

**MUNICIPAL CARE FOR OLDER PEOPLE**  
**- experiences narrated by caregivers and relatives**

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## **ABSTRACT**

The overall aim with the longitudinal studies of the thesis was to gain an understanding of caregivers' experiences of working with older people within municipal care and of whether education and support have been meaningful for them **(I-III)**. A further aim was to gain an understanding of which aspects are important so that work will be able to be carried out in a care environment that provides fulfilment and work satisfaction and thereby creates the prerequisites for the staff to provide the older people with better care. Furthermore narratives from relatives were studied **(IV)** in order to increase knowledge about their experiences of having an old family member in special housing within municipal care and to increase knowledge about the relatives' wishes and their possibility of taking part in the care.

Studies **I** and **III** comprised an investigation of the deeper meaning of work satisfaction and work dissatisfaction at a newly opened nursing home for elderly residents before an intervention had started **(I)** and after a two-year intervention **(III)**. The studies focused on the narratives supplied by the caregivers at the nursing home. The interviews were analysed with a phenomenological-hermeneutic method inspired by Ricoeur's philosophy. The conclusion drawn is that the caregivers' experience of work dissatisfaction overshadowed their experience of work satisfaction before the intervention had started **(I)**. There was a shift from this dominance to a dominance of work satisfaction after the two-years intervention, which indicates that the intervention, consisting of: education, support, and supervision, might have facilitated this positive development **(III)**.

According to the caregivers' feelings of work dissatisfaction which appeared in study **I** the aim of study **II** was to investigate whether the caregivers' previous experiences could be understood and whether they reflected Ås' Five Master Techniques Theory. The interviews were analysed with a qualitative content approach. The findings showed that it was obvious that the caregivers' experiences of work dissatisfaction reflected and could be understood from feelings of being made to feel invisible, deprived of information, double punishment, and feelings of guilt and shame which is the content of Ås' Five Master Techniques Theory.

The aim of study **IV** was to describe the relatives' experiences concerning older family members living in special housing facilities and to increase knowledge about relatives' wishes and their possibilities of taking part in the care. The study focused on the narratives supplied by the relatives and was analysed using qualitative content analysis. The conclusion was that the relatives need more support and more opportunities, for a possibility to be able to participate in the care. The study also showed the relatives' engagement, in working for a just society, obligation towards the protection of older peoples' rights and the working conditions for staff.

The most important findings of this thesis **(I-IV)** were that in order to increase understanding for caregivers within municipal care for the older people and for the relatives' situation of having a close relative that lives there, one should see their situation both from an individual perspective, i.e. the direct contact between the older people, the caregivers, the relatives, and from a society perspective, i.e. to see the elderly's, caregivers' and the relatives' situation from a society perspective. Another conclusion one can make is that support, education and supervision are important and supervision needs to focus more on society's humanistic basic views in care work for both caregivers and relatives.

**Keywords:** older people, long-term care, work dissatisfaction, work satisfaction, intervention, supervision, feminist theory, relatives, relationship, caregivers and qualitative methods.  
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## ORIGINAL STUDIES

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

**I.** Häggström, E., Skovdahl, K., Fläckman, B., Kihlgren, A.L. & Kihlgren, M. (2004).

**To feel betrayed and to feel that you are betraying the older residents; Caregivers' experiences at a newly opened nursing home.** *Journal of Clinical Nursing*, 13, 687-696.

**II:** Häggström, E. & Kihlgren, M.

**Caregivers' experiences of being betrayed and feelings of themselves being a betrayer – A gender perspective** (submitted).

**III.** Häggström, E., Skovdahl, K., Fläckman, B., Kihlgren, A.L. & Kihlgren, M.

**Worksatisfaction and dissatisfaction – caregivers' experiences after a two-year intervention in a newly opened nursing home.** *Journal of Clinical Nursing*, 14, 9-19.

**IV:** Häggström, E., Kihlgren, A.L., Kihlgren, M. & Sörlie.

**Municipal care – The relatives' struggle for a better and just care for the older people** (resubmitted).

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

## **INTRODUCTION**

### **Municipal care for older people in special housing facilities**

During the last 50 years the number of older people in Sweden has increased and this development will continue by the years 2000-2015. It is expected that the number of people that are 90 years old and older will increase by 35% (National Board of Health and Welfare 2004). Simultaneously with this development the problems of the county councils and the municipalities with financing public care and nursing are increasing. The number of places in special homes within municipality care for the older people has decreased during the last few years and older people having the greatest need for care and multiple illnesses are therefore prioritised (Gurner & Thorslund 2003). This means that there is a greater need of well-educated and competent personnel within the municipality care for the elderly and an increased care burden in daily work (Thorslund *et al.* 2001). This also means that relatives of the elderly that live in special housing get increased responsibility as regards their close ones (Svedberg 2001).

### **The professional caregivers' perspective**

The caregivers within municipal care for the older people find themselves in a situation where the resources available for care for the elderly have been decreased while the number of very old people which have been diagnosed as having several illnesses and various function impairments in the Swedish population has increased and where the number of places in special housing has been reduced (Gurner & Thorslund 2003; National Board of Health and Welfare 2004). This results in the elderly living in special housing having a great need of care and for the caregivers that work there this means that the work is harder, the elderly require more professional input and the requirement of formal competence within care increases (Szebehely 2000).

The majority of the people employed within municipal care for the elderly in Sweden are women that are not highly educated and it is difficult to recruit men (National Board of Health and Welfare 2004). Historically women have been apportioned different values such as being passive, unreasonable and irrational, which is based on women acting on their feelings rather than on logical thinking, that men are considered to do (Hernes 1982; Wennström 1983). Several researching women object to this and they are of the opinion that it is the sex-segregated distribution of work in society that has made men and women develop different types of rationalities, where men are considered to be the bearers of instrumental/technical

rationality that is based on fact and where women are considered to be the bearers of care rationality, which is based on relationships and involves taking responsibility for other people's care needs (Sørensen 1982; Waerness 1980, 1984). Waerness (1984) defines care work as care for people who cannot manage things themselves and who therefore become dependent on the caregiver and, according to her, both common sense and feeling are included in the care rationality concept. Miers (2002) writes that gender-sensitive care involves the meaning of understanding nursing in relation to a socio-political context and care in relation to gender relations. Cloyes (2002) considers that nursing and care need to be made visible and be described in relation to care and nursing in political terms. Macintosh (2002) discusses how gender issues influence nursing practice and that education can be a strategy to understand visible and invisible gender-related issues in care better. Emancipation for nurses in decision-making concerning care alternatives is facilitated if the phenomena empowerment, personal knowledge, social norms, reflection and a flexible environment can be discussed and developed in care (Wittmann 2004).

A good leader in care must be able to exhibit care and to understand caregivers in the same way as caregivers must be able to manifest the same towards patients (O'Connors & Walkes 2003). Leadership also concerns exercising a determined influence on a sequence of events and activities and to get things done through other people within the framework of and goals of the organisation (Rubenowitz 1994; Abrahamsson & Andersen 2003). Today most of the problems in the public sector are considered to be associated with a lack of leadership (Albinsson 2002) and due to the public sector's dwindling economic resources and increased organisational changes, leadership is sometimes referred to as the problem and sometimes as the solution (Holmberg & Henning 2003). According to Hamran (1991), Daquette *et al.* (1995) and Silfverberg (1999) rationality, effectiveness and productivity are not desired factors within nursing and care and the management should therefore work more to support the development of interaction between caregivers and those that become caregivers. Both national and international studies show that the quality of care for the elderly is related to how well the management works and how it can meet the needs of the care personnel in care work (Bowers *et al.* 2001; Fagerberg & Kihlgren 2001).

Bowers (*et al.* 2001) also argues that the quality of the care for the older people is related to both external and internal motivation factors. Hyrkäs *et al.* (2002) asserts that external factors such as making decisions, staffing and the working environment are of significance for the caregivers' work. Skovdahl *et al.* (2003, 2004) shows in her studies that different care cultures where unexpressed external requirements, expectations and norms exist, can influence the



caregivers' work situation when meeting deviant demented people. The caregivers that worked in an organisation they considered to be supporting showed themselves to have a good chance of handling demanding situations. Fahlström (1999) describes in her thesis that caregivers act partly from internal motives and partly from external motives.

In order to be able to carry out care work, knowledge of the individual care receiver, sufficient time to be able to carry out the care tasks, material resources and the capability to be able to judge and make decisions concerning changes regarding the care receiver's needs are needed. Bowers *et al.* (2001) concluded that the nurses' experiences of stress in their work lead to them working with the elderly in a routine fashion. Fahlström (1999) has shown in a thesis that nurses aides want to have more time to spend with each care receiver. Melin Emilsson (1998) has found that the nurses aides' ability to take care of people diagnosed with dementia can be related to how well the caregivers experience the functioning of the organisation. Skovdahl *et al.* (2003) found in a study that there should be a balance between requirements and competence as far as the caregivers' work with the care receiver with their deviant behaviour is concerned. The caregiver's experiences of stress in their work increase, according to Rodney (2000), when the people they are caring for are aggressive and threatening. Brodaty *et al.* (2003) found in a study that the caregivers found it difficult to handle aggressive and unpredictable behaviour from the residents diagnosed with dementia.

The caregivers explained, according to Edberg & Bird (2003), that it was difficult to prioritise a resident's immediate needs in relation to the other residents' needs. Irrespective of how the caregivers balanced and prioritised the residents' different needs, there was always someone who was not satisfied. In an investigation carried out by Norberg *et al.* (1998) it emerged that when nursing assistants described difficult ethical situations in care for the elderly they had inadequate knowledge. Tutton & Seers (2004) identified that caregivers reacted mostly to the elderly's problems rather than satisfying the need for comfort that they expressed. It is possible that the caregivers that work with people diagnosed with dementia distance themselves and do not want to approach a resident for fear of themselves becoming emotionally involved in the older person's anguish (Hallberg 1990; Edberg & Bird 2003). It is important that the caregivers work to support the residents' possibility of living a life fit for human beings and even to ensure that the residents will retain their self-esteem (Nyström & Andersson-Segesten 1990; Nyström 1995). Further a good relationship between them and the relatives has to be developed in order to manage the new role that the relative faces concerning the move to special housing for a family member (Sandberg 2001).

### **The relatives' perspective**

Relatives that have a family member in special housing express that it is difficult to be able to change something for the positive in the elderly person's life or to influence the content of the nursing and care (Bowers 1988; Kellett 1996; Whitaker 2002). They experience that the elderly have to do a lot of waiting in special housing and express a wish to be able to contribute something to the older person's life so that their life can become more meaningful. This can be taken as a threat to the caregiver's way of working (Robinson & Thorne 1984). Further, studies that illuminate the difficulties in being a relative to the old person concern the problems with interacting with the personnel and being sufficiently involved in the care (Dellasega & Nolan 1997; Hertzberg *et al.* 2003). Relatives are seeking better information and communication between the personnel and the relatives according to several studies (Edwards & Forster 1999; Iwasiw *et al.* 2003). Additional needs that the relatives have are being able to help and support their family members in accordance with their own requirements and conditions (Edwards & Forster 1999; Ryan & Sucillion 2000).

Summarizing, it can be said that being a relative does not cease when a close relative needs to live in special housing (Ross *et al.* 1997; Wright 1998) but such a move entails great anguish for the relative that often has to make the decision about the move (Naleppa 1996; Dellasega & Nolan 1997). Many relatives also experience, according to several studies, happiness when caring for relatives. They feel useful and they feel that they receive appreciation for their efforts (Attimäki *et al.* 1999; Mossberg-Sand 2000). It is important for the relatives that the older person is seen, acknowledged and perceived as a unique individual by the caregivers within care for the elderly and that the relatives' knowledge and experiences of the elderly person is demanded by the caregivers (Bowers 1988; Whitaker 2004).

In Sweden the care for the elderly has undergone significant changes over the last few years (Gurner & Thorslund 2003), why it seems important to conduct further research about the relatives' view of the care situation of the municipality.

### **The older persons' perspective**

The eldest of the elderly and those in need of nursing and care make up the majority of those who live in special housing within municipal care for the elderly (Trydegård & Thorslund 2001). According to Whitaker (2004) life for the elderly in special housing is characterized by having to wait. The elderly wait for food, coffee, help, visits and for being allowed to go to sleep. A contributory reason for this experience of waiting is that the elderly are inactive. This inactivity is not only negative but can also be peaceful and it means that the caregivers can

balance, and see to the elderly's needs of activity and/or rest (Whitaker 2004). In an interview study carried out on people between 85 and 96 years old it emerged that there is a difference between being old and feeling old. The people that felt old were worried about becoming helpless and not being able to manage their own living situation and becoming dependent on other people's help (Nilsson *et al.* 2000) or one-sidedly needing to accept help (Baltes 1996). Older people that do not live in special housing expressed, in a study (Nilsson *et al.* 1998), that they were worried about needing to live in special housing in the future and thereby losing control over their own life. Older people experience meaning to their life if they have the possibility of getting involved. To experience meaning and involvement the older person needs to feel engaged, and feel a balance between giving and taking for example, continuity i.e. to feel that changes in life take place gradually, creativity by for example being able to influence their own life and transgression that develops in the company of others (Hagberg 2002).

For the caregivers that work with the elderly it is important, according to Coleman (1999), Kenyon (1996) to be able to listen to and to be interested in the elderly's stories about their lives because the stories facilitate the elderly's possibility of reflection, of understanding the meaning of their lives and even of understanding which life experiences have been the most meaningful for them (Öberg 1997; Coleman *et al.* 1998).

### **The meaning of teaching and supervision**

In order for organisations to adapt to the rapid changes that are currently taking place in the world around them focus has been placed on organisational teaching. The crux of organisational teaching is that the teaching process itself takes place in a given context and through a social collective process (Abrahamsson & Andersen 2003). According to Ellström (1994) teaching of lower order exists where the individuals learn from given tasks and teaching of higher order exists where the individuals learn from non-given conditions and take responsibility for identifying the task themselves. The higher order teaching requires a pedagogical working environment that promotes the development of competence and stimulates the development of the employees' familiarity.

There are several studies that show that the caregiver's well-being and the care receiver's care improves when the personnel receives support in the form of supervision (Kihlgren *et al.* 1992; Hansebo & Kihlgren 2004). The aim of supervision is, among other things, to develop

and improve the relationship between caregivers and patients and to provide more opportunities for caregivers to reflect upon their way of working (Severinsson & Hallberg 1996a; Severinsson & Hallberg 1996b; Bégat *et al.* 1997; Olsson & Hallberg 1998; Berggren & Severinsson 2002; Skovdahl *et al.* 2003). Care-focused supervision starts by considering the staff's feelings and experiences and is mainly focused on the caregiver in relation to the patient (Bowels & Young 1999; Holst *et al.* 1999).

Patient-focused supervision focuses on the care receiver, where the caregivers receive supervision regarding the care of the patient (Enarsson & Sandman 1998). Clinical group supervision helps nurses to reflect on their work and reflection is regarded as a means for professional development according to Gustavsson & Fagerberg (2004). Previous intervention studies in dementia care where staff received systematic clinical supervision combined with individual supervision, indicated less burn out, increased work satisfaction, empathy and creativity among staff (Hallberg *et al.* 1994; Edberg *et al.* 1996; Olsson & Hallberg 1998).

## **RATIONALE FOR THE STUDY**

Care for the elderly has, in Sweden under the 1990's and the beginning of 21st century, undergone significant changes in the form of reducing the number of places in special housing, a successively decreasing level of service for the majority of the elderly and a pronounced trend to firstly help the eldest of the elderly and the people in most need of help (Gurner & Thorslund 2003). This in turn has meant that people that live in special housing have become more dependent on healthcare efforts. Simultaneously with this development, municipal problems with financing public care have increased. For the caregivers, the majority of whom are women, which work within municipal care for the elderly this means that the work becomes harder, the care receivers require more professional care efforts and the requirement of formal competence within the field increases (Thorslund *et al.* 2001). For relatives this can mean that they assume a new role in securing welfare when the gap between needs and resources yields. In order for municipal care for the elderly to be able to meet future requirements with more older people that need advanced care during times when organisational changes are part of everyday life (Hertting 2004) it is important to attain increased knowledge of the caregiver's experiences of working within municipal care for the elderly and increased knowledge of relatives' experience concerning older family members living in special housing facilities.

## **AIMS OF THE THESIS**

The overall aim of this thesis was to investigate the deeper meaning of work satisfaction and dissatisfaction from caregivers' narratives at a newly opened nursing home before and after an intervention. A further aim was to investigate the experience from relatives' narratives of having an older person within municipal care.

Specific aims were

- to illuminate the caregivers' deeper meaning that is implied regarding work satisfaction and work dissatisfaction, at a newly opened nursing home, before an intervention had started **(I)**;
- to find out whether the caregivers' experiences, before the intervention had begun, from the newly opened nursing home can be understood from Ås' framework (1982b) of the Five Master- Techniques **(II)**;
- to illuminate the caregivers' deeper meaning that is implied in the context of work satisfaction and dissatisfaction over a period of time where; education, support, and clinical supervision was provided during a two-year period **(III)**;
- to describe the relatives' experiences concerning older family members living in special housing facilities and to increase knowledge about the relatives' wishes and their possibilities of taking part in the care **(IV)**.

## **METHODS**

### **Studies I-III**

The studies have been conducted as an intervention project within the municipal geriatric care system in the centre of Sweden (appendix 1).

This is part of a multi center study comprising one nursing home 'T' situated in a larger community (100 000 inhabitants). In the nursing home 'T', the staff has been provided with education, supervision and support during a two year period. The entire in the staff have been informed about the study, and had the opportunity to participate and 32 volunteered to do so. Occupational Therapists, Registered Nurses (RNs), Enrolled Nurses (ENs) and Nurses' Aides (NAs) participated in interviews; survey 1 before intervention, survey 2 after 12 months – during intervention, and survey 3 after 24 months – when intervention was closed.

### ***Setting***

In this thesis the expressions "geriatric care setting" and "municipal care setting" mean the same thing i.e. a special residence under municipal direction where elderly people live.

Nursing home 'T' was opened in the autumn of 1999 and was subjected to financial cut backs after one month. The number of employees was reduced and the number of residents was increased by two per unit, resulting in the following:

Unit 1, group dwelling, ten residents requiring help in daily living.

Unit 2, group dwelling, fifteen residents with somatic diagnosis.

Unit 3, group dwelling, ten residents with deviant behaviour.

Unit 4, group dwelling, ten residents with severe dementia disorder.

In all 45 residents.

### ***Sample***

The caregivers were firstly recruited through job advertisements and those that were chosen by the management were then interviewed. During the interviews the personnel received information that the T-residence would be a residence where the elderly's care needs and the caregivers' working situation would be prioritised. All of the caregivers that started work at the T-residence had more than 5 years experience of working with older people and more than 2 years experience of working with people who had been diagnosed as having dementia. The caregivers gave different reasons for why they had wanted to work at the T-residence. Some

were tired of their previous job but most of them chose the work because it would be an extraordinary residence.

Nursing home 'T' was staffed at daytime with 6 RNs and 35 EN/NA, and 9 EN/NA (at night time) giving 1.0 per bed. 'T' had only a consultant RN on call during night time.

In study **I** and **II** a convenient sample of twenty participants from nursing home 'T' were selected to be included. These were caregivers from the first interview occasion before the intervention had started, whose narratives had the richest content and caregivers who participated in direct daily residents care.

In study **III** a convenient sample of participants from nursing home 'T' was chosen which could be followed from the beginning to the end of the intervention; at three interview occasions, (n=10).

Most of the participants were aged between 35 and 55 years in studies **I**, **II**, and **III**. According to Kvale (1996) the number of participants in studies **I**, **II** and **III** is sufficient for qualitative studies.

### ***Data collection***

The interviews at nursing home 'T' were conducted by three researchers involved in the project, in a place chosen by the interviewees and the author conducted the final interviews. Initial open questions about the caregiver's expectations of their work and their experiences of caring for older persons were posed. The interviews were audio taped and transcribed verbatim.

### ***Intervention***

The caregivers at nursing home 'T' had been provided with education, supervision and support continuously for two years. The education had emanated from the requests from the caregivers, comprising of lectures about dementia disease, receiving persons suffering from dementia disease, integrity promoting care, stroke, Parkinson's disease, training in using resident assessment scales, communication and conflict management. Education in tactile massage had been given to the caregivers at nursing home 'T', and, they had also practised it. Supervision in caring for residents had been given in small groups, once a month, which concerned the care of residents per se as well as co-operation in the team. The provided support concerned the researchers' participant observations in the direct care of the residents as well as being available and answering questions at the units (Enarsson & Sandman 1998).

The intervention at nursing home 'T' started three months after the opening of the nursing home and after the first interviews had been carried out. The clinical supervision was conducted as voluntary group supervision, led by a researcher, whereby the group met once a month in a special room at the nursing home. The focus in the clinical supervision was to develop and improve the relationship between the caregivers and residents in providing opportunities for caregivers to reflect upon their way of working (Severinsson & Hallberg 1996a; Severinsson & Hallberg 1996b; Bégat *et al.* 1997; Olsson & Hallberg 1998; Berggren & Severinsson 2002). During the sessions the caregivers were encouraged by the researcher to talk about their feelings and experiences regarding the care and interactions with the residents and their colleagues (cf. Bowels & Young 1999; Holst *et al.* 1999).

## **Study IV**

### ***Setting***

The study has been conducted as part of a multi-center study in Sweden with 24 randomly selected special housing included in from a county council (appendix 2). This study has a descriptive design, comprising 10 of the specific residences. Special types of housing exist in Sweden for older people requiring services, nursing, and support, twenty-four hours a day. In these types of residences the municipal management has the responsibility of fulfilling both the social and medical needs of the residents.

### ***Sample***

During one year every tenth relative, ( $n=17$ ; 7 daughters, 6 sons, 4 other relatives), of residents from the 24 special housing who had been to emergency care were interviewed, focusing their views on care for older people living in special housing facilities and about their wishes and their possibilities of taking part in the care.

### ***Data collection***

Data were collected with narrative interviews (Mishler 1986) by two researchers who were involved with the project with a focus on the aims of the study. The interviews, that lasted 30-60 minutes, took place at a location chosen by the informants, at the special housing facility, where they felt that they could speak freely without being interrupted. The interviews began with an open question concerning the relatives' experience of having an older family member at a special housing facility and about their wishes and their possibilities of taking part in the care. The interviews were audio taped and transcribed verbatim.



## **Studies I-IV**

### ***Interview approach***

In all the studies **I – IV** personal narrative interviews (Mishler 1986) were chosen for collecting the data to gain entry to the caregivers' and relatives' lived experiences in caring and in having an older relative in a special housing. Interviews as a data collection method also achieve a good understanding for the lived experiences (Kvale 1996).

The interview questions were in form of a ground tour open ended question (Polit & Hungler 1999) in order to obtain rich narratives from the participants lived experiences. Conversational narrating between the participants and the researcher involves an interaction and they together create the narratives (Mishler 1986). In all interviews the role of the interviewer was to encourage the caregivers and the relatives to narrate about the question and the respective topics and they were asked, e.g., 'Please narrate on your experience of an ordinary day at work' or 'Please narrate on your experience of having a relative in a special housing facility', or 'Tell me more about your experiences of difficulties and pleasures during a day'.

According to Mishler (1986) the participants was encouraged to narrate with as little interruption from the interviewer as possible only when clarifications were requested the interviewer sometimes interrupted with a question like 'Please explain what you mean by that' or 'Please continue'. Mishler (1986) also declares the importance of establishing a familiar communicative context for the interview situation and all the interviews were carried out in a quiet room chosen by the participants.

### ***Analyses***

#### ***Phenomenological-hermeneutic approach***

The interview text of studies **I** and **III** were interpreted using a phenomenological-hermeneutic approach inspired by Ricoeur's philosophy (1976, 1984, 1991). This method was developed at the Departments of Nursing Science at the University of Tromsø, Norway (Lindseth *et al.* 1994) and the University of Umeå, Sweden (Söderberg *et al.* 1997; Lindseth & Norberg 2004). Ricoeur (1976) argues that the basic step in analysing is to disclose what is revealed by a text, i.e. the meaning of the text. A text can mediate several meanings of lived experiences, but the reader is the one who makes the most probable interpretation. According to Ricoeur (1976), lived experiences will always remain private and therefore it is not possible to express them to another person, although the meaning of the experiences can be conveyed.

The interpretation is carried out in a dialogue between the whole and the various parts and between understanding and explanation to an interpretation of the text as a whole. Explanation is a transitional form, from naïve understanding to critical hermeneutic understanding (Ricoeur 1991). The method implies that the researcher interprets the narratives that have been written down, in order to be able to understand the meaning of the experiences. The analysis is carried out in three steps. First, the text is read several times in a naïve reading, to get a feeling for the entire text, the context, and to grasp the essence of the content. In the next step, the aim of the structural analysis is to get a grasp of the narrative itself and validate or falsify the impression of the naïve reading. In the final phase, the entire text is interpreted. The naïve reading and the results of the structural analysis were read in relation to the authors' pre-understanding and the questions which had arisen during the analytic stage were transformed to an interpreted whole (Ricoeur 1997).

This method was used in study **I** where the interpretation started with a naïve reading to grasp the meaning of the text as a whole. This gave a direction for the further process where the author asked questions (structural analysis) and interpreted an understanding and sometimes changed the interpreted meaning of the caregivers the lived experiences at the nursing home. The focus was to understand the utterance meaning in a hermeneutic circular process (Ricoeur 1976). Finally, the sense from the naïve reading, the findings from the structural analysis and the theory as a whole were reflected upon by the author's and the caregivers' meaning with their lived experiences at the nursing home were interpreted into named experienced themes.

In study **III** the meaning of the caregivers lived experiences at the nursing home was analysed and compared during a two year period. To feel secure and to be sure of how the caregivers had expressed their lived experiences in the text from the first to the last interview occasions the first structural analysis was made deductively. The author read the text from the first interviews to again grasp the content seriously (Häggström *et al.* 2004). Thereafter the second and third interview text was read through and marked when the content was similar to the sub themes which had arisen from the first interviews. The remaining text, not marked, from the second and third interviews was then inductively analysed in a second structural analysis where the author followed the steps in the phenomenological-method inspired by Ricoeur (1976). The caregivers lived experiences at the nursing home had changed from the first to the second interviews and those interpreted changes still remained in the third interviews. Finally, the caregivers' meaning with their lived experiences at the nursing home were then interpreted into new named experienced themes.

### *Content analyses*

Latent content analysis (Baxter 1991) is an interpretative process where the researcher considers the content of the text. There are no particular methodological roots in latent content analysis and different processes have been suggested by (Berg & Welander Hansson 2000; Söderberg & Lundman 2001). In a naturalistic setting where data are collected by narrative interviews this method can be used and it requires a communication between the participants and the researcher, meaning that the researcher has to consider if the text can be focused latently. The goal with latent content analysis is to systematically understand and interpret the underlying meaning of the text (Downe-Wamboldt 1992; Kondracki *et al.* 2002). This method was used in papers **II** and **IV**. In paper **II** this choice was based on already existing conceptions (Ås 1982b) and the authors wanted to systematically and deductively identify the conceptions of Five Master-Techniques (Ås1982b) from the selected meaning units identified in study **I** including the following described conceptions:

*Making a person feel invisible:* To make a person feel invisible means being left out, forgotten and ignored. Making people feel invisible creates a feeling of having no value, a feeling of unimportance for the exposed person.

*Ridiculing:* Ridiculing means that people are made fun of or scorned for some action they have taken, or they are given insulting nicknames, which results in feelings of incompetence and inadequacy.

*Withholding information:* Withholding information can, for example, exist in a work place when important information concerning: meeting times, agendas, and important decisions are withheld from staff.

*Double punishment:* Double punishment affects people that are told that they are not doing their work correctly and this criticism continues no matter what actions they take.

*Guilt and shame:* Criticising a person leads to feelings of guilt and shame and when women are told that they are both untalented and incompetent, this increases their feelings of humiliation. Guilt occurs when women are told, either in groups or individually, that as females, they themselves have caused some of the deplorable conditions existing in society.

Thereafter an interpreted inductive process started to focus on understanding the meaning of the conceptions in relation to the text (Berg & Welander Hansson 2000).

In study **IV** the choice of this method was based on the characteristics of the text e.g. with not so long and with concrete sentences. An analysis process of identifying marginal notes, open coding “working headings”, meaning units that dealt with the open coding were identified, then classifying sub-categories followed, and categories were then interpreted. Finally a main category emerged throughout the whole process.

### ***Co-assessment***

The co-assessment agreement was constructed as follows in the different studies;

In study **I - IV** all authors performed a co-assessment in order to validate if they could follow the track through the analysis process.

In study **I** the third and fourth co-author made an independent analysis from five/each of the twenty interviews. Their interpretation was then discussed with the first author as regards similarities and differences in the findings until they reached agreement.

In study **II** the last author checked the interpretation by firstly reading Ås’ (1982b) theory of the Five Master-Techniques and then comparing the first authors’ findings to five of the twenty interviews in relation to Ås’ theory (1982b).

In study **III** the second, fourth and last author made an independent discussion for checking the first and second structural analysis. All of them reflected, firstly alone and then together to validate if the interpretation was made in an approach inspired by Ricoeur (1976). The third co-author made an independent analysis from five of the thirty interviews and after discussions with the first author about similarities and differences of the interpretation in the findings they reached an agreement.

In study **IV** the first author analysed and interpreted the text. All the co-authors checked the whole analysis process and they sometimes had different opinions about naming the sub-categories and categories, which they discussed with the first author until they all reached an agreement.

## **ETHICAL CONSIDERATIONS**

The caregivers and relatives narrated lived experiences of both good and difficult caring and working situations. This personal information had to be dealt with carefully by the researchers. Although the focus was on the caregivers and relatives the older people were

indirectly involved in the narratives and therefore it was important to respect their autonomy and integrity (Polit & Hungler 1999). The anonymity of the caregivers and relatives was also guaranteed to them. All of the caregivers and relatives were informed verbally and in writing about the purpose of the studies, that the material would be confidential, and that they could, at any time, withdraw their participation, without any explanation or consequences to themselves. The caregivers and the relatives gave their informed consent to take part in the studies, which were given approval from the Regional Research Ethics Committees (803/99, 99310-17).

## **FINDINGS**

The findings from studies **I** and **III** illuminate the meaning of caregivers' lived experiences of work satisfaction/dissatisfaction in municipal care at a newly opened nursing home before and after an intervention. Findings from study **II** describe these caregivers' narrated lived experiences of work dissatisfaction at the newly opened nursing home, before the intervention, in relation to a gender perspective. Finally, findings from study **IV** describe the narrated experiences of relatives having an older family member living in special housing facility. and the relatives' wishes and their possibilities of taking part in the care (**IV**).

### **Study I**

#### ***The meaning of lived experience of work dissatisfaction and work satisfaction before the intervention***

##### *Experience of betrayal*

The caregivers at the newly opened nursing home experienced *betrayal* in several ways which was described on three levels: 1)- betrayal from society concerning loss of professional status in law, salary, politicians' disinterest within geriatric care, broken promises and empty words from the politicians; 2)-betrayal from the organisation concerning the disappointment of introducing budget cuts directly after the opening, which also destroyed the caregiver's expectations of a nursing home out of the ordinary; 3)-betrayal from the management concerned a lack of support including the caregivers' feelings of having to supervise themselves, which led to anger, concern and dejection for the caregivers. Betrayal from colleagues concerned colleagues calling in sick because of the working situation.

### *Experience of failing others*

The caregivers also expressed *Experiences of failing others* concerning stress feelings such as a burden of having responsibility for too many residents, which resulted in irritated irrelevant behaviour from the caregivers towards both residents and colleagues. The caregivers also felt guilt towards the residents by ignoring the older people when they sought contact with them or when they, against their will, worked on an assembly line. The caregivers also often felt tired and their own bad wellbeing affected the residents in the caregivers' feelings of failing them.

### *Experience of insufficiency in their work*

In the meaning of work dissatisfaction the *Experience of insufficiency* for the caregivers concerned both situations at workplace and in the caregivers' spare time. They forgot things and became unfocused and distant in their behaviour towards the residents. Working in stress led to difficulties to relax, sleep and sometimes problems in the caregivers' personal relationships in their spare time. The *insufficiency* could also be expressed in experiences of demands; from management – too many decentralised tasks, from residents – concerning their well being, from relatives – by answering difficult questions and demands from themselves – regarding the care of the residents, and at the same time managing to do all the other tasks.

*Experience of betrayal, Experience of failing others and Experience of insufficiency in the work* were implied in *the caregivers' meaning of lived experience of work dissatisfaction in municipal care, before the intervention.*

### *Experience of work satisfaction*

Feelings of *satisfaction* existed at the newly opened nursing home although the heavy work load, support from co-workers and the feelings of being able to trust each other were examples of the support the caregivers received from each other. Hope for the future also existed where the caregivers believed in a better future for the nursing home. *Work satisfaction* also concerned feelings of being able to individualise and to make use of one's competence when they had the opportunity to use and develop their competence to its fullest. When the caregivers felt feelings of confirmed validity by the residents it was a great source of *work satisfaction*. A lot of humour and joy together with the working team and the residents was an extra benefit and it sometimes existed at the nursing home.

*Experience of work satisfaction was implied in the caregivers' meaning of lived experience of work satisfaction in municipal care, before the intervention.*

## **Study II**

### ***Work dissatisfaction before the intervention in relation to a gender perspective***

#### *Made to feel invisible*

The caregivers at the newly opened nursing home narrated that they had been viewed as *invisible* people when politicians failed to arrive after they had been invited to the nursing home to discuss the budget cuts and difficulties in the working situations. *Invisible making* was also expressed as lack of professional status in municipal care compared to emergency care, which has more value in society. The legal value of working in municipal care was made *invisible* when the selected caregivers for this nursing home had to work with, and at the same time educate people that had no education in care. The management made the caregivers *invisible* by not listening to them and seldom visiting them at work. At work-place meetings with management the *invisible making* appeared afterwards when none of the discussed changes were made. Due to the *invisible making* the caregivers experienced a vague and unclear leadership and they felt abandoned by the management. The *invisible making* also affected the co-operation between the fellow workers badly and had a negative effect on the caregivers' spirits.

#### *Ridiculing*

A male caregiver explained that *ridiculing* existed between the male and female caregivers at the nursing home, in special care situations when a female resident did not want to be given a bed and bath by a male carer. This was not accepted by the female caregivers when the man wanted to delegate the task to a female colleague. The man was met with *ridicule* and lack of understanding.

#### *Withholding information*

When the nursing home first opened and personnel were recruited, they were promised an adequate staff and were told that there was no need to bring in substitutes. This nursing home would be something out of the ordinary, there would be time to stimulate the residents and time for the caregivers to plan activities together. Instead the caregivers experienced that they had been deprived of important *information* about budget cutbacks and budget deficits, when

the project was in its first stages. This had contributed to the caregivers' feelings of disappointment and feelings of being deceived: when the promises and goals connected with the venture could not be realised. Important *information* had been *withheld* from them.

### *Double punishment*

To be *double punished* was a very dominant feeling for the caregivers. This was expressed in that it did not matter how they carried out their work because it always seemed to be wrong. They wanted to do more, together with the residents, but then other tasks were neglected instead. Whatever they did it turned out to be wrong, even though they put in a lot of extra work. No matter how much they did; the management always asked for more, told them to save more money and work more, which led to feelings of inadequacy and feelings of failing the older people, a *double punishment*. The caregivers worked hard and narrated that they did their best at work but their home life suffered because of this, adding yet another *double punishment*.

### *Guilt and shame*

The caregivers shouldered as they said a great responsibility in their work with the older people and they felt that they had betrayed the residents when they were unable to meet their needs. This led to feelings of *guilt* and *shame* in the situation. Everybody wanted to do a good job, but felt that it was impossible within the existing team, because the goals and demands were inhuman. Although the caregivers constantly reminded the management of their working situation, they explained that no changes had been made despite their criticism. Since their opinions were ignored by management they felt that the caregivers themselves were responsible for the bad situation and they felt *guilt* and *shame* for the older people and towards the whole situation.

## **Study III**

### ***The meaning of lived experience of work satisfaction and work dissatisfaction after the intervention***

The findings illustrated that the themes previously reported before the intervention still existed. *Experience of betrayal*, *Experience of failing other* and *Experience of inadequacy* continued to exist during the two-year period at the nursing home but this was experienced to a lesser extent. The *Experience of work satisfaction* had increased. All caregivers except for a



small number of ENs, had changed from a perspective where the dominant expression of dissatisfaction with work had developed into an experience of work satisfaction.

The following themes about *Experiences of a changed perspective, of Open and Closed doors* that emerged in the second analysis of the interviews made after 12 months still remained when the third interviews were conducted after 24 months. These interviews are therefore reported together.

#### *Experience of a changed perspective*

This *changed perspective* concerned the caregivers' way of looking and thinking of doing their best in their work situations in new ways; they were prepared to meet different situations such as sad and confused residents, inadequate number of staff or when they felt under the weather themselves. The caregivers were willing to give preference to the residents before other duties. The most important thing was that the caregivers were aware of the fact that some things mostly concerning the residents care had to be done here and now, the residents came first. They had now learned to structure the work, which gave them more security in work. A feeling of support from the work management, their co-workers, the RNs and from the research team also created a *changed perspective* in the caregivers' way to look at their work more positively than before.

#### *Experience of open doors*

*That doors had been opened* was expressed in the caregivers' meaning by a faith in the future and this was implied that the caregivers were referring to the possibility of an improvement in their work and that there would be a balance between work and spare time. They felt secure, both with each other, alone or in groups and in different care situations and there was a mutual feeling of how each person functions. The caregivers now reflected more on questions such as *where, how* and *why* in different care situations and the clinical supervision might have encouraged that. To be stimulated in work revealed as permitted challenges for all caregivers to try new solutions for the residents with for example deviant behaviour in order to maintain good quality care. They also felt stimulated by being part of a research project. *That doors had been opened* was also expressed in feelings of a more tolerant atmosphere where a common humanistic basis of values existed among the caregivers and they allowed each other to have different opinions about how to reach goals regarding care. *Experience of a changed perspective and Experience of open doors* were implied in *the caregivers' meaning of lived experience of work satisfaction in municipal care, after the intervention.*

### *Experience of closed doors*

Feelings of disappointment maintained for a small number of caregivers at the nursing home which were directed towards: the public – negative attitudes from public towards their work; the work management – who did not listen to the caregivers sufficiently; their co-workers – in decision making and in organisation of the work; and the research team – supervision good in theory but rarely of any use in practice.

The experience of *closed doors* also appeared in disbelief and distrust of the local municipality as an institution where the management's chances of making decisions were regarded as almost non-existent, since they were dependent on others that were higher up in the organisation. Anger concerned feelings of being discriminated in different situations, lack of using research knowledge in dementia care and reduced breakfast meals for residents due to lack of caregivers during weekends are examples. Also an expression of stagnation in the work was stated from the caregivers concerning that the development in dementia care had not moved forward since the 1980's in Sweden. They asked for highly educated caregivers since the older people often need medical care as well as care of basic human needs.

*Experience of closed doors* is implied in *the caregivers meaning of lived experience of work dissatisfaction in municipal care, after the intervention*.

## **Study IV**

### ***The relatives' struggle for a better and just care for the older people***

Study **IV** describes the narrated experiences of relatives having an older family member living in special housing facilities and to increase knowledge about their wishes and their possibilities of taking part in the care.

### *To trust in caregivers*

To trust in caregivers describes the relatives' experience of education, staffing and continuity in special housing facility. The relatives desired a higher level of education for the caregivers. Different situations, where the caregivers showed a lack of knowledge and education were revealed for the relatives. Relatives were extremely aware that because of the residents' old age they needed to be well cared for. The relatives also felt that the caregivers did not have enough time for the older people, i.e. for each individual. Routine work and peripheral tasks occupied most of the caregivers' time. Continuity for the relatives and the older people was

expressed by relatives as being close to the special housing facility to be able to make spontaneous visits, being close if the older person became ill or needed urgent help from relatives, having familiar surroundings and not having to meet more caregivers than necessary.

#### *To be confirmed by caregivers*

It was obvious that relatives wished to have more influence in the older people's care. The majority of the relatives thought that the main way to influence anything was to get involved and be engaged i. e. they felt that taking the initiative in communication between caregivers and relatives must come from relatives. The relatives were afraid of doing that because they did not want to disturb the caregivers, be regarded as demanding or they were worried about whether the older people would suffer the consequences if they began to question the care. All the relatives spoke of their resignation. They wanted to be more involved and to do their best for the relatives, but different factors made them realise that their rights to participate in the care were limited.

#### *To trust in care*

Physical activity in outdoor daily walks, mental needs such as being emotionally stimulated, social needs with daily contacts and chats with other people were expressed by the relatives as important for the older people's well being. *To trust in care* also concerned the possibility to have confidence in the caregivers' ability to make the right decision in acute care needs.

#### *Receiving the care one considers one has the right to receive*

The incessant talk of cut downs in society, created a feeling of insecurity for both the older people and the caregivers, according to the relatives. The relatives narrated that discussions in economical terms overshadow the politicians' speeches rather than discussions of how to develop a better quality of care for the older people and better working conditions for the caregivers. Some relatives explained that they took more responsibility in the older people's care than they would like to, in order to help the caregivers. They believed that help should be given voluntary and with financial compensations.

## **DISCUSSION**

To sum up it emerges in studies **I** and **III** that the caregivers' experience of work satisfaction in the workplace exceeded their experience of dissatisfaction and that the intervention consisting of: education, support, and supervision might have facilitated this positive development where the older residents were prioritized. In studies **I-IV** it also emerges that caregivers and relatives within municipality care for the older people express that care for the elderly is an emotionally loaded and conflict-filled job. The conflict for caregivers is due to them meeting older people everyday that express that their needs are not satisfied while relatives express that the older people are not being adequately stimulated, that care for the elderly is sometimes insufficient and that they do not feel sufficiently involved in the care **I-IV**. The caregivers feel stressed and a large part of their working hours are spent carrying out subsidiary tasks that do not have anything to do with caring, which the relatives have realised and they therefore do not dare to bother the personnel and ask for help and support for their close relatives. This is a vulnerable situation for both parties in that both the caregivers and the relatives express that they want to help the elderly live in the best possible way. They point out the importance of the elderly getting good care and the best possible quality of life in their everyday lives. This is described as difficult to attain by the caregivers and relatives in the situation that currently exists within municipality care for the elderly and expressions such as "everything's going to pot with care for the elderly", from the relatives, or "should an old person that has worked hard all of their life have to end their life like this", from the personnel, reflect the difficulties that they experience.

The following discussion is a dialogue between the author and the accounts that caregivers have given in the deeper meaning of work dissatisfaction/work satisfaction (**I, III**). The dialogue also includes a description of work dissatisfaction from a gender perspective (**II**) and a description of the relatives' experiences of having a close relative living in municipality care, about their wishes and their possibilities of taking part in the care (**IV**). The dialogue runs in a hermeneutic circle back and forth through the empirical findings between the different parts, the entirety of the material and the theory (Ricoeur 1976; Lindseth & Norberg 2004).

### **Understanding the findings from an individual perspective**

In their everyday work the caregivers and the relatives meet older people that are dependent on them in different ways. This meeting is, according to Buber (2000), a mutual and vulnerable relationship and in it, the caregivers and the relatives express a desire to be able to

care for the vulnerable elderly in a good way, which is made clear when they experience acknowledgement in the care. According to Henriksen & Vetelsen (2001) a person needs acknowledgement to carry out their everyday work (cf Jodalen & Vetelsen 1997; Alsvåg 2003) and if this is reduced feelings of powerlessness might appear. The accounts expressed **(I)** that the caregivers experienced lack of acknowledgement from their management in the form of inadequate support and that they sometimes, although not to a sufficient extent, experienced acknowledgement from the elderly in their daily care. The acknowledgement given by the elderly and even work colleagues was however one of the contributing reasons for them having the energy to cope everyday. Relatives also lacked acknowledgement **(IV)** as they experienced inadequate contact with the caregivers and had too little possibility of taking part in, and influencing the care of the elderly. This acknowledgement can be compared with Maslow's (1987) view that it is important in an organisation for people to have their need to be appreciated fulfilled in order to be motivated and to feel that their work is meaningful, which is even probably also applicable to the relatives' possibilities of feeling motivation and meaningfulness in the care of the elderly (cf. Whitaker 2004). It is therefore necessary that a trusting and acknowledging interaction (cf. Lögstrup 1992) exists between the caregivers, relatives and management so that those in care feel well, which is not the case according to the caregivers' and the relatives' accounts **(I, IV)**. In a situation where the caregivers and the relatives experience stress, unattainable demands and concern for the residents' well-being, the trust between them is reduced (cf. Lögstrup 1992). The elderly can, according to the caregivers, receive worse care, the caregivers become irritated and the relatives do not feel as though they participate in the care **(I and IV)**. A conflict therefore arises between what one wants to do for the elderly and what one may do due to the stressful situation for both parties. For the relatives the conflict has a lot to do with wanting to criticize the deficiencies in the caregiver's competence, which they consider exist in the care of the elderly, both physical and mentally. According to the above Hertting (2004) shows in her thesis that the working conditions for care personnel have become worse during the 1990s.

When organisations are slimmed down and residents have bad health, the work situation become intolerable, which is expressed in the caregivers' feelings as experiencing betrayal **(I)** and in the relatives' views by having dual loyalties **(IV)**. The relatives are loyal to both the elderly and to the caregivers and they are affected by the living situation of the elderly and by the caregivers' everyday world in the same way that the caregivers are affected by the living situation of the elderly. A consistent pattern in the caregivers' and the relatives' account is that they feel that they are being let down. According to Buber (1989); she who can not take

responsibility for something, the elderly's living situation in this case, experiences that she is responsible deep inside, which can lead to feelings of betrayal and personal feelings of guilt. A person that feels guilty can according to Buber (1989) be affected by a guilty conscience and the only way to overcome the guilt is for the person who is guilty to get a real insight into the essence of the guilt. The personnel's feelings of betrayal from an individual perspective can be derived from the management's and the work colleagues' betrayal and even the betrayal from themselves while the relatives express feelings of betrayal from caregivers in the form of not being able to participate enough in the care of the elderly. Since the caregivers and the relatives have a desire (I, IV) to satisfy, interpret, meet and understand the needs and expectations of the elderly, the situation leads to that they themselves experience that they are betraying the elderly when they can not live up to that which is right for them (cf. Buber 1989). Lögstrup (1992) speaks about this as regards ethical demands, which means that a person's life is involved in another person's life and this requires caring for that other person's life spontaneously.

Martinsen (1989) describes that care relates to some form of inter-human relationship and that it is based on community spirit and solidarity and according to that the caregivers betrayed the elderly even in this aspect. The experience of feeling betrayed can be related to the caregivers' possibilities of developing distance from and relationships with the older people receiving care (cf. Buber 1997). When one feels betrayed the ability of personal engagement decreases and the balance between necessary relations and care at a distance becomes more difficult to manage, which can be a reason for caregivers' experiences of doing that, which is absolutely most necessary everyday for the elderly and simultaneously distancing themselves from the care situation (cf. Buber 1997). By "distance" Buber (1997) means a way of restricting oneself to the caring, and the caregivers have to learn to see the situation, i.e. the elderly's living situation, as something independent and thereafter build up a relationship with them. This distanced way of relating without building up a relationship then becomes a way of surviving a stressful day (Asplund 1991; Tappen 1997) and an ethical conflict therefore arises in not having the possibility of doing that which feels right for the caregivers towards the elderly (cf. Lögstrup 1992).

Martinsen (1989) describes that in a sensible care situation ethical and moral aspects are involved in the relationship between the caregivers and the elderly and if a moral problem arises between them it can adversely affect the caregivers' morale in different ways. This conflict and the feeling of being betrayed and of themselves betraying the elderly everyday affects even the relatives that experience feelings of guilt towards the elderly when they are

able to experience their sometimes meagre and non-stimulating everyday life within municipality care (cf. Whitaker 2004). The caregivers and the relatives then feel a guilt for insulting the elderly because their fundamental existential needs are not being met (cf. Buber 1989).

The feeling of guilt, which the caregivers felt in the home, also arose when accounts were analysed from a gender perspective (II). The guilt can then be related to the expression "power" which can be expressed in several ways and our dependence on one another means that we are objects on which power can be exercised and that we ourselves exercise power (cf. Lögstrup 1992; Lögstrup 1993). Lindgren (1999) declares that it is men that have the formal power in the society while women have the informal power. In care and nursing the power is described according to Ås (1982a) in that women have been delegated power but they have limited possibilities of exercising it. Caregivers considered due to the narratives themselves to have had limited possibilities of influencing their situation and they then experienced a guilt (cf. Buber 1989) because they saw themselves as betraying the elderly. Further evidence of the guilt is that women, according to Sørensen (1982) act rationally with responsibility, i.e. in care tasks the person is the objective and not a means for reaching an objective. Sørensen (1982) considers that responsibility orientation has arisen because it is women in society that have taken care of the task of understanding other people's needs both privately and at work.

Formulations such as "the objective can not be lowered any more and the limit for acceptable care has already been reached" are an example of the caregivers' rational, responsible expressions that can lead to feelings of guilt. Exercising power can also, according to Martinsen (2000) be seen as a way of protecting oneself in a vulnerable situation, which emerged when the caregivers distanced themselves from their work by for example locking up an older person who insisted on immediate attention. It is also probable that the management at the home exercised power to protect themselves in a situation where a lot was about increased savings (cf. Martinsen 2000). Withholding information, making itself invisible, double punishment and levying guilt and shame (Ås 1982b) might then be examples of how the management protects itself by unconsciously exercising their ruling methods.

The caregivers' negative experiences concerning their work situation were improved over time and this improvement can be related to the intervention that was then taking place (III). The previous distanced way of relating was less common and the conflict between what one wanted to do and what one could actually do in everyday work had decreased after one to two years (cf. Hansebo 2000). It seems that caregivers can now better balance the needs that existed previously and which still exist within the home (cf. Edberg & Bird 2003), which is

expressed in the capability of prioritising the residents, structuring the day better and in an increased capability of reflecting over the care for the elderly amongst other things. Being able to reflect and ask questions such as What? How? and Why? about care for the elderly to a greater extent can be seen as doors to a new way of relating having been opened for the caregivers. The residents' needs, the caregivers' needs of self-well-being, the relatives' needs and wishes from the management were balanced better and the caregivers now had a greater capability to focus on the interaction between the elderly, their work colleagues, the management and the relatives (cf. Edberg 1999; Hansebo 2000). The caregivers showed a greater capability of going from a distanced way of relating to a closer way of relating to the elderly (cf. Buber 1997). The run of time and also the significance of the intervention as a tool could have contributed to the caregivers' increased capability of together developing a more trusting and acknowledging atmosphere in the home. Martinsen (1989) asserts that caring is something that has to be learnt under the supervision of an experienced teacher, which several of the caregivers spoke about after having taken part in the research team's supervision (III).

The objection against this reasoning is that all caregivers that took part from the beginning did not stay at the home and could not therefore be followed over time and so a bias arose. The situation was however improved and the previous clear pattern of the caregivers' feelings of being betrayed and of themselves betraying the elderly emerged to a lesser extent after one year and still after two years except for a minority of the caregivers. This confirms that intervention in the form of clinical supervision, education and support for the caregivers is meaningful (Edberg 1999; Hansebo 2000; Hansebo & Kihlgren 2004). It emerged that the caregivers' own needs of security increased in the more trusting and acknowledging atmosphere (III), which is an important basic prerequisite for people to be able to develop and feel motivation in a work organisation (Maslow 1987).

### **Understanding the findings from a society perspective**

There is a close connection between ethical discourse and human rights in a society. In several industrialised countries care and nursing is regulated by socio-liberal laws and the UN's declaration concerning human rights (Henriksen & Vetlesen 2001). The body that controls and establishes objectives for caregivers' work within municipality care for the elderly is the Health Care Law (HSL) and the Social Services Law (SoL). These laws create a discourse for the enterprise and build on basic humanistic values and caregivers can check whether the authorities are fulfilling their duties as regards human rights by reading these



laws. For a caregiver to carry out their work in respect of human rights this is not only a personal matter but it is connected with the professional ethical foundations upon which the organisation was built. Martinsen (1989) speaks about it not only being a private matter but a collective responsibility to take care of the society's weak and care is built on community spirit and solidarity. Rawls (1971, 1999) states that all parties in a situation, i.e. a care situation, have to make a choice that can be assessed as fair considering people's different needs in a theory about justice. Rawl's theory has had great significance in the debate about the welfare state's foundations.

The caregivers (**I, II, III**) and the relatives (**IV**) experienced an ethical dilemma in working with, and caring for the elderly as the elderly's needs could not be satisfied in a suitable way because of the economic pressure to which the municipality care is subjected. In the ethical dilemma that the caregivers and the relatives describe it is a case of values that they consider the most important being set aside i.e. the elderly's needs are not satisfied to a sufficient extent. To meet elderly people every day who express a desire for more time together, better continuity and wanting more attention on the whole, like the caregivers or the relatives, leads to the caregivers ending up in an ethical conflict (cf. Lögstrup 1992). They know which discourse is rule but they feel that neither they nor the organisation can live up to the objectives that govern the enterprise. Their feelings of guilt and of them betraying the elderly can in this way even be seen as a phenomenon that has its starting point in a system that is built up on equality where the elderly shall have their needs satisfied, which is often impossible for caregivers to satisfy under the prevailing circumstances. The betrayal felt by the caregivers from the society, politicians and the organisation can therefore have its origin in that they can not live up to the professional ethics that the discourse builds upon (cf. Rawls 1971).

The caregivers solved the conflict between what one will do and what one can do by distancing themselves from the elderly in work and/or by taking sick leave (cf. Buber 1997). The relatives' experiences can also be seen as them feeling betrayed by society and they get feelings of guilt towards the elderly, which emerges in that the relatives consider that the elderly's rights have been abused and that care is deficient (cf. Rawls 1971). In this way even the relatives find themselves in a vulnerable situation and in a similar ethical dilemma as the care personnel and their experiences can be related to the Swedish welfare state's discourse.

### **Understanding the findings from an individual/society perspective**

The following figures illustrate the humanistic basic view concerning peoples' equal worth and the ethical discourse that governs the caregivers' and the relatives' ethical considerations in municipal care for the elderly from society's values. Figure 1 shows a situation where good ethical prerequisites prevail allowing caregivers and relatives to experience good care for the elderly an, ideal circle. Figure 2 shows worse prerequisites not allowing caregivers and relatives to experience a good care for the elderly, which is the case today, an actual circle.

### Good prerequisites for care for the elderly

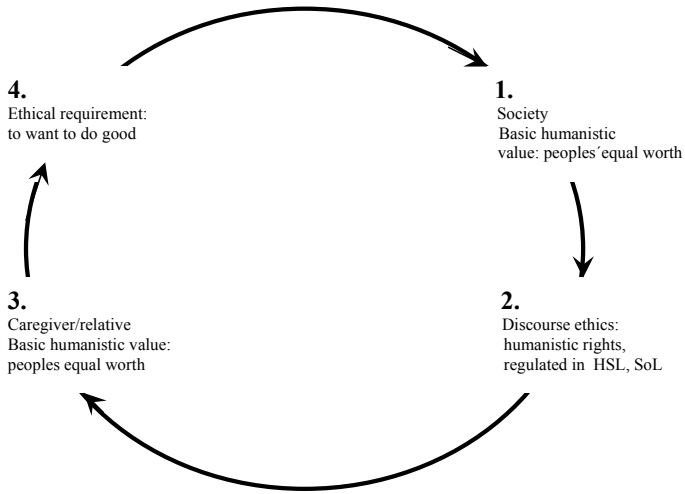


Figure 1: Ideal circle

### Worse prerequisites for care for elderly

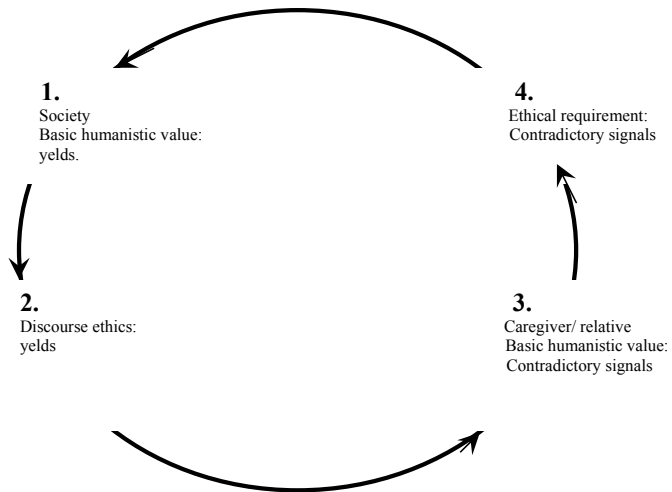


Figure 2: Actual circle

### **Explanation of Figures 1 and 2, which illustrates an ethical conflict**

In everyday care the caregivers and relatives meet older people that according to them desire more and better care. The caregivers and the relatives try to do their best for the elderly i.e. that which is good. The good is regulated by the society, people's equal worth in legislation (HSL, SoL), which leads to a common collective society responsibility for those who are weaker in society (Martinsen 1989). The caregivers and the relatives (I-IV) describe that they experience an ethical conflict in the current situation, they want to, but can not live up to the demands that are put upon them, which they describe through the guilt and betrayal that they feel. The betrayal that is felt can be connected to the fact that the caregivers feel contradictory signals, that something is not right as regards declared ethical basic values of society and the signals that society's representatives send out. This appears in the caregivers' frustration about low salaries, low professional status, lack of support from politicians and lack of morale from representatives of society. These feelings of contradictory signals can be a contributory reason for the caregivers not managing to live up to the goals set by society as regards care and the betrayal that they feel towards the elderly therefore arises. From a gender perspective this can be understood using Ås' (1982b) theory concerning the conception of levying guilt and shame, which means that the caregivers are made responsible for the situation existing for the elderly within municipal care.

Since the gap between needs and resources is increasing and prioritising within care and nursing is therefore becoming more common (Gurner & Thorslund 2003) the discourse ethics that govern human rights are all the more difficult to apply. Martinsen (2000) emphasizes that today's health care and nursing takes place at the cost of the weaker groups in society. According to Antonovsky (1979) it is important that people are allowed to experience a consistency in both their private and professional life by being able to influence their situation and by being acknowledged. These are important health factors and they can be lacking if people are subjected to too much stress. In the ethical dilemma that exists between caregivers' and the relatives' common humanistic basic values as well as of the society, one finds the elderly with different needs that are valued and prioritised in accordance with resources of society. This can, as one of the caregivers described, feel stressful and be similar to finding oneself in feelings of insecurity, which according to her led to her taking sick leave, "a temporary escape from reality" and to a distanced way of relating to the elderly.

## **METHODOLOGICAL CONSIDERATIONS**

The study was conducted in a period when demographic changes, where the number of older people in Sweden has increased substantially since 1960 and where the number of older people over 80 years old today constitute 5% of the population. During the same time an increasing gap between the resources that are available and the care needed for older people in Sweden increased (Thorslund *et al.* 2001). For the caregivers, working in municipal settings, this leads to changes in the organisation and a heavier workload and the overall aim of this thesis was to investigate the caregivers' deeper meaning of work satisfaction and work dissatisfaction at a newly opened nursing home for older residents before and after an intervention. A further aim was to investigate relatives' experiences of having an older person living in a special housing facility and to increase knowledge about the relatives' wishes and their possibilities of taking part in the care. The studies focused on the narratives supplied by the caregivers at the nursing home and the relatives at the special housings.

### **Pre-understanding**

The author of this dissertation is a nurse/midwife, sociologist and teacher with several years of professional experience from work within private and public women's health care as a teacher training nurses. I have often seen, both privately and through work that women's living situations can vary a lot depending on their different family, professional and social conditions. The leap from women's health care to becoming a researcher within care for the elderly should be seen in the light of my engagement in women's living situations, which was established through my earlier professional experience. After having worked as a teacher training nurses for several years it felt both challenging and very exciting to once again be professionally engaged in women's lives but this time from a care worker's work situation. Likewise it felt engaging to be able to get an insight into a man's situation in a female dominated profession and the relatives' experiences of care for the elderly, where I came into contact with both men and women.

I have worked with municipal care for the elderly in the South of Sweden during several summers and my understanding of the elderly's living situation stems from these occasions and even from several years' work as a clinical teacher for nursing students that practice there. My own understanding is central in this dissertation and I have tried to put my conscious understanding to one side, but it is impossible to avoid the material being influenced subjectively. However, by being sensitive to the care personnel's and the relatives'

actual experiences of municipal care for the elderly, and in my attempt to be as objective as possible, their accounts may have contributed to bringing forward new knowledge that will hopefully lead to better care for the elderly.

## **Design**

The advantage of using a quasi-experimental approach for studies **I**, **II** and **III** lies in the practicality feasibility to investigate the study's aim in the real world in a naturalistic setting, here where the care for the older people is taking place (Polit & Hungler 1999). The research team were interested in following the caregivers meaning that is implied in work-satisfaction and work dissatisfaction at a newly opened nursing home during a two year period, before and after an intervention in order to be able to get new knowledge on circumstances that existed at the nursing home from the opening. Therefore two nursing homes were selected. One in a big city 'T' (100 000 inhabitants) and one in a small city 'B' (20 000 inhabitants) in the centre of Sweden. The selected control nursing home 'C' had existed for ten years. This was a disadvantageous selection but necessary due to the difficulties in finding another newly opened nursing home in this area and no new nursing homes were planned to start in the near future, instead the politicians were planning to close a few.

Disadvantages with the choice of a quasi-experimental longitudinal approach is that the presumptions might change while the study is taking place (Polit & Hungler 1999; Polit & Beck 2004). This was happening during this intervention study. The nursing home 'T' was subjected to financial cut backs after one month. The number of employees was reduced and the number of residents was increased by two per unit. This might have affected the caregivers in several ways. In connection with the interviews the staff answered two different questionnaires, one about burnout, the Maslach Burnout Inventory (MBI) and one about working milieu (Ekvall 1996). An unpublished study shows that the caregivers at nursing home 'T' had the highest burnout symptoms, moderate, compare to nursing home 'B' and 'C' from the beginning of the intervention but later in the 12 and 24-months rating nursing home 'T' had decreased to low burnout symptoms. The narrated stories could be influenced by the changing conditions at the nursing home. A lot of the caregivers quit their jobs and those who stayed could be the most harmonious persons. Accordingly the missing participants have probably influenced the findings, which might have been, a bias, i.e the most important factor for the caregivers change from a dominant experience of work dissatisfaction to a dominant experience of work satisfaction after one and two years instead of being influenced by the intervention. The caregivers at the control nursing home should receive the content of the

intervention given to nursing home 'B' and 'T' after the intervention was closed. However, this also turned out to be disadvantageous because the control nursing home closed its activity during 2003 and therefore the research team could not fulfil their commitment towards the caregivers.

### **Intervention**

The author was not responsible for the intervention. This might be seen as a disadvantage but also as an advantage due to the fact that the author was not involved, had no pre-understanding in experience or knowledge from the continuing intervention process at the nursing home 'T'. This might have influenced the first authors' interpretation of the interviews positively in reaching confirmability (Polit & Beck 2004). An effect which has to be considered when using intervention is the Hawthorne effect were the informants are influenced by being aware that they are participants under study (Polit & Hungler 1999). However longitudinal intervention studies might reduce this effect and the caregivers at the nursing home 'T' seemed according to the research team to look at them as a natural implementation in their ordinary work after a few months. In a critical review Kneeborn & Martin (2003) recommend that the most appropriate studies of specific caregiver' problems should be that the researchers undertake longitudinal intervention studies.

### **Credibility**

Lincoln and Guba (1985) point out that credibility in qualitative research involves that the study is carried out in a way which encourages the reader to believe in the findings and that steps are taken to demonstrate credibility for readers. Prolonged engagement with sufficient time collecting data is essential for building trust and in-depth understanding of the informants. The steps taken to demonstrate credibility also concern investigator triangulation, which refers to the use of two or more researchers to analyse and interpret the interviews in order to reduce biased interpretation (Polit & Beck 2004). This was done in studies **I**, **II** and **III** where one or two more researchers analysed and interpreted four or five interviews. In study **IV** all the co-authors took part in checking the whole analysis process. When data are collected time triangulation also increase credibility to determine the congruence of the phenomena (Polit & Beck 2004). The same phenomenon, i.e. work satisfaction and work dissatisfaction, with the same people, that could be followed from the first, second and last interview occasions were according to that investigated in studies **I** and **III**. Credibility also increased by using personal triangulation in studies **I** and **III** (Polit & Beck 2004). Data were

collected from different professions in different levels in the organisation, RN, ENs and ANs, in order to speak about the same phenomena from multiple perspectives.

In study **IV** latent content analysis was used (Kondracki *et al.* 2002; Graneheim & Lundman 2004) in which, the informants, the subjects' narratives are interpreted by the researcher from the transcribed text. To reach credibility in this study one way was to describe representative quotations from the subjects' narratives.

### **Transferability**

Lincoln & Guba (1985) declare that if the findings can be transferred to another setting it will increase the transferability of the study and the findings are therefore also analogous to generalisation as in quantitative studies. The first author has several times checked the findings from studies **I**, **II** and **III** with groups of people who had not participated in the studies but who worked in a similar setting and the experience is that the new caregivers recognised the findings well as if they had been investigated at their own work. In study **IV** the number of participants (n=17) might increase the possibility of transferability to other persons in similar settings (Polit & Beck 2004).

### **Interpretation**

The narrative interviews in studies **I** and **III** were analysed and interpreted by a phenomenological hermeneutic method and in studies **II** and **IV** with latent content analysis.

According to Ricoeur (1976) more than one interpretation of a text is possible and the interpretations presented in studies **I** and **III** are those that the researcher (s) found the most credible and one interpretation has to be more credible than others. The essential part in the interpretation is to remain in the hermeneutic circle where the text touches the researcher and start the interpretation process there instead of going too far in the hermeneutic circle, which might decontextualize the interpretation from the original text (Lindseth & Norberg 2004).

In the analysis of study **III** metaphors have been used to designate two themes, experience of open doors and experience of closed doors. Ricoeur (1991) claims that metaphors say something other than the literal meaning. They provide a description of the world i.e. they disclose that which we know so that it gets a new meaning and point out new possibilities. Polkinghorne (1988) declares that the trustworthiness of the interpretation increases when the analysis is presented in a way to convince the reader that its findings are accurate and possible to follow and this has been the ambition in all of the studies in this thesis.



In study **III** the first author analysed the second and third interviews deductively by using content analysis to compare them with the first interviews from study **I**. Thereafter a phenomenological-hermeneutic interpretation of the remaining text was started. This was done in order for the author to feel more secure when she compared interviews by using the phenomenological-hermeneutic approach during a period of two years. Ricoeur (1991) considers that this is the explanation that is methodical and this is the explanation that develops understanding and analysis. Against the background of this the analysis of study **III** was started by analysing interviews two and three deductively on the basis of findings from interview, in study **I**.

## **CONCLUSION**

In order to increase understanding for caregivers within municipal care for the elderly and for the relatives' situation of having a family member that lives there, one should see their situation both from an individual perspective, i.e. the direct contact between the elderly, the caregivers, the relatives, and from a society perspective, i.e. to see the caregivers' and the relatives' situation from a society perspective. The caregivers experienced betrayal from several sources but the betrayal from society and direct management dominated. They explained that society's ideology was not in agreement with their work situation. Economical savings, broken promises, empty words from politicians and low salaries confirmed for the caregivers that the goals set by society for good care for the elderly, which is governed by society's legislation, was not in agreement with the reality they lived in. They constantly felt that they themselves betrayed the elderly as work was stressful, i.e. because they had too little time to be able to take a break and recognize the elderly's needs here and now. As a consequence of the situation the caregivers often became distanced in their way of relating to the elderly and they were often plagued by a guilty conscience, as they knew that they often acted against their own competence towards the elderly and against that which felt right for them to do. These feelings of guilt affected the caregivers both at work and privately and many of them did only what was absolutely necessary at work, in order to survive the day, or took sick leave in order to cope. The betrayal they felt from the direct management expressed itself in them having a lot of delegated tasks, which they had to complete and to which they were assigned but were not prepared to be able to complete the tasks themselves. The management was described as non-acknowledging and absent and the caregivers felt that they had been abandoned by the management and by society. The feelings of guilt felt by the

caregivers can be understood from a society, individual- and gender perspective in that they were delegated tasks to solve the elderly's living situation at the home having limited possibility of being able to take the necessary measures for achieving an improvement. As a consequence of this the caregivers' blamed themselves for the existing society phenomenon.

What was positive and important in caregiver's work was the closeness they felt towards the elderly and the acknowledgement they received from them and even the support and the acknowledgement that existed between work colleagues. This was what stopped them from leaving.

The relatives also felt that they were betrayed by society and even by the caregivers. This was channelled from society through the demands requiring them to take greater responsibility for the elderly than they themselves wanted. The connection between economical cuts and worsened care was also described as the elderly's rights in society having been worsened. As far as betrayal from the caregivers was concerned it was the relatives' experience of themselves not being able to get sufficiently involved and participate in the care of the elderly. At the same time the relatives felt a great loyalty towards the caregivers because they saw how stressful their work situation was and they did not therefore want to point out the deficiencies that they had noticed to them. Those that did so were anxious about bothering the personnel and this feeling fits in with the caregivers' accounts stating that they felt that the relatives could be demanding. The relatives experienced an ambivalent situation with loyalty towards the old person and the caregivers. They blamed society's economical cuts for the elderly's worsened situation and the caregivers' stressful work situation. They, like the caregivers, lacked an ideological debate that was about values and care rather than money.

The intervention had a positive effect on the caregivers' increasing experience of work satisfaction and the conclusions one can make is that support, education and supervision are important in care work. However, the education and supervision needs to focus on society's humanistic basic views and the ethical rules that govern caregivers' work in accordance with existing legislation besides focusing on direct care and the interaction between caregiver, relative and older person. It is important for the caregivers and the relatives to realize that they are part of a greater system in society and that they are not responsible for the situation that exists within care for the elderly. The caregivers also need support, management and acknowledgement from a management whose presence is felt and acknowledgement from society in the form of increased salaries and not only "empty words" telling them that they are irreplaceable and that they're doing a good job for the elderly. The signals that society sends

to the caregivers and relatives must be in agreement with how its representatives themselves work in order to improve care for the elderly so that caregivers and relatives will be able to feel security in the care of the elderly. As is the case now, a situation has emerged where the caregivers and the relatives do not see themselves in the collective conception that society represents as far as municipal care for the elderly is concerned.

The knowledge obtained by this thesis could serve as a necessary starting point for further research of the interaction between politicians, caregivers, management, relatives and older people with the aim of improving today's municipal care. Another way of improving municipal care for older persons seems to be to increase education and support for caregivers.

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## POPULÄRVETENSKAPLIG SAMMANFATTNING (SWEDISH POPULAR SCIENCE SUMMARY)

### **KOMMUNAL ÄLDREOMSORG – vårdares och närståendes berättelser**

Äldreomsorgen har i Sverige under 1990 och början av 2000 talet genomgått stora förändringar genom reducering av antalet platser i särskilda boenden, en successivt minskad servicenivå för majoriteten av de äldre och en stark inriktning mot att i första hand hjälpa de allra äldsta och mest hjälpbehövande. Detta har i sin tur inneburit att personer som bor i särskilda boenden har blivit mer beroende av sjukvårdande insatser. Samtidigt med denna utveckling ökar kommunernas problem med att finansiera offentlig omsorg. För vårdarna, där majoriteten är kvinnor, medför detta att arbetet blir tyngre, då vårdtagarna kräver mer professionella vårdinsatser och kravet på formell kompetens inom området ökar. För anhöriga kan detta innebära att de tar på sig nya uppgifter när gapet mellan behov och resurser sviktar. För att den kommunala äldreomsorgen i tider där organisationsförändringar tillhör vardagen ska kunna möta framtidens krav där fler äldre behöver avancerad omsorg är det viktigt att få insikt om vårdpersonalens erfarenheter och de anhörigas syn på sina närståendes problem.

Det övergripande syftet med avhandlingen är därför att redovisa vårdares upplevelser av att arbeta inom kommunal äldreomsorg och utröna om utbildning och stöd har betydelse för personalen. Ytterligare syfte var att få förståelse för vilka aspekter som är viktiga för att arbetet ska utföras i en vårdmiljö som ger arbetsglädje och arbetstillfredsställelse och därigenom skapa förutsättningar för vårdare att ge äldre bra omvårdnad. Vidare studerades berättelser från närstående i syfte att öka kunskapen om deras upplevelser av att ha en nära anhörig som bor i särskilt boende och om deras möjligheter till delaktighet i omsorgen.

Delstudie I är en intervjustudie vid ett nystartat boende inom kommunal äldreomsorg. Där berättade vårdare om hur de upplevde arbetstillfredsställelse/otillfredsställelse i arbetet med de äldre vårdtagarna innan en intervention bestående av utbildning, stöd och handledning hade påbörjats. För analysen av intervjuerna användes en Fenomenologisk-hermeneutisk metod inspirerad av filosofen Ricoeur. I berättelserna framkommer att personalen uttrycker att vården av de äldre är ett såväl känsloladdat som konfliktladdat men dock glädjefyllt arbete. I sitt dagliga arbete möter de äldre som ger uttryck för allmän olust och leda, pockar på uppmärksamhet och visar oro, aggressivitet och ångest. Personalen vittnar dock om att de älskar sitt arbete och att de får bevis på uppskattning genom t ex en kram, ett igenkännande eller ett leende. I det komplicerade arbete som vårdpersonalen har känner de sig ibland

övergivna och har svårt att hantera alla starka känslor. De är hänvisade till att leda sig själva och utan ett gott kamratskap skulle arbetet inte fungera. En stor del av arbetstiden går också åt till kringuppgifter som kan utföras av andra personer än de med omvårdnadskompetens.

Besvikelse över organisationen i det nystartade boendet bottnar i att den yrkesmässiga kompetensen inte får användas och utvecklas tillräckligt.

Vårdarnas upplevelser namnges i följande teman och subteman;

- 1) **Upplevelse av svek** - att känna förlorad yrkesstatus, att känna bristande samhällsmoral, att känna grusade förväntningar, att känna avsaknad av stöd, att känna ilska, att känna oro, att känna uppgivenhet, att inte känna kamratstöd och att uppvisa somatiska symtom.
- 2) **Upplevelse av att själv svika** - att känna irritation, att ha skuld-känslor gentemot de boende och att känna trötthet.
- 3) **Upplevelse av att själv inte räcka till i arbetet** - att känna stress, att känna ouppnåeliga krav, att känna ständig oro för de boendes välbefinnande.
- 4) **Upplevelse av arbetstillfredsställelse** - att känna kamratstöd, att känna hopp, att kunna individualisera och använda sin kompetens omvårdnaden, att känna bekräftelse och att känna glädje.

Studien visar att vårdpersonalens upplevelser av ostillfredsställelse i arbetet dominerar och att flera stödjande insatser behöver göras för att öka upplevelsen av arbetstillfredsställelse.

**Delstudie II:** Flera feministiska forskare talar om en kvinnokultur där kvinnor har överlåtit ansvar för viktiga omsorgsuppgifter som ska lösas men med att det samtidigt getts begränsade möjligheter för att bestämma hur de ska lösas. Mot bakgrund av detta var det viktigt att ytterligare studera innebörden av de upplevelser som vårdarna vid det nyöppnade äldreboendet visade i delstudie I. Kunde skuld-känslor, svek och ostillräcklighet i arbetet relateras till ovannämnda kvinnokultur? Gick vårdarnas upplevelser från det nystartade äldreboendet att förstå utifrån Berit Ås teori om de Fem Härskarteknikerna?

- 1) **Osynliggörande**, som pågår när människor blir bortglömda, förbigångna eller överkörda.
- 2) **Förlöjligande**, som innebär att människor blir hånade eller utskrattade för någon handling eller att de får olika epitet påklitrade på sig.
- 3) **Undanhållande av information**, som förekommer när människor undanhålls viktig information om viktiga beslut.
- 4) **Dubbelbestraffande**, som sker när människor får höra att de gör fel hur de än gör.

- 5) **Påförande av skuld och skam**, som kan innebära att människor får skulden för att de inte själva skaffar sig den information som medvetet undanhållits dem och samtidigt blir förlöjligade för sitt beteende, som anses falla utanför normen för det normala.

För analysen av intervjuerna användes Latent innehållsanalys. Resultatet visar att vårdarnas upplevelser av skuld-känslor, svek och otillräcklighet i arbetet kunde förklaras och bättre förstås utifrån innehållet i de fem Härskarteknikerna och att användandet av dessa härskartekniker var ett mönster i det maktspel som fanns vid boendet.

Delstudie **III** syftar till att i vårdarens berättelser om sitt arbete med de äldre vårdtagarna, under en två års intervention, undersöka den djupare innebörden av arbetstillfredsställelse/otillfredsställelse när utbildning, stöd och handledning ges. Den utbildning som genomförts har utgått från vårdarnas önsknings och innehöll föreläsningar om demenssjukdomar, bemötande av personer med demens, integritetsbefrämjande omvårdnad, stroke, Parkinson, kommunikation och konflikthantering. Vårdarna har också tillsammans med forskarteamet haft möjlighet att få omvårdnadshandledning i mindre grupper en gång per månad. För att ge vårdarna kontinuerligt stöd i omvårdnadsarbetet har någon ur forsakrteamet funnits tillgänglig för att svara på frågor gällande omvårdnaden av de äldre och ibland deltagit i direkta omvårdnadssituationer. För analysen av intervjuerna användes en Fenomenologisk-hermeneutisk metod inspirerad av filosofen Ricoeur.

Efter ett till två års arbete vid äldreboendet verkar det som om personalen fortfarande upplever att de befinner sig i en känsloladdad och konfliktfylld situation men att de i samarbete med forskarteamet har lärt sig att bättre kunna hantera och bemöta de äldre. Samtal, reflektion och handledning tycks ha haft betydelse för känslan av att bättre behärska arbetssituationen. Ytterligare en faktor som kan ha haft betydelse för förbättringen är den förändrade synen på arbetsledningen som nu förefaller kunna ge mer stöd och bättre lyssna till personalens önsknings. Det verkar också som om personalen kommit närmare varandra och skapat en struktur för hur de vill arbeta tillsammans vilket tycks ge ökad trygghet i arbetet. Svårigheter tycks hanteras som viktiga utmaningar som är till för att gemensamt lösas. Endast ett fåtal vårdare förefaller besvikna över boendets utveckling. De verkar hysa känslor av nedvärdering för sitt eget yrke, förlorad självkänsla, övergivenhet och hopplöshet inför framtiden.

Vårdarnas upplevelser namnges i följande teman och subteman;

- 1) **Upplevelse av förändrat perspektiv** - att vara realistisk, att vilja ge de boende företräde, att kunna strukturera och att känna stöd.

- 2) **Upplevelse av öppna dörrar** - att känna framtidstro, att känna trygghet, att kunna reflektera, att känna stimulans och att vara tillåtande.
- 3) **Upplevelse av stängda dörrar** - att känna besvikelse, att känna misstro, att känna vrede och att känna stagnation.

Studien visar att vårdpersonalens tidigare upplevelser av otillfredsställelse i arbetet enligt delstudie **I** nu har börjat väga över till arbetstillfredsställelse enligt delstudie **III** vilket tyder på att interventionen innehållande utbildning, stöd och handledning kan ha haft betydelse.

Delstudie **IV**: En orsak till det ökade intresset för anhöriga inom äldreomsorgen är att gapet mellan tillgängliga resurser och vårdbehov för äldre ökar i Sverige och i Europa. För anhöriga kan detta innebära en tung och svårbemästrad ansvarsbörda. Mot bakgrund av detta och att personalen i ett nystartat kommunalt äldreboende (**I**) upplevde sig svikna av det rådande samhällssystemet när det gällde prioritering och satsning för de äldres omvårdnadsbehov och vårdarnas arbetssituation var syftet med delstudie **IV** att ta del av anhörigas redogörelser. I denna delstudie som var en del av ett länsövergripande äldreprojekt ingick 10 särskilda boenden. För analysen av intervjuerna användes Manifest och Latent innehållsanalys. Resultatet visar att de anhöriga framhåller vikten av att deras äldre får god vård, omsorg och högsta möjliga livskvalitet i sin vardag och att detta är svårt att uppnå i den situation som nu råder inom den kommunala äldreomsorgen med dess krympande resurser. Detta resulterar enligt de anhöriga i att de ofta känner att de inte vill störa vårdarna i deras arbete av rädsla för att verka krävande och för att de tror att vårdarna inte har tid och för att vårdarna också ibland har svårt att interagera med de anhöriga. Som ett led i detta kan man säga att de anhöriga har dubbla lojaliteter, dels gentemot de äldre som de vill göra sitt allra bästa för när det gäller omsorgen och dels gentemot vårdarna som de vill måna om eftersom de har en pressad arbetssituation.

De anhöriga ger ett tydligt samband mellan vården och samhällsekonomin. Utvecklingen går mot att de anhöriga pressas till allt större ansvar för sina äldre närstående. Dessa upplevelser framkom från de anhörigas berättelser och namnges i den övergripande kategorin: **De anhörigas kamp för en bättre och rättvis vård för äldre**, med tillhörande kategorier och subkategorier;

- 1) **Att lita på vårdarna** – utbildning, bemanning och kontinuitet.
- 2) **Att få bekräftelse av vårdarna** – inflytande och engagemang.
- 3) **Att tro på vården** – fysiska behov, psykiska behov, sociala behov och medicinska vårdbehov.



#### 4) **Att få den vård man anser sig ha rätt till** – ekonomiska faktorer och ansvar.

Resultaten av studien är viktiga i diskussioner. Kopplingen mellan personal och anhöriga stärks eftersom bägge parter arbetar mot samma mål, d v s en bra omsorg för de äldre, och eftersom både personal och anhöriga känner av samhällets åtstramningar inom äldreomsorgen.

#### **Sammanfattande resultat**

De sammanfattande resultaten visar att för att öka förståelsen för vårdpersonalens och likaså för de anhörigas situation bör man beakta problemen både i ett individperspektiv, d v s i den direkta kontakten mellan de äldre, vårdarna och de anhöriga, och i ett samhällsperspektiv, d v s se vårdarna och de anhörigas situation ur ett samhällsperspektiv. Vårdarna upplevde svek från flera håll. Sveket från samhället och den direkta arbetsledningen dominerade. De ansåg att samhällets ideologi inte stämde överens med deras arbetssituation. Ekonomiska besparingar, svikna löften, tomma ord från politiker, låga löner var för vårdarna en bekräftelse på att samhällets målsättning med god omsorg för de äldre inte stämde överens med den verklighet de levde i. De upplevde ständigt att de själva svek de äldre i och med att arbetet var stressigt eftersom de hade för kort om tid för att kunna stanna upp och bejaka de äldres behov. Som en följd av situationen blev vårdarna ofta distanserade i sitt förhållningssätt gentemot de äldre och de drabbades ofta av dåligt samvete för att de visste att de många gånger handlade emot sin egen kompetens och emot vad som kändes rätt för dem gentemot de äldre. Dessa skuld känslor påverkade vårdarna både på arbetet och privat och många utträttade bara det allra nödvändigaste för att få dagen att gå eller också sjukskrev de sig för att orka med. Sveket mot dem från den direkta arbetsledningen yttrade sig i att de hade många delegerade arbetsuppgifter som de skulle klara av utan att först fått erforderliga kunskaper för att klara dem. Ledningen beskrevs som icke bekräftande och frånvarande och vårdarna upplevde att de var övergivna av ledningen och samhället. De skuld känslor som vårdarna kände kan utifrån ett samhälls- och könsperspektiv förstås som att de delegerats uppgifter att lösa de äldres livssituation vid boendet men med begränsade möjligheter att kunna genomföra nödvändiga åtgärder till förbättring. Som en följd av detta la vårdarna skulden för det rådande samhällsfenomenet på sig själva. Det som var positivt och viktigt i deras vardag var den närhet och bekräftelse de fick av de äldre och även av det stöd och den samhörighet som fanns mellan arbetskamraterna. Det var det som höll dem kvar i arbetet.

De anhöriga upplevde också att de var svikna av samhället och även av vårdarna. Från samhället kanaliseras detta i krav på att behöva ta större ansvar än de själva ville ha för de

äldre. Kopplingen mellan ekonomiska åtstramningar och försämrad omsorg beskrevs också som att de äldres rättigheter i samhället hade försämrats. När det gäller sveket från vårdarna bottnade de anhörigas besvikelse i att de inte själva blev tillräckligt involverade och delaktiga i omsorgen av de äldre. Samtidigt kände de anhöriga en stor lojalitet gentemot vårdarna eftersom de såg hur stressig deras arbetsituation var och därför ville de inte påtala brister som de noterat. De som gjorde det var oroliga för att stöta sig med personalen. Den känslan stämmer enligt vårdarnas beskrivning av att anhöriga kunde upplevas som krävande. De anhöriga upplevde en ambivalent situation med lojaliteter gentemot både de äldre och vårdarna, och de gav samhällets ekonomiska åtstramningar skulden för de äldres försämrade situation och vårdarnas stressiga förhållanden. De saknade liksom vårdarna en ideologisk debatt som mer handlade om värderingar och omsorg än om pengar.

Interventionen hade positiv inverkan på vårdarnas arbetstillfredsställelse och de slutsatser man kan dra är att stöd, undervisning och handledning är viktigt i omsorgsarbetet. Vidare behöver innehållet i utbildning och handledning, förutom inriktning på direkt omvårdnad och interaktion mellan vårdare, anhörig och äldre, fokusera på samhällets humanistiska grundsyn och de etiska regler som styr vårdarnas arbete genom den lagstiftning som finns. Det är viktigt för vårdarna att bli medvetna om att de är en del i ett helt system i samhället och att de inte är ansvariga för den situation som nu råder inom äldreomsorgen. Vårdarna behöver också stöd, ledning och bekräftelse av en närvarande arbetsledning samt bekräftelse från samhället i form av höjda löner och inte bara tomma ord om att de är oersättliga och gör en bra insats för de äldre. De signaler samhället sänder till vårdare och anhöriga måste stämma överens med hur dess representanter själva arbetar för att förbättra äldreomsorgen för att vårdare och anhöriga ska känna trygghet i omsorgen om de äldre. Som det nu är har det uppstått ett dilemma för vårdarna och de anhöriga. De kan inte känna igen sig i det kollektiva sammanhang som samhället representerar när det gäller den kommunala äldreomsorgen.

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