Caring for people with dementia disease (DD) and working in a private not-for-profit residential care facility for people with DD

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Caring for people with dementia and working in dementia care is described as having both rewarding and unpleasant aspects and has been studied to a minor extent. This study aims to explore care providers’ narrated experiences of caring for people with dementia disease (DD) and working in a private not-for-profit residential care facility for people with DD. Nine care providers were interviewed about their experiences, the interviews were recorded, transcribed and analysed using thematic analysis. The analysis revealed that participants were struggling to perform person-centred care, which meant trying to see the person behind the disease, dealing with troublesome situations in the daily care, a two-edged interaction with relatives, feelings of shortcomings and troubled conscience, and the need for improvements in dementia care. The analysis also revealed an ambiguous work situation, which meant a challenging value base, the differently judged work environment, feelings of job satisfaction and the need for a functional leadership and management. The results illuminate participants’ positive as well as negative experiences and have identified areas requiring improvements. It seems of great importance to strive for a supportive and attendant leadership, a leadership which aims to empower care providers in their difficult work. Using conscience as a driving force together in the work group may benefit care providers’ health.

Keywords: care of older people, dementia, private not-for-profit profile, care providers’ experiences, troubled conscience.

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Introduction

There is an increased policy interest in the needs of older people with dementia disease (DD) \textsuperscript{(1, 2)}. Due to lack of beds in care institutions, people with DD are quite ill when they are transferred to residential care \textsuperscript{(3)}, they have a multiplicity of medical problems \textsuperscript{(4)} and the period of illness is long \textsuperscript{(5)}. The guidelines of the Swedish National Board of Health and Welfare (NBHW) \textsuperscript{(1: 8)} state that the care of people with DD should be person-centred. In Sweden, the municipalities are responsible for the care of older people up to the level of advanced nursing care. Residential care facilities are run by the municipalities or by private companies, as the market is open.

Privatisation of the care of older people in Sweden has increased during the last 20 years \textsuperscript{(6)}. A Swedish study, comprising about 3500 participants working in care of older people, shows that there are no pervading, large or clear differences in care providers’ assessment of their work environment between publicly and privately operated residential care facilities \textsuperscript{(7, 8)}. A Swedish study comparing privately and publicly operated residential care for older people showed that number of employees per resident was significantly lower in private care, while the proportion of residents participating in planning their care, the proportions of a reasonable duration between evening meal and breakfast and of different food alternatives were significantly higher. Accordingly, the private actors seemed to emphasise service aspects rather than structural prerequisites for good care \textsuperscript{(8)}.

Registered Nurses (RNs) and nursing aides (NASs) caring for people with DD in a municipal residential care facility for older people in Sweden described feelings of guilt...
towards residents and a constantly concern for their well-being (9). Meanings of caring for people with dementia disease in advanced stage in a psycho-geriatric county council clinic have been disclosed as both closeness and distance, having a light and a dark side. The light side was connected to mutuality in the nurse–patient interaction, and the dark side was connected to not reaching out to each other (10). In a study among care providers working in both municipal and private organised dementia care, those with work experience from 1 to 2 years were more likely to express hopeful or person-centred attitudes than those who had worked for a longer period of time (11).

In Australia, 91% of 253 care providers working with people with DD reported that they were happy in their job (12). Care providers in small-scale dementia units reported higher levels of job satisfaction and motivation than those in regular psycho-geriatric wards (13), while care providers in small-scale dementia units reported higher levels of emotional strain than those in traditional settings (14). Care providers working in dementia care in Sweden, Australia and UK expressed worries about lack of resources and time, poor support from management, feelings of not having the power to change their situation and not being recognised and acknowledged for their work (15). In municipally provided dementia care in Sweden, RNs and NAs reported that they lacked managerial support and information, that they sometimes felt that the management was unskilled and uninterested in dementia care, that they were unsatisfied with RNs’ involvement in daily care, and with the amount of education and supervision (16). In municipal residential care facility for older people in Sweden, RNs and NAs described how they lacked support from management and were expected to supervise themselves. Despite their workload, there were occasions when they experienced job satisfaction (9). Care providers in municipal dementia care in Sweden narrated experiences of exposure, insufficiency and troubled conscience, not being respected or valued, doubting oneself and others and simultaneously being devoted to residents (17). A study in municipal care of older and disabled people in Sweden indicates that staff felt lonely and struggling to maintain self-esteem and to be confirmed (18). Attitudes to people with DD have been found to significantly and positively correlate with the level of job satisfaction among care providers working in not-for-profit aged care organisations (19).

In summary, no consistent understanding emerges in the research findings mentioned above about care providers’ experiences of caring for people with DD, and both the foreign and the Swedish studies described above indicate both light and dark experiences. Working in dementia care is also sparsely studied, and as apparent in the mentioned studies, the mode of operation is not always pointed out. The studies reveal that some care providers are satisfied, while others often feel abandoned and alone in their work situation. Implementation of and conditions in private care of older people is a widely debated topic in Sweden and in the Western world. Studies illuminating experiences of working in private not-for-profit dementia care context are rare, underlining the need to explore these issues. This study aims to explore care providers’ narrated experiences of caring for people with DD and working in a private not-for-profit residential care facility for people with DD.

Method

This study is part of the larger study, ‘Stress of conscience and burnout among health care personnel in elderly care – an intervention’ that concerns caring for people with DD in a municipal residential care facility in Northern Sweden and in a private not-for-profit residential care facility in Middle Sweden (e.g. 20). This study reports interviews with care providers working in the private not-for-profit residential care facility.

Participants

All care providers (n = 12) in one residential care facility for older people with DD were invited to join the study. Seven enrolled nurses (ENs) and two NAs gave their informed consent to participate. They had worked with older people for between 5 and 47 years and in this particular unit 4 months to 8 years. Three ENs had a wider training in dementia care, and four were trained in the validation method (method described in e.g. 21).

Context/Setting

The study was performed at a private not-for-profit residential care facility in a large town in Sweden. The care provided is described as based on Christian humanistic values combined with professionalism, specialist knowledge and active knowledge and method development. There is no demand that employees should be Christians. The unit is relatively new and was built especially for care for residents with DD. The building is a one-storey house with an inner garden and is divided into two sections with eight residents in each. All residents have varying stages of DD, combined with other medical conditions, such as neurological and cardiovascular diseases. Each resident rents a small, one-room apartment with a kitchenette and bathroom, and there is a communal dining area and TV room. Some residents had relatives who regularly visited the residence. During the study period, 24-hour staffing was provided and one RN worked day shifts on weekdays. Evenings, nights and weekends there was a RN on call, stationed locally and responsible for covering several units. ENs and NAs worked days,
evenings, nights and weekend shifts, and five ENs/NAs covered the day shifts on weekdays. During evenings and weekends, four ENs/NAs were on duty. One EN/NA and the RN on call covered the night shifts. General practitioners were consulted regularly.

The first-line leader at the unit was responsible for 58 employees, and her/his office was not connected to the unit.

**Data collection**

The second author performed semi-structured personal interviews September 2010–January 2011 in a secluded room within the care facility. Participants were encouraged to speak freely about their experiences of working with older residents with DD in a dementia care unit, for example what they regarded as important aspects of care, support functions, problem solving and attitudes towards residents. The recorded interviews lasted 40–60 minutes and were transcribed verbatim (names and places were changed).

**Data analysis**

A thematic qualitative analysis method, inspired by Patton (22), was used. First, the interviews were read through several times to gain an overall impression. Then, according to the study aim, significant patterns in the text were identified, that is, key phrases, which were compiled systematically into a coding scheme (22: 432, 440, 454, 463). A code is a word or a short phrase that symbolically assigns a summative attribute of, for example, interview data (23: 3), that is, codes give the key phrases a label (22: 463). The codes that had something in common, that is, built up a pattern, were gathered into subthemes and themes (22: 463, 23: 6, 8). An example of the coding scheme used in the analysis is presented (Table 1). To ensure trustworthiness, each interview was independently coded by the three authors, and all steps of the analysis were openly and critically discussed. In presenting the findings, representative quotations are used to allow the reader to judge the trustworthiness of our interpretations. Important aspects of the authors’ preunderstanding consist of experience of previous work and research in the care of people with DD.

**Ethical considerations**

Before giving their oral and written informed consent, participants were provided with oral and written information about the study. They were informed about the voluntary participation and that they at any time could end the interview without giving any reason. They were guaranteed confidentiality and anonymous presentation of results.

**Results**

The interview data were sorted into two themes (see Table 2); The difficult struggle to perform person-centred care and an ambiguous work situation.

**Table 1 An example of coding scheme in the analysis**

<table>
<thead>
<tr>
<th>Keyphrases</th>
<th>Code</th>
<th>Subtheme</th>
<th>Theme</th>
</tr>
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<tbody>
<tr>
<td>The morning we have together is absolutely wonderful, when I see how good she is feeling … I’m doing a tasty breakfast to her, providing her opportunity to eat in her apartment in order to have this moment together … she laughs, we sing and she is doing well and everything is so good. I think, it gives me something to …</td>
<td>The care provider recognises the residents’ need and respond to it, a situation which also benefit the care provider</td>
<td>Trying to see the person behind the disease</td>
<td>The difficult struggle to perform person-centred care</td>
</tr>
<tr>
<td>I sing to her these old songs she likes, and I think I can see a gleam in her eyes, sometimes I sing wrong to see if she reacts, and then I can see a little smile but otherwise it’s not much reaction, I use to make sure that she has it good</td>
<td>The care provider has found a way to reach the resident and how to respond</td>
<td>Trying to see the person behind the disease</td>
<td>The difficult struggle to perform person-centred care</td>
</tr>
<tr>
<td>You have to confirm the resident, even if you do not have much time, a touch or a small caress, can make them feel safe</td>
<td>The care provider has found a way to respond to the residents’ when time is scarce</td>
<td>Trying to see the person behind the disease</td>
<td>The difficult struggle to perform person-centred care</td>
</tr>
<tr>
<td>You have to respect and try to understand the person you are caring for, they need security, they need routines, they need human warmth, they need joy, they need grief, they need all that we need, but on their own terms</td>
<td>The care provider recognises that the residents’ have special needs</td>
<td>Trying to see the person behind the disease</td>
<td>The difficult struggle to perform person-centred care</td>
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A challenging value base
Trying to see the person behind the disease.
Some participants described that they sought to be responsive to residents’ individual needs. They knew and perceived that residents with DD, as most other people, needed to be treated with respect and appreciation, and not exposed to excessive demands. It was important to make residents feel safe and secure and to carefully consider how to speak to them, for example not to ask several questions or to give several options. It was also described as important for the participants to feel good in themselves in order to have successful interactions with residents and thus make them become happy and satisfied.

The difficult struggle to perform person-centred care

This theme consists of five subthemes: trying to see the person behind the disease, dealing with troublesome situations in the daily care, the two-edged interaction with relatives, feelings of shortcomings and troubled conscience and the need for improvements in dementia care.

Trying to see the person behind the disease

Some participants emphasised that society, generally, incorrectly regarded the DD as a mental retardation and not as a disease. Suffering from DD was by the participants perceived as unworthy, and involving loss of dignity, integrity and sometimes self. Participants meant that residents had lost themselves and that they were shadows of what they used to be. They described how they tried to see the person behind the disease, that is, to see each person as who they really are.

It’s a horrible disease, it’s like they aren’t themselves anymore. It’s like they aren’t there, they are like an empty shell. I can’t really explain. It’s like they are nothing … that’s horrible; I don’t want them to lose their dignity. It’s horrible when a person loses everything, and they do. But that’s something we have to learn. It’s our job to help them and build up what’s left.

Participants described that they sought to be responsive to residents’ individual needs. They knew and perceived that residents with DD, as most other people, needed to be treated with respect and appreciation, and not exposed to excessive demands. It was important to make residents feel safe and secure and to carefully consider how to speak to them, for example not to ask several questions or to give several options. It was also described as important for the participants to feel good in themselves in order to have successful interactions with residents and thus make them become happy and satisfied.

The interaction with the resident … it’s so important that it ends up well, if it does, the residents are so happy and satisfied … but if you don’t feel good yourself, then it may end up in a disaster.

Residents’ life histories were described as crucial in order to strengthen the picture of residents as persons. It was important to provide activities that took into account each resident’s life history and health condition. As activities were described as sometimes worrying residents, individualising the activities was emphasised. The daily routine was also described as important to individualise.

She needs to recognize that she’s safe, and it’s important not to break her daily routine, she needs to sit down and talk in peace and quiet, to hold her hand, discuss what’s in the paper, take her for a walk in her wheelchair or just be in her apartment, you have to give her time …

Participants described that they were careful about not violating residents’ integrity, for example through knocking on their doors when entering their apartment, making themselves guests in the residents’ home. It was also described important to focus solely on the resident when fulfilling their individual needs.

For example, you cannot talk to a co-worker when you are helping a resident at mealtimes, you have to focus.

Dealing with troublesome situations in the daily care

When something went wrong in the relation to the residents, the participants tried to handle it immediately by changing the care provider, that is, another person was entering the scene. This method usually worked, and the resident became calmer. Participants described how they often tried to distract or coax the resident instead of confronting critical situations. It was also described of great importance to foresee and prevent problematic situations for the residents, both as individuals and as a group. Telephones were described as difficult to deal with for some residents. Participants had noticed that it was sometimes hard for residents to understand where the voice in the phone was coming from, that they often became anxious when they did not see the person they were talking to and that they became homesick when they recognised the voice. In these difficult situations, in order to do what was best for the residents, they therefore disconnected the phone as agreed with relatives.

It may sound cruel, but we sometimes disconnect the phones … a phone call can totally destroy a day … they get anxious and ask where the person [in the phone] is, and when you explain they start to talk about taking the bus home.

Table 2  Subthemes and themes in the thematic analysis

<table>
<thead>
<tr>
<th>Subthemes</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Trying to see the person behind the disease</td>
<td>The difficult struggle to perform</td>
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<tr>
<td>Dealing with troublesome situations in the daily care</td>
<td>person-centred care</td>
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<td>The two-edged interaction with relatives</td>
<td>An ambiguous work situation</td>
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<td>Feelings of shortcomings and troubled conscience</td>
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<td>The need for improvements in dementia care</td>
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<td>A challenging value base</td>
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<td>The differently judged work environment</td>
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<tr>
<td>Feelings of job satisfaction</td>
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<td>The need for a functional leadership and management</td>
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Feelings of shortcomings and troubled conscience. Participants described how their relationship with relatives often was problematic, although they understood relatives' vulnerable role. They emphasised how they understood relatives' plight, that is feelings of guilt, and that relatives sometimes had unrealistic expectations of the care provided and that they did not always agree about what was the best for the resident. Some relatives visited the residents less frequently as the residents' health declined, and they developed problems in communicating. In some situations, participants described how they did not tell the truth to the relatives in order to protect a vulnerable resident. Participants described that it was difficult to inform relatives about the need of peace and quiet at the unit to respect coresidents; many relatives believed that they were entitled to come and go as they pleased.

Most of our residents need calm at mealtimes. We use to say to the relatives, ‘Don’t come visiting during mealtime’, many residents become anxious when they see an unknown face and therefore stop eating. But they insist that this is the resident's own home and that they have the right to come and go as they wish ... it’s difficult to present the problem in an understandable way.

An ambiguous work situation

This theme consists of four subthemes: a challenging value base, the differently judged work environment, feelings of job satisfaction and the need for a functional leadership and management.

A challenging value base. Participants described that they knew about a brochure describing the prevailing Christian humanistic value base at the residence. Sometimes their manager mentioned it during meetings, but they felt it as too abstract and difficult to understand and did not discuss it. Some thought that the value base was expressed through Christian sermons. Others described that although they did not discuss them, they felt certain values included mercy, dignity and integrity. They had an idea of what was right and wrong and based their care on these values. Some participants criticised the management regarding their marketing of the value base, as they perceived that it was not a true account of the care provided.

If they are portraying this residential unit in a special way, then the personnel should also be aware of and understand it. You can’t portray a value base which we don’t have when it comes down to it.

The differently judged work environment. The physical work environment was described as satisfying; the location, the architecture and planning of the residential care facility...
were supportive for a good work environment. The physical environment provided pretty attractive scenery and easy access to nature.

The environment is very nice, it’s the first thing that hits you when you come here.

The psychosocial environment, for example workload, was described as both exhausting and stimulating. Some participants described a persistent heavy workload and lack of resources, while others described that they usually had enough personnel resources, despite there being sometimes, a lack of engaged and educated personnel. Some participants described anxiety for the future of the care facility, for example selling it out on the market. Some described that the cooperation within the work group and with the RNs as satisfactory, while others disagreed. Some described conflicts in the work group resulting in discord and disagreeing about how to help residents. One example concerned a lady who constantly wanted to change her clothes. Some thought that she could change her clothes whenever she wanted, while others locked her wardrobe when they were on duty. Consequently, participants tried to solve problems on their own, based on their own assumptions about what constituted good care.

It was decided that we were supposed to lock her wardrobe so that she could not keep getting dressed and come out in the middle of the night with clothes on. Now, I think it varies, sometimes her wardrobe is locked and at other times it is not.

Feelings of job satisfaction. Participants described their work as challenging, rewarding and important. Working with older people with DD was described as a job that requires certain skills such as patience and creativity. They often felt proud of their everyday work achievements. It was described as a joy to share moments when residents expressed and showed ‘themselves’ as they are and showed that they knew that someone was present, for example when participants sang to them and they showed their awareness with a look in their eyes or a touch of their hand. Moments of happiness and closeness were described as breeding a sense of job satisfaction and bringing meaning to their life.

You have to catch the moment, you may laugh and think, ‘What a wonderful moment this was’, it maybe lasts only for a few minutes, but that contact…when you see that you have reached the resident, it’s fantastic, even if I know that they will forget the moment almost immediately. I can feel that I have enriched their life, and also mine…even if the moment is soon past, it’s still left in me, it’s meaningful to me.

The need for a functional leadership and management. Participants described divergent feelings towards management and leadership. Most of them described that they often lacked support from managers, while they provided the very best care they could, based on their own will to do good. The manager was described by some as easy to talk to and having a difficult task, and by others as absent, and not addressing problems due to improper care providers. When there were problems, they asked co-workers or the RN for advice. They described how they did not feel confirmed as care providers and that they had needs that were not fulfilled.

We are very efficient, we manage on our own.

We don’t receive any appreciation from the manager, no stimulation, only a little would be enough … at our workplace meetings we only hear the negative news about bad economy and so on, never any appreciation. I think it’s fatal.

Discussion

The aim of the study was to explore care providers’ narrated experiences of caring for people with DD and working in a private not-for-profit residential care facility for people with DD. The analysis revealed a difficult struggle to perform person-centred care; that is, they were trying to see the person behind the disease, dealing with troublesome situations in the daily care. Some described conflicts in the work group and with the RNs as satisfactory, while others disagreed. Some described conflicts in the work group resulting in discord and disagreeing about how to help residents. One example concerned a lady who constantly wanted to change her clothes. Some thought that she could change her clothes whenever she wanted, while others locked her wardrobe when they were on duty. Consequently, participants tried to solve problems on their own, based on their own assumptions about what constituted good care.

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awareness of person-centred values, care processes remain largely ritualistic and routinised and offer few opportunities for the building of meaningful relationships between care providers and their residents. However, our results differ from those in McCormack et al. (25); care providers in our study are struggling to perform person-centred care but are due to organisational obstacles prevented. It is of great importance to further explore organisational influences on possibilities to perform person-centred care, in both municipal and private care of older people.

One aspect of concern in care providers’ struggle to perform person-centred care was shortcomings and troubled conscience described when they perceived that they were not doing a good job and when they were forced to prioritise between residents. Similar results in a similar context have been found previously (20). Conscience has among healthcare personnel been perceived as an authority, a warning signal, an asset, a burden, as demanding sensitivity and depending on culture (26). Conscience perceived as an asset may help care providers to provide good care (26, 27), but conscience may also be a burden, which may generate stress of conscience (stress caused by troubled conscience). Stress of conscience can be generated when care providers are not able to follow their conscience to provide the care they want (28). Some participants described that they were dialoguing with themselves in order to cope with their troubled conscience, results that are similar to those of another study in Sweden (29). In order to ease the burden of a troubled conscience, it is important to share and reflect on what conscience is telling us together with co-workers, that is, dialoguing with others and use conscience as a driving force, in this case to facilitate care providers’ struggle to perform person-centred care. Conscience as an asset and thus using it as a driving force may also promote work-related health and quality of care.

The results show that care providers narrated an ambiguous work situation, consisting of a challenging value base, a differently judged work environment, feelings of job satisfaction and the need for a functional leadership and management. Care providers described that they lacked support and confirmation for their work efforts from their manager. In a study by Scott-Cawiezell et al. (30), poor leadership was expressed as a barrier to provide the best possible care in 15 public nursing homes. Moiden (31) found that the psychosocial needs of private care home staff were by the leaders met to a lower degree compared to the voluntary care home staff. Supportive leaders are required for the provision of person-centred care (32), and supervisor behaviour can affect employee well-being (33). The studies described above imply that leaders and their actions are crucial for both quality of care and care providers’ health. According to the NBHW (34: 8), the publicly managed care of older people lacks leadership. Hjalmarsson (35: 11) found that the heads of many units in the city and county of Stockholm reported that they lacked the time and other resources to confirm care providers and get to know residents. The care of older people is controlled from a distance in both Sweden (36), and in England, that is, leaders seldom visit wards except when dealing with problems; this distance leads to mistrust and negative criticism and focus may shift from care, to documentation and defence against criticism (37). Transformational leadership is suggested suitable to meet healthcare personnel’s perspectives (38). Leaders with transformational intentions recognise and seek to satisfy the existing needs of their followers, look for potential motives, and engage the co-workers’ full person. This leadership may achieve a relationship of mutual stimulation and elevation (39: 4). A review study reported that transformational leadership was related to job satisfaction, well-being, decreased burnout and stress in healthcare personnel (40). Staff nurses who perceived their manager as more transformational reported a higher organisational commitment (41). Care providers described a vulnerable situation when lacking support from managers. Working in an organisation controlled from a distance, exposed to heavy demands and simultaneously lacking support and being without a value base which permeates all aspects of care may jeopardise quality of care and care providers’ well-being, probably regardless of mode of operation. An attendant and supportive leadership, aiming to clarify the value base, motivate care providers and confirm their important role, should benefit them and therefore promote good work-related health.

This study was performed in a private not-for-profit context. Comondore et al. (42) report in their systematic review and meta-analysis of care in for-profit and not-for-profit nursing homes that there seems to be a lower quality of care in for-profit nursing homes. For example, in private not-for-profit nursing homes, there was a lower prevalence of pressure ulcers and less use of physical restraints, compared with for-profit nursing homes. McGregor et al. (43) found that staffing levels, that is number of hours per resident day, were higher in private not-for-profit long-term care facilities, compared to for-profit facilities. vonDras et al. (44) found that nursing staff in a private not-for-profit nursing home were subject to stress due to co-workers, intrapersonal processes, interaction with residents, management-related factors and demands from residents’ families. Thus, foreign studies show some quality differences according to mode of operation, but there are still inconsistencies in results and overall too few studies performed to enable a comprehensive understanding of the issue. As mentioned above, there are no clear quality differences dictated by the mode of operation of the care of older people in Sweden, according to NBHW (8). However, comparative studies concerning public vs. private not-for-profit residential
care of older people in Sweden are still rare and therefore needed.

The intention was to comply with standards for establishing trustworthiness (45). Therefore, an effort was made to thoroughly describe the process of analysis, for example by exemplifying the coding process and applying the results with quotes. During the analysis, the results were regularly discussed together in the research group to ensure consistency. The method of analysis was considered appropriate to the type of data collected. There is always a risk to break down data in pieces and then lose the integrity of the entire text. Therefore, the whole text was read through repeatedly, in order to keep it in mind during the analysis (e.g. 46).

Conclusions and implications

Our results reveal that care providers caring for people with DD in a private not-for-profit residential care facility are struggling to perform person-centred care, for example to see the person behind the disease. They strive to do good, but some aspects are ‘putting a spoke in the wheel’.

They are also facing an ambiguous work situation, filled with both positive and negative experiences. These results would possibly have been revealed regardless of mode of operation. Providing possibilities for using conscience as a driving force together in the work group along with a supportive leadership may facilitate care providers’ struggle to perform person-centred care. In order to overcome care providers’ ambiguous work situation, a supportive and attendant leadership is suggested to empower staff. Comparing studies concerning public vs. private not-for-profit residential care of older people in Sweden is an area that still needs to be explored.

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Author contributions

Astrid Norberg contributed to study design; Lise-lotte Franklin Larsson collected data; Eva Ericson-Lidman, Lise-lotte Franklin Larsson and Astrid Norberg contributed to data analysis; and Eva Ericson-Lidman, Lise-lotte Franklin Larsson and Astrid Norberg participated in manuscript preparation.

Ethical approval

The study was approved by The Regional Ethical Review Board (Dnr 09-099).

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