient for the CCQ subscales in Study I is 0.85.

Table 4. The 10 dimensions and what they represented (Ekvall, 1996).

Challenge: Indicating the degree of emotional involvement in operations and goals in the organization
Freedom: Indicating the degree of independence and decision-making
Idea support: Describing the way new ideas are apprehended
Trust/openness: Indicating the emotional security in relations
Dynamism/liveliness: Describing the event fullness that exists in the organization
Playfulness/humour: Representing the ease in the atmosphere
Debates: Indicating the extent to which it is possible to discuss and share experiences and ideas
Conflicts: Indicating the degree of personal and emotional tension (low scores are desirable, in contrast to other dimensions)
Risk-taking: Indicating the organization's ability to tolerate uncertainty
Idea-time: Representing the time available to work out new ideas

Maslach Burnout Inventory (MBI)

The MBI instrument (Maslach et al. 1996, 1981) was used (I) when exploring the extent of burnout at the three NHs. The sources of burnout in healthcare are multiple and complex, and the work environment is believed to be one of the major reasons for the increase in burnout (Glasberg 2007). The MBI has become one of the most widely used and validated instruments for assessing burnout and was translated into Swedish by Hallsten (1985). The scale consists of 22 items divided into three subscales. Emotional Exhaustion (EE) uses nine items to assess 'feelings of being emotionally overextended and exhausted by one's work'. Depersonalization (DP), another subscale, consists of five items and assesses 'unfeeling and impersonal response towards recipients of one's care'. The Personal Accomplishment (PA) subscale, with eight items, assesses 'feeling of competence and successful achievement in one's work with people' (Maslach et al. 1996, 1981). The MBI is scored on a 7-point scale from never (0) to every day (6). Responses are summed to give separate scores for each of the three subscales and are categorized into low, average or high degrees of burnout according to normative data (Maslach et al. 1996). Carers with a high degree of emotional exhaustion and depersonalization and a low degree of personal accomplishment are believed to suffer from more burnout (Maslach & Jackson 1981). The reliability coefficient for the MBI subscale in Study I was 0.75.

Analysis

Qualitative content analyses

Qualitative content analysis was performed in the studies presented here (Study **I–IV**). The method provides interesting and theoretically useful generalization with minimal loss of information from the original data (Downe-Wamboldt 1992). Downe-Wamboldt (1992) and Kondracki et al. (2002) have differentiated the manifest analysis from the latent analysis by stating that the manifest content is what the text says and the latent content is what the text is talking about. Qualitative content analysis is an interpretative process, where the researcher takes the content of the text into consideration. The analysis is based on how the different aspects in the text relate to each other. Three approaches to qualitative content analyses have recently been described as conventional, directed and summative (Hsieh & Shannon 2005). The differences between those approaches are related to the coding schemes and the origins of codes. Directed content analysis begins with the aim to further study the phenomenon when theory or prior research is incomplete. The research will be guided by the existing theory or previous research findings, and the analysis may have initial schemes of coding and predetermined codes. Even though this method uses a deductive approach, it is still based on the naturalistic paradigm (Hsieh & Shannon 2005).

For the qualitative analysis of the interviews in Study **I**, a direct content analysis was used (Hsieh & Shannon 2005). Ekvall's (1996) ten dimensions presented in Table 4 and the three subscales in MBI by Maslach et al. (1996) were used in the deductive phase as a raster. The interviews were analysed by two co-authors who had not performed the interviews. After reading the entire texts from the three interview periods several times, this strategy begins by coding immediately with the predetermined codes (Hsieh and Shannon 2005). Notes were made indicating if and how the interviews changed over time dependent on occurrences and intensity. To validate the outcome, all authors discussed the findings until consensus was reached.

For the interviews in Study **II–IV**, a qualitative content analysis was used based on work by Graneheim and Lundman (2004). Considering the aim of the studies, it was regarded as an appropriate method, as it facilitates a systematic description of the manifest and latent content of the interviews. The analysis was performed in several steps: First, the interviews were read through several times to obtain a sense of the whole. Then the text from the interviews at start was divided into meaning units and condensed. The meaning units were critically analysed, considered and coded. Then the text from the second and third interviews in Study **II** and **III** was analysed in the same way and notes were made indicating how the

interviews changed over time. The codes were compared with each other based on differences and similarities and sorted into subcategories, categories (**IV**) and then themes (**II-III**). The analysis in Study **IV** followed the same process, but without analysing changes over time. To validate the outcome of Study **II-IV**, the sub-categories, categories, main categories (**IV**) and themes (**II-III**) that emerged from the text (Downe-Wamboldt 1992) were discussed and revised until agreement was reached between all of the authors.

Statistical analyses

Descriptive analysis using means and standard deviations was used for all responses. The Kruskal-Wallis non-parametric method was used to analyse the differences within the three independent NHs at start and both follow-up measurements. When significant differences emerged, the Mann-Whitney U-test was used (Polit & Beck 2008). A P value ≤ 0.05 was considered statistically significant. The analyses were made using the SPSS computer program, version 12.

Ethical consideration

The focus of the present studies was on the caregivers, and the old persons they were caring for were not directly involved. However, as they were present in the narratives, one has to remember to treat the information given about the older persons with respect. They are frail and vulnerable, and it is important to respect theirs as well as the caregivers' autonomy and integrity as far as possible (Polit & Beck 2008). When interviewing people, it is very important that the interviewer is aware of and understands the interviewees' vulnerability and the potentially exposed situation they are in, and this requires sensitivity. Contact was made with the employer, the local authority, who gave us permission to conduct the present longitudinal study. The local Research Ethics Committees (§ 803/99, § 00-070) granted permission. All caregivers were verbally informed about the aim of the project and gave their informed consent to participate. Confidentiality was guaranteed, and they were informed that their participation was voluntary and they could withdraw at any time without giving a reason. During the study, many caregivers dropped out due to illness, personnel turnover, inability to respond for personal reasons and others declined without giving a reason. In an effort to avoid revealing the participants' identity, the interviews from the respective NHs were analysed as a group.

RESULT

Study I

NH I

NH I showed an improvement over the two-year period on both the CCQ scores measurement, the MBI measurement and in the interviews. The qualitative findings differed, however, from the quantitative measurements. Significant differences for the better were found over time in the CCQ dimensions of 'idea support' and 'idea time' (Figure 3a), and in MBI, the degree of burnout changed for the better (Figure 3b). The improvement was not as distinct in the interviews as in the scores. Difficulties in implementing new ideas were seen in the interviews at start due to lack of time and support from management. Conflicts were also prevalent in the personnel group, the interviewees held, due to different opinions about prioritizing work and informal leaders. A lack of independence to work out new ideas was also obvious at the 12-month follow-up interviews. Conflicts still existed among the caregivers as well as frustration over weak leadership, although the CCQ scores for conflicts improved to an innovative level. The caregivers expressed that they tried to do their work, but they saw no possibility to use their competence in the work. Conflicts and lack of idea time created a lack of freedom. At the 24-month assessment, the CCQ scores had passed the innovative level positively, and the third interviews showed a more favourable development, but some conflicts still existed due to weak leadership. Despite the conflicts, an ability to accept uncertainty and disparity was indicated among the remaining caregivers. After the two years, a more playful and humorous atmosphere was seen, which was useful for tackling avoided discussions and in coping with their work.

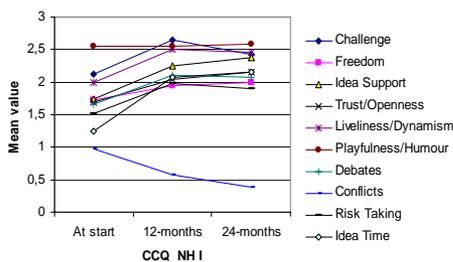


Figure 3 a. Caregivers' (NH I) response rate from CCQ with mean values. High values (except conflicts) are representative of a more positive climate.

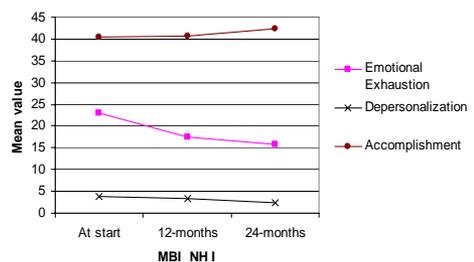


Figure 3 b. Caregivers' (NH I) response rate from MBI with mean values. Low values (except accomplishment) are representative of a more favourable score.

NH II

At NH II, the qualitative findings and the quantitative measurements were more similar over time. In most of the CCQ dimensions, an unfavourable development was seen (Figure 4a), but no changes were significant. The MBI scores worsened at the 12-month assessment (Figure 4b), which corresponded to the time when the interviewees received information about financial cutbacks (Figure 1). The first interviews showed that challenge, freedom and playfulness were prevalent, including positive feelings and expectations regarding their new work. The caregivers felt support from management, time was available to work out new ideas, and the workplace climate was characterized by an easy atmosphere. After one year, uncertainty was obvious in the interviews, and trust and openness with regard to the management had decreased. Conflicts were increasing in the work groups, and freedom and independence in decision-making were no longer prominent. In the 24-month interviews, the caregivers reported being more watched over in their work. Lack of emotional involvement and trust in management was striking. Conflicts existed in the groups, and lack of idea support was seen. Their expectations of giving good care would not be fulfilled, they realized, but they were not willing to give up.

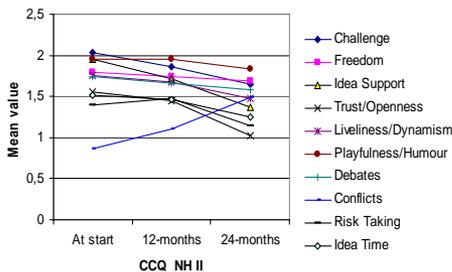


Figure 4 a. Caregivers' (NH II) response rate from CCQ with mean values. High values (except conflicts) are representative of a more positive climate.

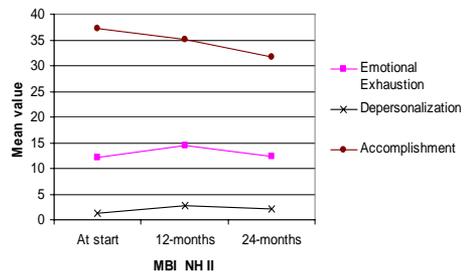


Figure 4 b. Caregivers' (NH II) response rate from MBI with mean values. Low values (except accomplishment) are representative of a more favourable score.

NH III

The scores from NH III were rather stable throughout the study regarding the quantitative measurements. However, half of the CCQ dimensions demonstrated less favourable conditions at the 24-month follow-up (Figure 5a). In the MBI measurement, the mean scores worsened at 12 months, but ultimately improved from baseline after 24 months (Figure 5b). The interviews at start showed that trust, dynamism and playfulness predominated. In the interviews after a year, feelings of insecurity and increasing conflicts were expressed.

Discussions about reductions and termination notice filled their days. At the 24-month follow-up, the caregivers talked about making the best of the situation. They were safeguarding of themselves and the residents, and their feelings of responsibility for the residents caused them to continue to struggle.

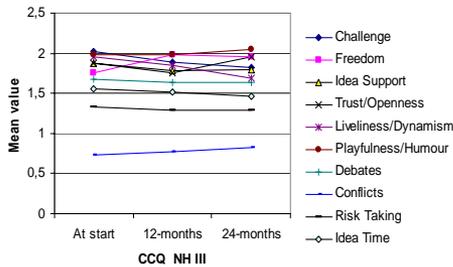


Figure 5 a. Caregivers' (NH III) response rate from CCQ with mean values. High values (except conflicts) are representative of a more positive climate.

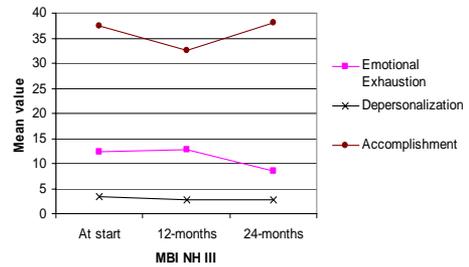


Figure 5 b. Caregivers' (NH III) response rate from MBI with mean values. Low values (except accomplishment) are representative of a more favourable score.

Study II

Looking at the NH II caregivers' work experiences while receiving education and clinical supervision for two years, it was obvious that they *valued a caring milieu and valued knowledge*. Their willingness to care continued despite their disappointment in the worsened working conditions. The main theme that resulted was: *Despite shattered expectations a willingness to care for elders remains*.

Value of a caring milieu

The initial interviews were marked by positive experiences from starting the new NH and optimistic outlooks for the future. The caregivers were proud of the freedom they had been given to implement a positive milieu for themselves and the older people in the NH. By the time of the second interviews 12 months later, the caregivers were informed about the coming changes. They realized the importance of being able to voice their demands regarding the work situation. Time to spend with the older people was further decreased. Some of the caregivers felt a strain in their relationship with the older people and other caregivers. They wished they had a leader who did not back down or hide when difficult situations arose, and they were disappointed by the lack of support. After two years, the work pace was hectic, it

seemed that their expectations of giving good care would not be fulfilled, but they were not willing to give up. Their feelings of caring for the older people were unchanged. They still saw the importance of meeting the residents' needs, but they now viewed this more as a quality aspect. They also felt that the manager did not do what a manager ought to do. The RN's role was brought up and discussed, but she was not seen as a leader.

Value of knowledge

The caregivers' different backgrounds and experiences were seen as a source of strength and something to build upon, at start. After 12 months, the support through education and clinical supervision was viewed as useful and important for developing the care they were providing. However, they realized that they could not provide more than basic care, and there was a threat that they would not be able to do a good job. The importance of reflection in both their working and private lives was discussed. Still, there was some hope that they could continue to have influence over their work and to use most of their skills and knowledge. In the 24-month follow-up, the caregivers realized the importance of knowing more about the residents and their needs and saw them from a different perspective. They pointed out the need for support from the manager and the RN to actualize what had been gained from education, and they asked for help with implementation of this knowledge.

Study III

The main findings indicated that the threat of organizational changes and notice of termination changed the caregivers' experiences of the work conditions at NH III. A transition seemed to have occurred during the study period, and they struggled to adapt to the new situation. At start, the theme that resulted was *Having a professional identity and self-confidence*. The categories that emerged from the caregivers' experiences were: *Experiences of pride and satisfaction* and *Experiences of having professional competence*.

Experiences of pride and satisfaction

At start, pride and satisfaction were expressed among the caregivers with regard to doing a good job and feeling the appreciation of relatives, older people and the manager. The workplace was familiar to them, which created security and feelings of a relaxed atmosphere among the staff. Co-operation between management and co-workers was good.

Experiences of having professional competence

Likewise, they also reported having professional competence, which they expressed as having a 'good flow' in their work, seeing what was going to happen before it happened, and being able to handle any situation that might arise. They expressed that they had the opportunity to provide care and emphasized the importance of an adequate work group and workload, likewise of having a manager who is present. However, they felt that the running of the NH was not based on older people's needs and desire.

After 12 months, the theme that resulted was *Being a professional in a threatening situation created by someone else*, and the categories that emerged from the caregivers' experiences were: *Experiences of losing control* and *Experiences of decreasing influence*

Experiences of losing control

The caregivers described a weaker position, feelings of insecurity and increasing conflicts, feelings of losing co-workers, and of resignation. Their freedom of action had been minimized; they did not know where they would be working when they arrived or which resident they would be responsible for. Discussions about reductions and termination notice had given rise to an unpleasant atmosphere.

Experiences of decreasing influence

The caregivers felt that how and when things should be done were directed from above, without any dialogue. Tasks had been delegated to them, e.g. to call stand-ins, purchase clothes for the residents, which were tasks they did not feel they had the competence or time for. Now they were back at point zero, but they were ready to accept anything to keep their work. They emphasized that relationships with residents, relatives and their manager were important.

After 24 months, the theme that emerged was *Struggling to adapt to the changed working environment as a person and professional*. The categories that emerged from the caregivers' experiences were expressed like: *Trying to do one's best to complete the caregiver's duties despite loss of something important*. They tried to make the best of the situation despite the loss of something important: their pride and satisfaction. The caregivers concentrated their energies on the older persons' needs and were worried about the residents' future. They had

feelings of lack of commitment and tried to shut off negative feelings. Safeguarding the residents' and their own well-being was more prominent than before.

Study IV

The main findings indicated that all caregivers' decisions to leave their work in eldercare could be encompassed in one main category: *Unmet expectations*.

The caregivers' narratives indicated that it was not the work with the older persons per se that caused them to leave. Instead, it was the information about the impending administrative reorganization and personnel reductions that caused them to leave. The caregivers' experience of *lack of encouragement* – that they were not given recognition for their contribution or encouragement at the workplace – was another reason. The management was experienced as weak and distant from them. The *lack of trust* included absence of trust in everything, from the caregivers' own professional knowledge to their colleagues, supervisors and the organization. The category *lack of professional development* referred to their feeling that their professional knowledge had not been fully made use of or allowed to develop. Their skills in caring for people with dementia diagnosis were not appreciated. *Feelings of insecurity* and instability were reported at the workplace, which included lack of continuity and no introduction period. Different opinions about care giving and how various tasks should be performed constituted a breeding ground for conflicts. The interviewees emphasized that managers and supervisors should dare to talk about grievances, otherwise conflicts will grow. They felt disregarded and betrayed, and alluded to an inadequate number of qualified caregivers. Further, they felt that they were betraying the old people by not having enough time to individualize care, but they also felt betrayed by the leadership. These expectations led to thoughts about taking advantage of other opportunities and leaving work.

METHODOLOGICAL CONSIDERATIONS

Due to the administrative reorganizations and reductions, which were instituted at all three of the NHs and partly carried through during the two-year period, the focus of the main project was changed. Caregivers' experiences of working in an eldercare system undergoing organizational changes were added to the earlier focus: experiences of work in eldercare during support through education and clinical supervision. These changes were considered

part of the real world and seen as something we could learn from. It seemed important to gain new knowledge of caregivers' experiences during these circumstances.

The two NHs selected for receiving support were newly opened, one located in a city (NH I) and one in a community area (NH II). NH III, also from a community area, was included as the control, despite its ten-year existence, as no other newly opened NH was eligible in the area. Over time, the sample size became smaller than originally planned, mainly due to the two-year study period with organizational changes. The changes were instituted and partly carried out, and thereby affected the number of participants and the evaluation of staff support. Therefore, given the changes in the present study, any conclusions about the influences of the support have to be made with caution. The uncontrolled factors influencing the study and the prior design are confounding factors that make drawing conclusion more difficult. Having control over confounding factors is a strength, but it was not within the power of the research team in this case. Changes in eldercare are a common reality today. With respect to doing research, the alternative to accepting that changes occur would be to avoid research in areas where variables are difficult to control, which would mean a continued lack of knowledge in those areas. The sample size, however, was regarded to be large enough to achieve the aims of the different studies.

The present author was not involved in the support given in the project, but in the data collection and analysis processes. This may be seen as a disadvantage, but also as an advantage, as the author had no pre-understanding of experiences or knowledge about the continuing supporting process at the nursing homes. In quantitative research, the concepts of validity, reliability and generalizability are used for describing truth of findings (Polit & Beck 2008). For establishing the trustworthiness of qualitative data, credibility, dependability, confirmability and transferability were seen as interrelated aspects (Graneheim & Lundman 2004, Lincon & Guba 1985, Polit & Beck 2008).

The design of Study I included a combination of both quantitative and qualitative approaches, which facilitated a deeper understanding within the area, among caregivers in eldercare, and this can be seen as a strength of the present study. Certain questions require a mixed method approach (Polit & Beck 2008) and 'mixed-method research can expand the scope and improve the analytic power of studies' (Sandelowski 2000 p. 254). Mixed methods can also help the researcher obtain different perspectives and a fuller picture (Happ et al. 2006). Another strength of the present study is that there are several data collection points over time. The methodological weakness of the quantitative part was that no power calculation with regard to

sample size was estimated, likewise the small sample sizes and high dropout rates. Therefore the informants were not always the same at the three data collection points, but no new caregivers were included in the study during the two-year period. As a consequence of the small sample size, there was a skewed distribution in the data that restricted the use of statistical operation to a non-parametric test in the analyses (Altman 1991). The obvious question regarding the limitation of self-reported questionnaires is how individuals respond to them (Polit & Beck 2008). Personality can influence how individuals rate their responses or to what degree individuals know about their attitudes or are willing to disclose them. Threats to internal validity include, for example, selection biases and other changes or events during the study period. Threats to external validity are, for example, reactions to the support through education and clinical supervision, and the arrangement and timing of assessment. However, staffs leaving for various reasons, high turnover rates and absence due to illness constitute a greater problem. Studies in other settings and contexts are needed to extend the generality of the findings. Study I is based on the use of well-established scales. The two self-assessments – CCQ and MBI – were used to measure the creative climate and the burnout symptoms at the three NHs. These instruments have been used in several international and Swedish studies and have been judged to be valid and reliable tools.

The qualitative data in Study I-IV were obtained via interviews. All interviews were guided by open-ended questions framed to reflect the aim of the studies and were conversational in nature (Mishler 1986). By using qualitative interviews, we were able to collect a rich variety of experiences. There may be problems, however, concerning how the interviewer and the interviewee connect to and interact with each other. Another risk is that the interviewee may try to narrate things in order to please the interviewer. The use of an audio tape-recorder may be one aspect affecting the content of the interviews. However, the interviewees were asked to talk freely, and most of the interviews were rich in length and quality. The informants narrated similar events, acknowledging their shortcomings and feelings as well as criticizing and examining their own way of acting. Trustworthiness will be discussed in terms of the concepts credibility, dependability, confirmability and transferability (Graneheim & Lundman 2004, Lincon & Guba 1985, Polit & Beck 2008). Different persons performed the interviews and the analyses, and this can be viewed as a strength. In Study I, the analysers were able to consider the interviews as a whole and without any pre-understandings based on the interview situations or earlier analyses.

Credibility refers to people's confidence in the truth of the data and the researcher's interpretation of the data. This involves carrying out the study so that the findings will be believable and taking steps to demonstrate credibility to consumers (Polit & Beck 2008, Lincoln & Guba 1985). In the present thesis, describing and illustrating the research process used, the data collection procedure and the steps in the analysis together constitute a way of establishing the credibility of the present studies. More than one of the researchers has analysed four or five interviews or they took part in checking the whole analysis process. The present results have been discussed with authors and presented at seminars. This is in line with Sandelowski's opinion (1986) that a qualitative study is credible when other people recognize the experience described in the study when they are confronted with the results.

Dependability concerns the stability of data over time and across different conditions (Polit & Beck, 2008). The detailed descriptions of the procedures demonstrate the dependability of the present studies. Three interviewers were involved in the data collection, but followed the same structure when interviewing. The aim was to make the interview situation somewhat similar, which contributed to achieving stability and consistency. However, using three interviewers can influence the results, because in a qualitative interview, the interviewee and the interviewer are said to give shape to the data together (Kvale 1997, Lincoln & Guba 1985).

Confirmability refers to the objectivity or neutrality of the data, the agreement between two or more independent people about the accuracy, relevance, or meaning of the data (Polit & Beck 2008). Use of a tape recorder during the interviews, as well as the verbatim transcription of the data, which was done by an experienced secretary, is believed to be valuable in ensuring the confirmability of the results. Listening to the tapes and reading the transcripts constituted a way of assuring agreement between what was said during the interviews and the transcription. Furthermore, the above-described co-assessments are believed to have contributed to the confirmability of the results (Polit & Beck 2008). The presentation of data, description of and analyses has been made concerns the confirmability of the present studies.

Transferability deals with the extent to which the findings can be transferred to other settings or groups (Lincoln & Guba 1985, Polit & Beck 2004). The transferability of the findings from these studies to other settings may be more or less comparable, but can be understood in relation to and applied to similar situations in a new context (Sandelowski 1986).

Pre-understanding

The authors' interest in and pre-understanding of the field of study and the research are of great value. As a researcher, it is important to distance oneself in order to avoid influencing the data, while at the same time maintaining closeness to the clinical field and the knowledge necessary to understand it (Sandelowski 1998). According to Sandelowski (1998), personal clinical experience in the research field under study is considered a strength. The questions and reflections generated in the present studies are based upon the first author's own experiences of healthcare, acquired as a nurse's aid in eldercare and later as a nurse in primary healthcare and a teacher of nursing students. The co-authors have experiences as RNs in eldercare, as managers, teachers and as senior researchers in nursing science.

REFLECTION OF THE RESULTS

The overall aim of the present thesis was to reveal nursing home caregivers' work experiences when receiving support through education and clinical supervision for a two-year period, while the workplace was undergoing organizational changes. The goal was to gain a deeper understanding of how changes and cutbacks, a common reality today, affect caregivers' working situation. Such an understanding would benefit anyone involved and has implications for high-level decision-makers, managers and caregivers exposed to similar experiences and situations in working life. Successful changes require a vision that justifies them.

The present results show that changes in the organizations created a vulnerable situation for the caregivers working there, as they caused major stress and frustrations among the three personnel groups. The announcements of planned cutbacks and their realization, at different times during the study period, had negative influences on the caregivers' working situation in all three NHs. Together with work pressure, this caused some of them to leave work on account of unmet expectations. Further, the caregivers felt that support through education and clinical supervision, together with involvement in the training programmes, were important during times of changes. However, feelings of responsibility for the older people they cared for was one reason for caregivers to stay. They struggled to adapt to the changed working environment as a person and a professional, but they seemed to have lost something important: their pride in giving good care.

A transition seems to have occurred in the personnel groups at the three NHs during the study period when undergoing the change process (Meleis et al. 2000). The assessments and

the interviews at start showed that the caregivers had established something new associated with several expectations about being able to provide better care, and this was tied to feelings of professional identity and self-confidence. Later experiences of frustration and conflict were obviously due to poor organizational prerequisites, such as weak leadership and financial cutbacks. The length of a transition process may vary, as may changes in self-perception and self-esteem that occur during such a process (Meleis et al. 2000). In the present thesis, adaptation to and development of a new situation seemed to be affected by several factors.

Working in eldercare during organizational changes

In the present thesis (**I-IV**), the effects observed among caregivers, working during organizational changes and threat of termination notice, have been described from different perspectives. The results show a negative progression on both the CCQ and MBI measurement and in the interviews, which corresponded to the time when the caregivers received information about financial cutbacks (Figure 1). In Study **I**, the outcome for the caregivers at NH I showed improvement over time in the self-assessment instruments (CCQ and MBI) and the interviews. On the contrary, NH II showed a negative progression, and for the caregivers from NH III, a more stable progression over time was seen. Meleis et al. (2000) described the process of adaptation to and development of a new situation. This time span can vary from a short period to many months. The interviews after a year (**II-IV**) showed that several had left their work and that others had attempted to accept their working situation and found the best way to move on. The caregivers at NH I had time to work through and handle the changes that arose, and the negative situation seemed to have created a turning point between the first and second data collection. At the 24-month follow-up, the caregivers there adopted a wait-and-see attitude towards the work and a safeguarding attitude towards their own and the residents' well-being. For NH II, the time between receiving the information and the follow-up was perhaps too short, as the turning point was not seen before the 24-month follow-up (**I-II**). By that time, the caregivers at NH III were familiar with the plan to reduce the staff. The threatening situation seemed to have created a turning point after the 12-month follow-up.

The situation, characterized by changes, led to experiences of *losing control*: a weaker position, feelings of insecurity and increasing conflicts. Likewise experiences of *decreasing influence* were reported, implying feelings of decisions being made over one's head. Previous working life research has shown that the first period of organizational changes results in the greatest uncertainty and anxiety among employees (Brenner et al. 1988, Herting

et al. 2003), and this was also seen in the present studies (I-IV). Studies from other countries have also revealed similar patterns (Joelson & Thomsgård, 2000). Organizational changes, cutbacks and rumours about layoffs are perceived as negative by employees (Vakola & Nikolaou, 2005), because they cause stress and insecurity.

The caregivers in our study reported *insecurity and instability* at the workplace (IV). The caregivers who stayed at their workplace were sad about losing co-workers, and loss of staff was devastating when planning care and for maintaining the quality of care (III-IV). Feelings of job insecurity are common in working life today, and Pfeffer (1997) even argued that job security is a thing of the past. Working conditions and health are affected by a number of aspects of change, such as ‘waste of human resources’ and ‘competence drain’ (Herting et al. 2004). This is described in Study IV, where both the team spirit and loyalty in their own occupational group had decreased when fellow workers left, and this led to an obvious loss of competence in the group. *Lack of trust* in everything was reported, for example in their colleagues and managers, and the dialogue was minimized.

The employee is in constant interchange with the *work environment*. These interactions require continuous struggling to adapt on the part of the employee, which was obvious at NH III after the information about cutbacks and termination (III). In Study I, the results showed that the working climate and tendency towards burnout altered during the study period. According to Ekvall, working climate is ‘a conglomerate of attitudes, feelings, and behaviours that characterizes life in the organization’ (1996 p.105). There has been a great deal of controversy surrounding the concept, but Ekvall states that the climate is important because it affects behaviours such as communication, problem-solving, decision-making, conflict-handling, learning, and motivation (Ekvall 1996). Ekvall et al. (1999) mean that innovative organizations have the capacity to adapt to constantly changing environments in order to survive, and these adaptive organizations require climates that stimulate creative behaviour. In a stagnated working group, contact between group members has often been broken – people talk to each other and not with each other. In the present studies (I-IV), conflicts within the personnel group were frequent when the cutback and changes had started. Helping groups involves keeping a positive dialogue open and alive. Some people in a group may be “difficult”, but the chief principle here is that people become difficult when their working conditions are not satisfactory (Svedberg 2007). In Study II, the caregivers emphasized that managers should dare to talk about grievances. Conflicts among caregivers resulted in feelings of being outside the working team and of being isolated. *Different opinions* about care-giving and how tasks should be performed stand out in interviews (II-

IV), and such things may be devastating for the quality of care for the older people.

Organizational changes and high workloads can serve as a breeding ground for disagreements and can lead to conflicts with the employee's knowledge and competences. These situations produce strong feelings and reactions that can lead to both rational and irrational actions (Lind Nilsson 2003). If negative stress increases for employees, their capacity to effectively cope with stressors decreases (Cox 1987).

Workload is a factor that has been identified as a job stressor and has been linked to employees' well-being (Karasek & Theorell, 1990). Studies have shown that employees are confronted daily with greater demands, a faster pace, increased job complexity, increased complexity of patients' health problems, increased need of care, increased pressure from patients and society, and an increased overall patient load (e.g., Arnetz 2001, Cronqvist et al. 2001). Being unable to meet the demands one perceives to be real can cause aggravation and stress. When an individual experiences a situation as stressful or threatening and makes the judgement that he/she does not have the capacity to deal with the specific situation, he/she experiences stress (Lazarus 1991, Sarafino 2006). Stressors at the workplace include workload, time pressure, role ambiguity, interpersonal conflicts and lack of control (Landy & Conte, 2004). The difficulties that arose in the different groups can be followed on the basis of the caregivers' narratives, in the results (**I-IV**). The problems mostly concerned conflicts over how care of the elderly should be carried out, but of course purely personal conflicts could also be discerned. A displacement has occurred from the physical working environment to the more psychosocial aspects of the organization of work. The responsibility for tasks and assignment is located further down in the organization. The ambitions of the individual, the capacity of the working group to manage conflicts, the changed relationships between employees, manager and the older people and so on are influenced by such things (Allvin & Aronsson 2001).

Being a caregiver during organizational changes

Most of the caregivers who began working at the two newly opened NHs, I and II, had several years' experience in eldercare in different areas. Their focus was on the older care recipient and the care they were supposed to provide. They were filled with positive experiences and had optimistic outlooks on the future. Initially, the different backgrounds and experiences the caregivers at NH II had (**II**) were seen as a source of strength and something to build upon when planning for the care. At this stage, they did not see their different opinions on how work should be organized and carried out as a hindrance. Over time, the caregivers (**I-IV**)

realized that a gap existed between their ideals and ambitions and their possibilities to deliver good care. They felt that the system kept them from providing good quality care as well as from experiencing professional growth (**IV**). The incongruence between personal and organizational values hindered the caregivers in following the dictates of their values (**IV**), which is in accordance with the findings of Sørli et al. (2004) and Glasberg (2007).

Ethically difficult situations are common in healthcare today (Mamhidir 2006), which also seems to have an effect on the consciences of care providers (e.g., Söderberg 1999, (Glasberg 2007)). According to Levinas, ethics are based on human existence, our interpersonal relations, and the ethical requirements directed at us by the Other (Levinas 1998, 1969, Kemp 1992). In face-to-face encounters with other people, we discover what a human being is. Eyes, nose, mouth and ears perceive, but the eyes and mouth are primarily expressive organs that speak to and address the Other. The caregivers in Study **IV**, who left work, were disappointed because their skills were not appreciated at the workplace. They were conscious of the importance of meeting, e.g., the communication problems of older persons with dementia face-to-face and with eye contact. However, Levinas (1969) states, and as interpreted by Kemp (1992), that the face is the whole representing what we perceive and what we invite into a relationship that resists injuring but instead takes responsibility for the Other. If we take responsibility for the Other, we acquire knowledge about reality through the Other. Nearness is required if we are to learn about the Other and his/her language. Levinas' way of relating to the Other can be translated into the way caregivers relate to the elderly. The caregivers in the present studies (**II-IV**) were well aware of the older people's needs and their dependence on them as caregivers. According to Levinas, values become meaningful in the encounter between the ego and the Other (Levinas 1969, Kemp 1992). In this encounter with the Other's face, the existence of the ego is tested, and this does not entail self-contemplation. The Other is unlike the ego, different. Herein lays the respect, responsibility and love for the Other, and this code of ethics is based on a relationship (Levinas 1969, Kemp 1992). The caregivers studied (**II-IV**) spoke warmly about the older people they cared for and about the duty they had undertaken and taken full responsibility for. To make that possible, caregivers have to get close and learn about the Other's needs and desires, which according to Study **II** had become obstructed.

Levinas stresses listening, responsibility and preserving the Other's right to be different – we should not strive for likeness. The caregivers (**II**) described the prerequisites for establishing a good relationship while caring in accordance with Levinas (1969) and Kemp (1992): being responsible, being available, having the ability to be involved, having patience,

having understanding and being able to see the older adult for the persons they are. This can be difficult for caregivers when they realize that, for various reasons, they cannot provide the care that older persons need. In Study **IV**, it became clear that the unmet expectation of providing high quality care was one of the reasons why several caregivers left their work. Other caregivers continued struggling and wanted to complete their duties (**II-III**).

Caregivers' experiences of support

Support through education and clinical supervision

The two-year support through education and clinical supervision started the same year NHs I and II opened, while NH III was included as a comparison. The research team provided support and a follow-up evaluation in order to fill a gap in our knowledge about the effects of caregiver support over a longer period on eldercare (SBU 2007). Previous studies have already emphasized the importance of caregivers' competence and attitudes towards achievement of high quality in eldercare (Cheung & Yam 2005). Findings indicated that the caregivers in the present thesis viewed the support they received as useful and important for developing the care they were providing (**II**). The importance of planning ahead and being ready for difficult situations was discussed. They stated how they could better understand dissatisfaction and aggressiveness on the part of the older adult and could deal with it more effectively. The importance of reflection in their work stands out in the caregiver interviews at the 24-month follow-up. The interviewees become more aware of the individual nature of each resident and believed in the importance of getting to know a person and her/his history to providing good care (**II, IV**). They also noticed areas they had not been aware of before. Factors of importance to the fulfilment of high quality care are described as: knowing the person (Murphy 2007), patients' autonomy and participation (Themessl-Huber et al. 2007), correct and timely assessment of patients' needs, accesses to information, and relationship aspects (Depla et al. 2005, Grönros & Perälä 2005, Westin & Danielsson 2006, Jacob et al. 2007). The interviewees (**II**) felt, however, that the manager and the RN were not in attendance at the educational opportunities. Despite this, they realized that they needed management support in implementing the collectively planned eldercare they had just received more information about. Jubb-Shanley and Stevenson (2006) support the statement that practitioners and managers do not necessarily recognize this state of affairs. Feelings of resignation became obvious when the caregivers realized that they would not be able to implement the knowledge they had obtained (**II**). They realized that they could not provide

more than basic care due to the cutbacks, and there was a threat that they would not be able to do a good job.

The supporting leadership

In the present studies (**II-IV**), the leadership has been described somewhat differently. At NH III (Study **III**), the caregivers experienced a manager who was present, expressed her appreciations of them, was committed to the caregivers' work, had meetings regularly and listened to them. This was in contrast to NH II (study **II**) and also mirrored in the experiences of those who left work (**IV**). Their managers were described as not supporting them, keeping them at a distance and as hiding when difficult situations arose. One reason may be that NH III was an older enterprise, with established patterns and staff who knew each other well. A working group should be able to function on its own, but if there is no purposeful and structured working method, the consequences could be devastating (Hertzberg et al. 1999). The fact that a manager with an invisible leadership style can affect job satisfaction in a negative way has often been described (Sellgren et al. 2006, Fransson-Sellgren et al. in press). Similarly, a manager's success is not solely dependent on his/her knowledge, but also on the group atmosphere he/she has created (Lewin 1951). A clear and purposeful working method can ensure quality in the work itself and in personal work satisfaction as well as clarify the content, process and significance of the work (Bass 1990). It is vital that the manager support co-workers' intellectual incentive to make an effort to be innovative and creative. Leadership that is transformational also tries to give co-workers the prerequisites for, e.g., seeing problems from a new perspective or in a new way (Bass 1985, 1998). Bass (1985) pointed out the importance of 'transformational leadership', as characterized by the value of personal recognition and support. A consequence of the invisible leadership observed in our study was lack of recognition, support and communication (**IV**).

The time factor was a recurrent problem for caregivers in the present studies (**I-IV**). Every organization and working group has a primary duty. One prerequisite for focusing on this primary duty is the ability to set limits or to establish frameworks that defined the form and content of the enterprise in question. When it becomes obvious that duties must be prioritized, a boundary has to be drawn between what is possible and what is desirable (Miller 1990). In Study **I**, the caregivers realized the difficulties of implementing new ideas due to lack of time and support from management. Studies dealing with the relationship between leader behaviour and employee stress show that leadership is important to how employees deal with stress (Bass 1998, 2006). The leadership makes a difference in how employees cope

with the stress that arises from their jobs, for example the stress of a changing environment (Arvonen 1995, Bass 2006). Transformational leadership has been shown to be beneficial when it comes to helping employees deal with their stress in a better way (Bass 2006). Further, one absolute requirement of a leader is to see workers as co-workers and to adapt leadership to staff members' conditions and need for support and guidance. How time is used and allocated is a controversial issue in many organizations and a common cause of unhealthy stress (Svedberg 2007). Miller (1990) stressed that a leader's main duty is to create flexible structures that allow the group to manage its primary duty and that regulate the group's boundaries. The caregivers in Study **I-II** and **IV** would have benefited from a manager who helped them in this way.

Study **IV** shows clearly how the caregivers that left work had no confidence in their own competence, or in that of their colleagues, their manager or the entire organization. Schutz (1997, 1989) considered that if the conditions and environments are created that encourage people to feel important, competent and appreciated, their level of fear will be reduced. In such situations, honesty, co-operation, responsibility and contentment are promoted. Moreover, the workplace atmosphere is characterized by trust and confidence (Schutz 1997, 1989). One of the reasons why certain caregivers left their work at the nursing homes was *lack of trust*. Manion (2004) found that one good management strategy was to put staff first so that they will put the patient first. Kindness and respect for the individual as expressed by the manager can cause the staff to show the same behaviour towards patients.

Work in eldercare - staying or leaving

The present thesis shows a vulnerable situation for caregivers working in the three nursing homes. The organizational changes have caused stress and frustration among the three personnel groups. This meant that their expectation for their work could not be met. During the study period, some left their work due to *unmet expectations* (**IV**) and others struggled to adapt to the changed working environment (**I-III**), but seemed to have lost something important: their pride in giving good care. Many of the caregivers (**I-IV**) had chosen these particular workplaces among other alternatives, because they expected an approach to care that would give them more opportunities to base care on each care recipient's individual needs. Vroom's (1964) expectancy theory suggests that an employee's performance is based on individual factors such as personality, skills, knowledge, experience and abilities. Expectancy theory states that individuals have different sets of goals and can be motivated if they have certain expectations. The purpose of having choices is to maximize pleasure and

minimize 'pain'. We know that a supportive workplace promotes satisfaction and retention of workers (Riggs & Rantz 2001). Vroom (1964) stated that there is a positive correlation between efforts and performance: favourable performance will result in a desirable reward, the reward will satisfy an important need and the desire to satisfy the need is strong enough to make the effort worthwhile. In this way, they create a motivational force, such that the employee will act in a way that brings pleasure and avoids 'pain'.

The conditions surrounding the caregivers in the present studies give rise to the following question: What causes nursing home staff to stay or leave work while working under such circumstances? Perhaps some of them left the work due to experiences of 'pain', as according to Vroom (1964). The caregivers realized that a gap existed between their ideals and ambitions and their possibilities to deliver good care. Company policy and administration are the single most important factors underlying bad feelings about a job. Positive job attitudes are described using terms such as recognition, achievement, interesting work, responsibility, and advancement (Hertzberg et al. 1999). In the present studies (**I-III**), the reason for staying was the caregivers' feelings of responsibility for and their relationship to the older people. The appreciation and acknowledgement the caregivers (**II-III**) received from the older persons were very important to them and helped them carry out their duties. Further, these aspects helped the staff as they struggled to adapt to the changed working environment. The changes, cutbacks, increased workload and notice of termination created a climate characterized by uncertainty about the future, negative health symptoms (**I-IV**) and a desire to leave for some of them (**IV**), which is in accordance with Hellgren (2003). Such periods have contributed to feelings of a 'waste of human resources' and 'competence drain' (Hertting et al. 2004). Considering the current difficulties in recruiting and retaining staff with a formal education (SALAR 2006), the management must be aware of the importance of training and development, and providing opportunities for staff in reflection on their every day caring of older persons in order to fulfil their ambitions and discuss staff performance if they are to succeed in getting caregivers to stay in eldercare.

IMPLICATIONS FOR ELDERCARE PRACTICE

One of the most critical issues in the care of older people is the shortage of qualified healthcare personnel. Therefore, to recruit and retain care personnel, it is important to offer appropriate and attractive working conditions. Likewise, it is important to offer high quality and effective eldercare characterized by equity of care provision for all older people. It has been stressed that quality deficiencies in community care are related to factors such as lack of competence and lack of support to caregivers. It would seem to be necessary to acknowledge the need for the medical contributions of physicians and registered nurses, because registered nurses number only a few and physicians function as consultants.

The major findings of the present thesis show that organizational changes with financial cutbacks affected caregivers' working reality and caused a vulnerable situation at three nursing homes. Together with work pressure, and a leadership they did not find supporting, caused some of the staff to leave work on account of unmet expectations. Older people have unique and special needs, and those with the greatest needs are prioritized and offered NH care. These needs make eldercare an area of specialization. In the present studies, the caregivers mentioned the hidden position of the single registered nurse.

The present findings ought to serve as arguments for caring managers and political leaders, who are responsible for the quality of older people's care, to employ highly competent or educated and proficient caregivers in adequate numbers, and to take continuity into account when organizing staff. The caring environment and the organization around the care are important factors for quality of care, such as the decision-making system, staff relationships, a supportive organizational system, and the potential for innovation. An awareness of the possible effects of change on caregivers' situation and care provision is of great value.

POPULÄRVETENSKAPLIG SAMMANFATTNING

(SUMMERY IN SWEDISH)

Arbete i äldrevard – att stanna eller lämna vården **Vårdarens upplevelse av arbete och stöd under organisationsförändringar**

Avhandlingsarbetet syftar till att belysa vårdarens upplevelser av att arbeta i äldrevard under två år när organisationsförändringar genomförs. Tre äldreboenden (B I-III) ingick i studierna där utbildning och handledning gavs till B I och B II under de två åren och som sedan jämfördes med B III där ingen utbildning eller handledning gavs av forskargruppen. Under många år har arbetsförhållandena inom äldrevarlden varit ett återkommande inslag i den allmänna debatten. Vårdarna möter gamla som ofta har en komplex sjukdomsbild som kräver avancerad vård och omsorg (Aminzadeh & Dalzell 2002, Wimo et al. 2002). Finansiella nedskärningar är en realitet och det har resulterat i färre vårdplatser på sjukhus och äldreboenden. De vårdplatser som erbjuds inom äldreomsorgen är därför prioriterade för dem med de största behoven (National Board of Health and Welfare 2008), vilket innebär en ökad belastning på den svenska äldrevarlden (Gurner & Thorslund 2003). Inom akutsjukvård, har nedskärningar av personal och organisationsförändringar upplevts som 'slöseri med mänskliga resurser' eller 'dränering av kompetens' (Hertting et al. 2004). Däremot är det en brist på kunskap om hur vårdare på äldreboenden upplever konsekvenserna av nedskärningar och förändringar. Att personal slutar eller är sjukskrivna är välkänt liksom de svårigheter som finns med att rekrytera och behålla personal med adekvata utbildningar. Organisationsteorier och empirisk forskning visar att en stödjande arbetsplats främjar tillfredsställelse på arbetsplatsen och att personalen då stannar kvar (Riggs & Rantz 2001). Några rapporter visar positiva effekter av utbildning och stöd hos såväl vårdtagare (Kihlgren 1992) som anställda, liksom vårdkvaliteten (Edberg 1999, Hansebo & Kihlgren 2004) men det är brist på kunskap om effekter under en längre period.

Delarbete I syftade till att undersöka organisationsklimatet och förekomsten av symptom på utbrändhet, under två år, bland vårdare i tre äldreboenden (B I-III) som genomgår organisationsförändringar. Vid studiens början accepterade 75 vårdare att delta: i B I 32, i B II 21 och i B III 22 vårdare. Antalet deltagare i studien reducerades under studiens gång av olika anledningar och en bidragande orsak var de organisationsförändringar som genomfördes. Vårdarna vid B I och B II fick stöd i form av utbildning och handledning under den tid som studien pågick. Resultaten jämfördes sedan med vårdare vid B III. Vårdarna på de tre

äldreboendena besvarade två självskattningsinstrument/frågeformulär och intervjuades vid tre tillfällen, vid studiens början, efter 12 månader och efter 24 månader. Ett av frågeformulären var The Creative and Innovative Climate Questionnaire (CCQ), utarbetat för att mäta dimensioner av betydelse för organisationens förmåga till nytänkande och förändring (Ekvall, 1996). Det andra frågeformuläret var The Maslach Burnout Inventory (MBI), utarbetat för att undersöka hur ofta personer upplever ett antal påståenden och känslor som har anknytning till arbetet (Maslach et al 1996, 1981). Frågeformulären analyserades med beskrivande statistik. I intervjuerna berättade vårdarna vid B I och B II om hur de upplevde arbetet med de äldre vårdtagarna innan och efter handledning. Den del av intervjumaterialet som analyserades och rapporterades i denna studie valdes ut genom lottdragning. Fem intervjuer drogs från varje intervjuomgång inom de tre grupperna ($5 \times 3 \times 3 = 45$). Intervjuerna analyserades med direkt innehållsanalys (Hsieh & Shannon 2005), som innebär en deduktiv analys. Här användes dimensionerna i de två instrumenten CCQ och MBI som ett raster för den deduktiva analysen.

Resultatet från frågeformulären visade på en negativ utveckling när vårdarna fick information om organisationsförändringarna. Situationen som uppkom skapade stress och frustration i personalgruppen och de kände skuld över att inte kunna möta det åtagande de skulle utföra. De förändringar som skedde i organisationen tycks ha komplicerat deras arbete. Till skillnad mot B II var självskattningarna hos B I mer positiva efter två år, vilket kan tolkas delvis bero på, att neddragningarna genomfördes tidigare där och delvis på den utbildning som de erhöll. Resultatet från B I och B II visade även en besvikelse över brist på stöd från cheferna medan vårdarna på B III var mer nöjda. Studien visar att det behövs mer forskning inom detta område för att t.ex. undersöka faktorer som motverkar utbrändhet samt förbättrar kreativitet och innovation. En uppgift för chefer i vård och omsorg bör vara att hjälpa anställda att komma vidare vid organisationsförändringar. Studien visar att det är viktigt att möta vårdarnas behov liksom vårdarna önskar möta de äldres behov.

Delarbete II syftade till att utifrån vårdares berättelser beskriva deras upplevelser av att arbeta med de äldre vårdtagarna under två år med utbildning och handledning som stöd. Den utbildning som genomförts av läkare och sjuksköterskor har utgått från vårdarnas önskemål och innehöll föreläsningar om demenssjukdomar, bemötande av personer med demens, integritetsbefrämjande omvårdnad, stroke, Parkinson, kommunikation och konflikthantering. En sjuksköterska från forskargruppen genomförde omvårdnadshandledningen som erbjöds en gång per månad i grupper av sex till tio vårdare. Sjuksköterskan fanns också tillgänglig för att svara på frågor gällande omvårdnaden av de äldre och deltog i eller observerade ibland

direkta omvårdnadssituationer. Endast intervjuer från de vårdare (n=7) som hade intervjuats vid alla tre tillfällena på B II analyserades (7 x 3= 21). Intervjuerna analyserades med kvalitativ innehållsanalys (Graneheim & Lundman 2004).

Från vårdarnas upplevelser identifierades temat: Trots splittrade förväntningar kvarstår viljan att vårda. Följande kategorier och underkategorier framkom:

- Värdet av en vårdande miljö – upplevelser av aktiviteter på arbetet och förändringar, samt upplevelser av relationer
- Värdet av kunskap – upplevelser relaterat till vårdarnas olika bakgrunder och upplevelser relaterat till ökad kunskap

De berättelser, där vårdarna beskrev sitt arbete, förändrades under den undersökta perioden. De första intervjuerna genomsyrades av positiva upplevelser av att få vara med från början, när ett nytt äldreboende öppnades och de såg positivt på framtiden. De betonade att vård med god kvalitet var beroende av hur arbetet utfördes och de upptäckte områden i omvårdnaden, p.g.a. utbildningen, som de hade förbisett tidigare. Relationer är en viktig del i alla människors liv. I denna studie fungerade relationen med de äldre, närstående och andra vårdare som ett säkerhetsnät när svåra situationer uppstod och relationerna var en grund för vänskap som gav mening i deras dagliga liv. Relationerna mellan vårdarna försämrades under studieperioden och de önskade att deras chef, skulle ta tag i de konflikter och svåra situationer som uppstod. De betonade värdet av att vårdarna kände till, förstod och hade kunskap om den äldre de vårdade för att kunna möta dennes individuella behov och önskningar. Vårdarna önskade att chefen skulle uppmärksamma deras kunskap och kompetens och hjälpa dem att implementera den vård och omsorg som var beslutad. Arbetstempot ökade under studieperioden vilket innebar att de hade svårt att hinna med att ge en vård med god kvalitet, som de önskade. Vårdarna ville fortsätta att vårda trots att de kände en besvikelse över den försämrade arbetssituationen som också hade inverkat negativt på den utbildning och handledning de erhållit. Trots detta verkar den utbildning och handledning de fått vara en av anledningarna till viljan att stanna kvar i vården. Studien understryker behovet av ökad forskning om faktorer som påverkar vårdares beslut om att stanna eller lämna äldreboendet i syfte att kunna rekrytera och behålla personal.

Delarbete III syftade till att utifrån vårdares berättelser belysa deras upplevelser och reflektioner av att arbeta med de äldre vårdtagarna under hot om organisationsförändringar och uppsägningar. Endast intervjuer från de vårdare (n=11) som hade intervjuats vid alla tre

tillfällena på B III analyserades (11 x 3 = 33). Intervjuerna analyserades med kvalitativ innehållsanalys (Graneheim & Lundman 2004). Från vårdarnas upplevelser identifierades tre teman och sex kategorier från de tre intervjutillfällena.

- Att ha en yrkesidentitet och självförtroende – upplevelser av stolthet och tillfredsställelse, upplevelser av att ha professionell kompetens
- Vara i en yrkesidentitet under en hotande situation orsakad av någon annan – upplevelser av att tappa kontrollen, upplevelser av minskat inflytande
- Kamp för att anpassa sig till en förändrad arbetsmiljö som individ och yrkesprofession – upplevelser av att försöka göra sitt bästa för att fullfölja vårdarens uppgifter trots känslan av att ha förlorat något viktigt.

Resultatet visar en förflyttning i vårdarnas reflektion över arbetet genom informationen om neddragningar och hot om uppsägning. Vårdarna upplevde att deras inflytande minskade över tidsperioden, t.ex. att vad de ansåg vara viktigt för de äldre ignorerades. De orkade dock kämpa vidare genom att energin lades på den äldres behov, de fick uppskattning för det arbete de utförde och de hade en chef som var närvarande. Den hotande situationen verkade ha fått en vändpunkt efter uppföljningen vid 12 månader och intervjuerna efter 24 månader visade en acceptans inför den reduceringsplan som redovisats för dem. De tycktes ändå ha förlorat någonting viktigt; deras stolthet och tillfredsställelsen över att göra ett bra arbete, vilket även visats i tidigare forskning vid förändringar som upplevts svåra. Där har även redovisats att vårdkvaliteten kan påverkas negativt vid organisationsförändringar och neddragningar. Vårdarna upplevde ett avbrott i relationerna med de äldre och även med arbetskamraterna. I vården av de äldre anses kontinuitet i kontakten mellan de äldre och vårdarna mycket viktig. Den är basen för förståelsen av den äldres behov. Möjligheten att bygga tillit och känsla av säkerhet är, enligt tidigare forskning, faktorer som påverkar kvaliteten av vården.

Delarbete IV syftade till att utifrån vårdares berättelser belysa vad som har orsakat deras beslut att lämna anställningen i äldrevården. I denna studie inkluderades vårdare som hade beslutat att lämna sin anställning på de tre boendena och som accepterade att bli intervjuade (n=18). Intervjuerna analyserades med kvalitativ innehållsanalys (Graneheim & Lundman 2004). Resultatet visade att en kombination av information om nedskärningar, organisationsförändringar och stor arbetsbelastning som följd var orsaken till att vårdarna lämnade de tre äldreboendena. Satsningen på att ge utbildning och handledning överskuggades av beslutet om nedskärningar. Orsaken till att vårdarna lämnade anställningen

kunde sammanföras i en huvudkategori: Ej uppfyllda förväntningar. De flesta underströk att det inte var arbetet med de äldre i sig, som var orsaken. Deras upplevelser var grundade i att de inte fick någon uppmuntran, att de inte kände tillit samt misslyckandet med att förverkliga den yrkesmässiga utvecklingen, som vårdarna hade blivit lovade vid anställningen. Av detta följde otrygghet, olika åsikter om hur vården skulle genomföras, konflikter, känslor av att ha blivit ignorerad och sviken samt tankar på att söka andra möjligheter till arbete. Vårdarna upplevde inte att deras chef strävade efter en kvalitativt hög vård. Det bekräftades av att vårdarna både önskade och inbjöd chefen att ta aktiv del i att lösa problemen i vårdarbetet, men som inte infriades.

Sammanfattande reflektion

Avhandlingens fokus har varit att beskriva och belysa vårdares upplevelser av att arbeta inom kommunala äldreboenden. Av de tre äldreboenden (B I-III) som ingått gavs utbildning och handledning till B I och B II, vilka sedan jämfördes med B III. De organisatoriska förändringar med nedskärningar som genomfördes på de tre boendena, vid olika tidpunkter, har avspeglats i de resultat som redovisats.

Den utbildning och handledning som utlovades från forskargruppen skapade förväntningar. Många hade påbörjat arbetet på de två nyöppnade boendena just för att cheferna hade utlovat att det skulle bli ett nytt sätt att arbeta. Dessutom utlovades en bra bemanning. De förändringar som planerades och genomfördes innebar en ökad stress och kommunikationen mellan vårdare och chefer var under vissa perioder dålig eller obefintlig. Att inte alltid kunna delta i undervisning och handledning skapade också stress. Vidare ansåg personalen att cheferna inte alltid tog aktiv del i de problem som de själva ställdes inför. Vårdarna har upplevt att deras arbete med de äldre var meningsfullt men att det fanns arbetsuppgifter som skulle kunna utföras av annan personal. Det skulle då ge utrymme till att mer individanpassa den vård och omsorg som gavs till de äldre. Arbetsgemenskapen sågs betydelsefull liksom socialt stöd från vårdtagare, arbetskamrater och chefer. Arbetsuppgifter hade delegerats ut i de olika boendena och anledningen var att personalen skulle känna sig mer delaktiga i sin vardag. Uppgifterna kunde innebära att de blev ombud för olika ansvarsområden vilket till en början upplevdes positivt och stimulerande men när situationen och kraven förändrades gav motsatt effekt.

Tidigare forskning visar att organisationsförändringar, neddragningar och rykten om uppsägningar skapar ett arbetsklimat med otrygghet (Hellgren, 2003). Det som händer har

ett tydligt förlopp: En förebådande fas, varsel, en omställningsfas samt en omstart. Arbetslivsforskning visar att den första perioden skapar störst osäkerhet och oro bland de anställda (Brenner et al. 1988, Hertting et al. 2003), vilket är i enlighet med resultaten i avhandlingen (**I-IV**). Vid oro i en organisation reagerar ofta människor med primitiva psykologiska reaktioner (Joelson & Thomsgård-Joelson 2000). Det kan visa sig i isolering, förnekande och förvirring och kanske också som ett behov av att projicera ut sin oro. Relationerna till arbetskamraterna kan försvagas genom att den enskilda individen värnar om eller bevakar sina egna intressen. I avhandlingen avspeglas relationen till arbetskamraterna och hur den sattes på prov. Konflikterna mellan dem tilltog och kommunikationen försvårades. Det kan ha inneburit att vårdarna fick svårare att fatta beslut och att enas om hur arbetet skulle genomföras. Detta kan få konsekvenser för vårdkvaliteten. När förändringsfasen övergår i kunskap om effekterna av förändringen upplevs det oftast som en lättnad (Brenner et al. 1988) och det visade sig också i dessa studier (**I-IV**). Forskningen visar dock att den personal som blir kvar efter förändringar har en förändrad relation till arbetsorganisationen. Det kan innebära minskat organisatoriskt engagemang och även minskad kvalitet i arbetet. Personer som varit med om organisationsförändringar behöver en återhämtningsfas, vilket kan relateras till resultaten i studierna. I de presenterade resultaten i avhandlingen kan vårdkvaliteten och vårdarnas engagemang för den äldre vårdtagaren ha påverkats negativt. Cheferna som möter sin personal under organisationsförändringar har ett stort ansvar, vilket gör att de bör ha kunskap om verksamheten och mod att möta personalens oro och frustrationer.

TACK

Vårdpersonal. Först och främst vill jag tacka alla som deltagit i studierna och som delat erfarenheter och upplevelse. Utan er hade det inte blivit någon avhandling.

Annica Kihlgren, med dr, lektor och min huvudhandledare i slutfasen. Tack Annika för att du har hjälpt mig att slutföra detta arbete, gett mig mod när jag sviktat och för att du alltid är positiv.

Mona Kihlgren, professor, och min bihandledare i slutfasen. Mona du har varit med under hela doktorandtiden, från början som huvudhandledare, utvecklat mina tankar, stöttat och givit mig synpunkter för att jag skulle komma framåt och slutligen i mål, ett stort tack.

Görel Hansebo, med dr, lektor, prefekt och bihandledare i den senare delen av min studietid. Du är också medförfattare till en artikel, du har bidragit med synpunkter och kommentarer så att detta kunde slutföras.

Venke Sørlie, professor och min bihandledare under en tid och medförfattare till en artikel. Du uppmuntrade och stimulerade mig och såg mina starka sidor.

Ingegerd Fagerberg, professor. Det var du som tillfrågade mig och inspirerade mig att delta i detta projekt och fick mig att ansöka om att bli doktorand. Du var också min bihandledare under en tid och är medförfattare till två artiklar.

Elisabeth Häggström och **Kirsti Skovdahl**, lektorer, tidigare doktorandkollegor och medförfattare för råd och stöd under artikelskrivande.

Anna-Greta Mamhidir, lektor, kollega, tidigare doktorandkollega, för att du delat med dig av din kunskap, varit vän och stöttat mig under denna tid.

Mirjam Ekstedt lektor och **Karin Weman**, lektor tidigare doktorandkollegor, tack för vänskap, råd och stöd under seminarier och kurser.

Kerstin Forslund, lektor, tidigare doktorandkollega, för att du alltid har uppmuntrat och stöttat när det känts tungt.

Robin Quell, RN, MSc, language reviser to one article and friend. Thank you for revising my English and thank you for being the person you are.

Anette Lundin och **Cathrine Uggla**, personal på Region Gävleborg, för hjälp med pratiska problem att genomföra studien.

Kristina Lundh, institutionssekreterare för hjälp med alla papper från början till slut på Karolinska Institutet.

Maria Ekholm, sekreterare på COV i Örebro för din hjälp.

Marianne Hultén, bibliotekarie, för hjälp under åren.

Alla nuvarande och gamla arbetskamrater på Institutionen för vårdvetenskap och sociologi på Högskolan i Gävle för er support över åren.

Maritha Persson, klinisk adjunkt och magister i vårdvetenskap. Tack för att du är både kollega och vän.

Marita Petrell, magister i vårdvetenskap, kollega och vän. Du har betytt väldigt mycket för mig under dessa år. Med dig har jag kunna dela både med- och motgång.

Alla vänner som uppmuntrat mig under resan.

Ingrid min syster, **Lasse** min svåger och era söner **Johannes** och **Andreas** för att ni stått ut med mig under dessa år då jag tidvis inte varit helt närvarande.

Marcus vår son och vår sonhustru **Maria**, barnbarnen **Erik** och **Simon**, vår son **John** och din **Erica**, jag är tacksam att ni finns.

Anders, min man som alltid uppmuntrat, stöttat, haft tålamod och trott på mig .

Slutligen vill jag tacka Region Gävleborg, Centrum för omvårdnad vid Örebro Universitetssjukhus och Högskolan i Gävle, Institutionen för vårdvetenskap och sociologi för finansiellt stöd.

REFERENCES

- Allvin, G. & Aronsson, G. (2001) 'The future of work environment reforms' does the concept of work environment apply within the new economy. In: Thörnqvist, A. (ed.) *Work Live, Work Environment and Work Safety in Transition*. Historical and Sociological Perspectives on the Development in Sweden during the 20th Century (2001) (*Arbetsliv i omvandling*) 2001: 9. Stockholm: National Institute for Working Life.
- Altman, D.G. (1991) *Practical Statistics for Medical Research*. London: Chapman & Hall
- Aminzadeh, F. & Dalziel, W.B. (2002) Older adults in the emergency department: A systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. *Annals of Emergency Medicine* 39, 238-247.
- Arnetz, B.-B. (2001) Psychosocial challenges facing physicians of today. *Social Science and Medicine* 52(2), 203-212.
- Arvidsson, B., Löfgren, H. & Fridlund, B. (2001) Psychiatric nurses' conceptions of how a group supervision programme in nursing care influences their professional competence: a 4 – year follow – up study. *Journal of Nursing Management* 9, 161-171.
- Arvonen, J. (1995) *Leadership behaviour and co worker health – A study in process industry*. (No 801): Reports from Department of Psychology, Stockholm University.
- Bass, B.M. & Riggio R.E. (2006) *Transformational leadership*. New Jersey: Lawrence Erlbaum Associates, Mahway.
- Bass, B.M. (1998) *Transformational Leadership: Industrial, and Educational Impact*. New Jersey: Lawrence Erlbaum Associates.
- Bass, B.M. (1990) *Bass & Stogdill's Handbook of Leadership. Theory, Research and Managerial Applications*. New York: The Free Press.
- Bass, B.M. (1985) *Leadership and performance beyond expectations*. New York: Free Press.
- Bergren I. & Severinsson E. (2000) The influence of clinical supervision on nurses' moral decision-making. *Nursing Ethics* 7(2); 124-133.
- Boström A.-M., Wallin L. & Nordström G (2006) Research use in the care of older people: a survey among healthcare staff. *International Journal of Older People Nursing* 1, 131-140.

- Brannon D., Zinn J.S., Mor, V. & Davis J. (2002) An Exploration of Job, Organizational, and Environmental Factors Associated With High and Low Nursing Assistant Turnover. *The Gerontologist* 42(2), 159-168.
- Brenner, S. O., Petterson, I. L., Levi, L. & Arnetz, B. (1988) *Stressreaktioner på hot om arbetslöshet och upplevd arbetslöshet. (Stress reactions to threat of unemployment)*. (In Swedish) Stockholm: Stressforskningsrapport Nr.210. (Stress Research Reports No. 210). National Institute of Psychosocial Factors and Health.
- Brown H., Zijlstra F. & Lyons E. (2006) The psychological effects of organizational restructuring on nurses. *Journal of Advanced Nursing* 53(3), 344-357.
- Castle N.G. (2005) Turnover Begets Turnover. *The Gerontologist* 45(2), 186-195.
- Cheung, P.P.Y. & Yam, B.M.C. (2005) Patients autonomy in physical restraint. *Journal of Clinical Nursing*, 14(3a), 34-40.
- Cronqvist, A., Theorell, T., Burns, T. & Lütznén, K. (2001) Dissonant imperatives in nursing: a conceptualization of stress in intensive care in Sweden. *Intensive and Critical Care Nursing* 17(4), 228-236.
- Cox, T. (1987) Stress, coping and problem solving. *Work and Stress* 1, 5-14.
- De Witte, H. (1999) Job Insecurity and Psychological Well-being: Review of the Literature and Exploration of Some Unresolved issues. *European Journal of Work and Organizational psychology* 8 (2), 155-177.
- Depla, M.F.I.A., de Graaf, R., van Weegel, J. & Heeren, T. (2005) The role of stigma in the Quality of life of older adults with severe mental illness. *International Journal of Geriatric Psychiatry* 20, 146-153.
- Down-Wamboldt B. (1992) Content analysis: method, applications, and issues. *Health Care for Women International* 13, 313-321.
- Edberg A-K. (1999) *The nurse-patient encounter and the patients' state: effects of individual care and clinical group supervision in dementia care*. Medical Dissertation. Lund: Lund University.
- Ekvall, G. & Ryhammar, L. (1999) The Creative Climate: Its Determinants and Effects at a Swedish University. *Creativity Research Journal* 12(4), 303-310.
- Ekvall G. (1996) Organizational Climate for Creativity and Innovation. *European Journal Of Work And Organizational Psychology* 5(1), 105-23.

- Fransson-Sellgren, S., Ekvall, G. & Tomson, G. (In Press) Leadership behaviour of nurse managers in relation to job satisfaction and work climate. *Journal of Nursing Management*.
- Glasberg, A-L. (2007) *Stress of conscience and burnout in healthcare: The danger of deadening one's conscience*. Umeå: Umeå University. Medical Dissertation. New Series No 1088.
- Graneheim, U.H. & Lundman, B. (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today* 24, 105-112.
- Grönroos, E. & Perälä, M.-L. (2005) Home care personnel's perspectives on successful discharge of elderly clients from hospital to home setting. *Scandinavian Journal of Caring Science* 19, 288-297.
- Gustafsson, R.Å. & Szebehely, M. (2005) *Working conditions and regulation (Arbetsvillkor och styrning)* Stockholm University, Reports in Social Work no. 114
<http://www.google.se/search?hl=sv&q=Arbetsvillkor+och+styrning&meta=>
- Gurner, U. & Thorslund, M (2003) *No conductors in eldercare: On the necessity of co-ordination (Dirigent saknas i vård och omsorg för äldre: om nödvändigheten av samordning)*. (In Swedish) Stockholm: Natur och kultur. Sweden
- Hallsten, L. (1985) *Burnout. A study about adaption and development processes in a bureaucracy. (Burnout. En studie kring anpassning och utvecklings processer I en byråkrati)*. (In Swedish) Rapport 18:2, LAMI Arbetsmarknadsinstitutet, Länsarbetsnämnden I Stockholms Län, Stockholm.
- Hansebo, G. & Kihlgren, M (2004) Nursing home care: changes after supervision. *Journal of Advanced Nursing* 45(3), 269-279.
- Hansebo, G., Kumlin, S. & Ljunggren, G. (1993) Training manual of the Resident Assessment Instrument (In Swedish). RAI- enheten, Stockholm.
- Happ, H. B., Dabbs, A. D., Tate, J., Hricik, A. & Erlen, J. (2006) Exemplars of mixed Methods data combination and analysis. *Nursing Research* 55(2), 43-49.
- Hellgren, J. (2003) *The times they are a-changin'. Job uncertainty and the flexible labor market*. (Dissertation) Stockholm: Department of Psychology, Stockholm University

- Hertting, A., Nilsson, K., Theorell., & Larsson, U.S. (2004) Downsizing and reorganization. Demands, challenges and ambiguity for registered nurses. *Journal of Advanced Nursing* 45(2), 145-154.
- Hertting, A., Nilsson, K., Theorell., & Sätterlund-Larsson, U. (2003) Personnel reductions and structural changes in health care Work-life experiences of medical secretaries. *Journal of Psychosomatic Research* 54, 161-170.
- Hertzberg, H., Mausner, B. & Bloch Snyderman, B. (199) *The motivation to Work*. New Jersey: Transaction Publisher, New Brunswick
- Hov, R. (2007) *Nursing care for patients on the edge of life. Nurses' experiences related to withholding or withdrawing curative treatment, in the context of ICU and nursing home*. (Dissertation) Karlstad University
- Hsieh, H-F. & Shannon, S.E. (2005) Three Approaches to Qualitative Content Analysis. *Qualitative Health Research* 15(9), 1277-1288.
- Hägström, E. (2005) *Municipal care for older people-experiences narrated by caregivers and relatives*. (Medical Dissertations). Stockholm: Karolinska Institute.
- Jacob, M.E., Abraham, V. J., Abraham, S. & Jacob, K.S. (2007) The effect of community based day care on mental health and quality of life of elderly in rural south India: a community intervention study. *International Journal of Geriatric Psychiatry* 22, 445-447.
- Joelson, L. & Thomsgård-Joelson, B. (2000) Individuals and organizations in transition. In: K. Barklöf (ed.) *Path selection? An anthology on processes of change in slimmed organizations*. (Individ och organisation i förändring). *Vägval? En antologi om förändringsprocesser i magra organisationer*, (In Swedish) Stockholm: Rådet för arbetslivsforskning.
- Josephson, M. & Wingård, E. (2002) *The zeal to work and health – a report from the HAKul project (Arbetslust och hälsa- En rapport från HAKul-projektet)* (In Swedish) Stockholm: Karolinska Institute, Division of Personal Injury Prevention.
- Jubb Shanley M. & Stevenson C. (2006) Clinical Supervision revisited *Journal of Nursing Management* 14, 586-592.
- Karasek, R.A. & Theorell T. (1990) *Healthy work. Stress, Productivity and the Reconstruction of Working life*. New York: Basic Books Inc.
- Karsh B., Booske B.C. & Sainfort F. (2005) Job and organizational determinants of nursing home employee commitment, job satisfaction and intent to turnover. *Ergonomics* 48(10), 1260-1281.

- Kash B.A., Castle N.G., Naufal BA. & Hawes C. (2006) Effect of staff turnover on staffing: A closer look at registered nurses, licensed vocational nurses, and certified nursing assistants. *The Gerontologist* **46**(5), 609-619.
- Kayser-Jones, J., Schell, E., Lyons, W., Kris, A. E, Chan, J. & Beard, R. L. (2003) Factors that influence end-of-life care in nursing homes: the physical environment, inadequate staffing, and lack of supervision. *The Gerontologist* **43**, 76-84.
- Kemp, P. (1992) *Lévinas. En introduktion*. Göteborg: Daidalos AB.
- Kihlgren, M. (1992) *Integrity promoting care of demented patients*. Umeå University Medical Dissertations.
- Kivimäki, M., Vahtera, J., Pentti, J. & Ferrie, J.E. (2000) Factors underlying the effect of organisational downsizing on health of employees: Longitudinal cohort study. *British Medical Journal* **32**, 971-975.
- Kondracki, N.S., Wellman, N. S. & Amundson, D.R. (2002). Content Analysis: Review of Methods and Their Applications in Nutrition Education. *Journal of Nutrition Education and Behaviour* **34**(4), 224-230.
- Kvale, S. (1997) *The Qualitative Research Interview. (Den kvalitativa forsknings intervjun)*. (In Swedish) Lund: Studentlitteratur.
- Landy, F. J. & Conte, J.M. (2004) *Work in the 21st century: An introduction to industrial and organizational psychology*. Boston: McGraw-Hill.
- Lazarus, R.S. (1991) *Emotion and adaption*. Oxford: University Press.
- Lévinas, E. (1998) *Otherwise than being, or, Beyond essence*. (Translated by Lingis, A). Pittsburgh: Dugesne University Press.
- Lévinas, E. (1969) *Totality and infinity: an essay on exteriority*. (Translated by Lingis, A). Pittsburgh: Dugesne University Press.
- Lewin, K. (1951) *Field Theory in Social Science*. Harper & Bros.
- Lind Nilsson, I. (2003) Ledarskap i kritiska situationer. (Leadership in critical situations) I: Holmberg, I & Henning, R (Eds) Offentligt ledarskap – om förändring, förnyelse och nya ledarideal. (In Swedish) Lund. Studentlitteratur. Sweden.
- Lincoln, Y. S. & Guba, E.G. (1985) *Naturalistic inquiry*. Beverly Hills: Sage, California
- Lyth GM. Clinical supervision. A concept analysis. *Journal of Advanced Nursing* **31**(3),722-729.
- Lövgren, G., Rasmussen, B.H. & Engström, B. (2002) Working conditions and possibility of providing good care. *Journal of Nursing Management* **10**, 201-209.

- Mamhidir, A-G. (2006) *Meeting ethical and nutritional challenges in elder care. The life world and system world of staff and high level decision-makers*. Medical Dissertation Karoliska Institute, Stockholm
- Manion, J. (2004) Nature a culture of retention. *Nursing Management* 35(4), 28-39.
- Maslach C., Jackson S.E. & Leiter P. (1996) *Maslach Burnout Inventory Manual*. Consulting Psychologists Press, Inc. Palo Alto, California.
- Maslach C. & Jackson S.E. (1981) The measurement of experienced burnout. *Journal of Occupational Behaviour* 2, 99-113.
- Mattiasson, A-C. & Andersson, L. (1995) Organizational environment and the support of patient autonomy in nursing home care. *Journal of advanced Nursing* 22, 1149-1157.
- Meleis, A. I., Sawyer, L. M., Im, E., Messias, D. K. H. & Schumacher, K. (2000) Experiencing transitions: an emerging middle-range theory. *Advances in Nursing Science* 23, 12-28.
- McAiney, CA. (1998) The development of the empowered aide model. An intervention for long-term care staff who care for Alzheimer's residents. *Journal of Gerontological Nursing* 24(1), 17-22.
- Medical Services Act SFS 1982:763. Hälso- och sjukvårdslag (1982:763) In Swedish Electronic version <http://www.notisum.se/Rnp/SLS/LAG/19820763.HTM>
- Ministry of Health and Social Affairs (2007) Hälso och sjukvården i Sverige (Fact Sheet No 14, juni 2007). Access 2007-08-15 <http://www.sweden.gov.se/sb/d/574/a/24612>
- Miller, E.J. (1990) Experiential Learning in groups I: The development of the Leicester model. In: Trist, E. & Murray, H. (Eds.), *The social engagement of social science: Volume I: The socio-psychological perspective*. London: Free Association Books.
- Mishler E. (1986) *Research Interviewing: Context and Narrative*. Cambridge: MA, Harvard University Press.
- Moyle W., Skinner J., Rowe G. & Gork C. (2003) Views of job satisfaction and dissatisfaction in Australian long-term care. *Journal of Clinical Nursing* 12, 168-176.
- Murphy, K. (2007) Nurses' perception of quality and the factors that affect quality for older people living in long-term care settings in Ireland. *Journal of Clinical Nursing* 16, 875-884.

- National Board of Health and Welfare (2008) Vård och omsorg om äldre - en lägesrapport (Caring for older people – a situation report 2007). (In Swedish) 2008, Socialstyrelsen, Stockholm. Access 2008-04-08
<http://www.socialstyrelsen.se/NR/rdonlyres/4D793100-E677-4E98-997F-4805BDB1FECC/9991/20081316.pdf>
- National Board of Health and Welfare (2004) Varför kan inte behovet av särskilda boendeformer tillgodoses 2003? (Why couldn't the need for special housing be met in 2003?). (In Swedish). 2004, Regeringsuppdrag till Boverket och Socialstyrelsen, Stockholm. Access 2007-07-22
<http://www.socialstyrelsen.se/NR/rdonlyres/FBD798FB-BD2F-400F-A024-3A837ACB56C5/1416/20041102.pdf>
- Norberg, K-G., Hellze'n, O., Sandman, P-O. & Asplund, K. (2002) The relationship between organizational climate and the content of daily life people with dementia living in a group dwelling. *Journal of Clinical Nursing* 11, 237-246.
- Pfeffer, J. (1997). New directions for organization theory: Problem and prospects. New York: Oxford University Press.
- Polit D. F. & Beck C. T. (2008) *Nursing Research. Principles and methods*. Philadelphia. 7 ed. Lippincott Williams & Wilkins.
- Riggs, C. J. & Rantz, M. J. (2001) A model of Staff Support to Improve Retention in Long – Term Care. *Nurse Administration Quarterly* 25, 43-54.
- Robertsson EM., Higgins L., Rozmus C. & Robinson JP. (1999) Association between continuing education and job satisfaction of nurses employed in long-term care. *Journal Containing Education Nursing* 30, 108-13.
- Sandelowski, M. (2000) Combining Qualitative and Quantitative Sampling, Data Collection, and Analysis Techniques in Mixed-Method Studies. *Research in Nursing & Health* 23, 246-255.
- Sandelowski, M. (1998) The call to experts in qualitative research. *Research in Nursing and Health* 21, 467-471.
- Sandelowski, M. (1986) The problem of rigor in qualitative research. *Advances in Nursing Science* 8(3), 27-37.

- SALAR (2006) The Swedish Association of Local Authorities and Regions. *Care of the elderly in Sweden today*. Access 2007-08-07
<http://www.skl.se/artikeldokument.asp?C=536&A=413&FileID=147396&NAME=Care+of+the+elderly+in+Sweden+today+2006+.pdf>
- Sarafino, E. (2006) *Health Psychology: biopsychosocial interactions*. New York: Chichester Wiley, cop.
- SBU – Statens Beredning för Medicinsk Utvärdering. (2007) *Vård av personer med Demenssjukdom – vad vet vi i dag? (Caring for people with dementia – what do we know today?)* (In Swedish) Falköping: Elander
- Schutz, W. (1997) *The Human Element. Productivity, Self-Esteem and Bottom Line*. (In Swedish) *Den goda organisationen. En modell för utveckling av människor, grupper och organisationer*. Falun: Natur och kultur.
- Schutz, W. (1989) *Firo: a three dimensional theory of interpersonal behaviour*. Mill Valley.
- Secrest, J., Iorio, D.H. & Martz, W. (2005) The meaning of work for nursing assistants who stay in long-term care. *International Journal of older People Nursing* in association with *Journal of Clinical Nursing* **14**, 8b, 90-97.
- Sellgren, S., Ekvall, G. & Tomson, G. (2006) Leadership styles in nursing management: preferred and perceived. *Journal of Nursing Management* **14**, 348-355.
- SFS, 1982:763 Health and Medical service Act. (Hälso- och sjukvårdslagen).
Access 2008-04-08
<http://www.riksdagen.se/webbnav/index.aspx?nid=3911&bet=1982:763>
- SFS 1998: 531 Act on Professional Activity in the health and medical area. (Lag om yrkesverksamhet på hälso- och sjukvårdens område). Access 2008-04-08
<http://www.riksdagen.se/webbnav/index.aspx?nid=3911&bet=1998:531>
- SFS, 2001: 453. Socialtjänstlag (Swedish Social Service Act). Access 2008-04-08
<http://www.riksdagen.se/webbnav/index.aspx?nid=3911&bet=2001:453>
- Skovdahl, K., Fahlström, G., Larsson, B-M., Winblad, B. & Kihlgren, M. (In press) Demanding behaviors and workload in elderly care in Sweden – occurrence at two times points within a decade. *Scandinavian Journal of Caring Sciences*.
- Schnelle, J.F., Simmons, S.F. Harrington, C., Cadogan, M., Garcia, E. & Bates-Jensen, B.M. (2004) Relationship of Nursing Home Staffing to Quality of Care. *Health Services Research* **39**(2), 225-250.

- SOSFS 1997: 14. The National Swedish Board of Health and Welfare's regulations and general advice on delegation of working tasks in health, medical and dental care (Socialstyrelsens föreskrifter och allmänna råd om delegering av arbetsuppgifter inom hälso- och sjukvård och tandvård). (In Swedish) Access 2008-04-08 http://www.sos.se/sosfs/1997_14/1997_14.htm
- Statistics Sweden (2007) Statistiska Centralbyrån Access 2008-04-08 <http://www.ssd.scb.se/databaser/makro/start.asp>
- Stone, P. W., Larson, E.L., Mooney-Kane, C., Smolowitz, J., Lin, S. X. & Dick, A. W. (2006) Organizational climate and intensive care unit nurses' intention to leave. *Critical Care Medicine* 34(7), 1907-1912.
- Sung H-C, Chang S_M. & Tsai C-S. (2005) Working in a long-term care setting for older people with dementia: nurses' aides, *Journal of Clinical Nursing* 14, 587-593.
- Svedberg, L. (2007) *Group psychology. On groups, organizations and leadership (Gruppsykologi. Om grupper, organisationer och ledarskap)*. (In Swedish) Studentlitteratur. Narayana Press Denmark.
- Söderberg, A. (1999) *The practical wisdom of enrolled nurses, registered nurses and physicians in situation of ethical difficulty in intensive care*. Umeå: Umeå University Medical Dissertations, New Series No 603.
- Sørli, V., Kihlgren, A. L. & Kihlgren, M. (2004) Meeting ethical challenges in acute care works as narrated by enrolled nurses. *Nursing Ethics* 11, 179-188.
- Themessl-Huber, M., Hubbard, G. & Munro, P. (2007) Frail older people experiences and use of health and social care services. *Journal of Nursing Management* 15, 222-229.
- Vakola, M. & Nikolaou, I. (2005) Attitudes towards organizational change: What is the role of employees' stress and commitment? *Employee Relations* 27, 160-174.
- Westin, L. & Danielsson, E. (2006) Nurses' experiences of caring encounter with older people living in Swedish nursing homes. *International Journal of Older People Nursing* 1, 3-10.
- Westerlund, H., Ferrie, J., Hagberg, J., Jeding, K., Oxenstierna. & Theorell, T. (2000) Workplace expansion, long-term sickness absence, and hospital admission. *The Lancet* 363, 1193-1197.
- Wetle, T., Shield, R., Teno, J., Miller, S. C., & Welch, L. (2005) Family perspectives on end-of-life care experiences in nursing homes. *The gerontologist* 45(5), 642-650.

- Wimo A, Persson G, Sjölund B-M et al. (2002) Äldre med långvariga vårdbehov i Nordanstig. Baslinjeundersökning våren 2001 i Nordanstig SNAC- Vårdsystem (The Swedish National Study of Ageing and Care) (In Swedish). SNAC-rapport nr. 4. Stockholm: Stiftelsen Stockholms läns Äldrecentrum, 2002. Access 2007-10-23 <http://www.aldrecentrum.se/snacklindexsv.htm>
- Vroom, V.H. (1964) *Work and motivation*, New York, NY: John Wiley and Sons.
- Åberg, K., Öhman, A., & Lundin-Olsson, L. (2004) Disparate Professional practices and unknown team. Registered nurses' and local facility managers' attitudes to their work with older people as well as to physiotherapy and occupational therapy. *Nordisk Fysioterapi* 8, 3-11.

