Aim and objectives. To examine the association between caregivers’ work satisfaction and individualised care in different care settings for older people.

Background. Work satisfaction in older people care settings has been associated with absenteeism, staff turnover and the quality of care delivered. The management of individuality is an important quality of care issue. Although these two issues are important there is little evidence about the possible association between them.

Design. An exploratory and correlational survey design.

Methods. Data were collected using three questionnaires, the Individualised Care Instrument the Individualised Care Scale-Nurse and the Index of Work Satisfaction from a sample of professional nursing caregivers (n = 263, response rate 71%) in care settings for older people in one health care area in Finland in 2010. Statistical analysis included descriptive statistics, correlations, analysis of variance and multiple regression analysis.

Results. Caregivers support the patient’s individuality through specific activities, perceiving that they maintain individuality in care provision whilst reporting moderate work satisfaction. The ratings of individuality assessments were the lowest in nursing homes followed by long-term care in in-patient wards.

There were statistically significant correlations between work satisfaction and specific perceptions in the support of individuality. The sub-scales of the instruments used were: the Support of Individuality in general, Individuality in the Care Provided, Knowing the Person, Staff-to-Resident Communication and Staff-to-Staff Communication. Significant statistical differences in the results were found between staff working in home care, primary health care, in-patient wards and nursing homes.

Conclusions. Low job satisfaction can affect the provision of individualised care emphasising the need to promote individualised care at an organisational level as a means of improving work satisfaction.

Relevance to clinical practice. Instruments to measure work satisfaction and individualised care can be used to improve care quality.

Key words: aged care, individuality, individualised care, nursing, older people, quantitative approaches, questionnaire, survey, work satisfaction

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Introduction

The world population is increasing including the older age groups. Whilst the overall population is projected to rise by 33% between 2008 and 2040, those aged 80 and over are projected to increase by 233% and those aged 65 and over by 160% (U.S. Census Bureau 2009). This ageing of the world population impacts the social, economic and health climates of the affected countries influencing the management of the challenges ageing causes (Powell 2010). One of these challenges is older peoples’ living arrangements which may be categorised as home or institutional-based (Estes et al. 2003, Powell 2010). The number of older people living alone at home is rising in most countries (Powell & Leedham 2009, Powell 2010) and the number of those living in sheltered housing, nursing homes and long-term care institutions is also increasing (e.g. Forma et al. 2011). This rise is projected to continue so that, for example, in the USA and Canada, the estimated population of nursing homes is set to rise from a baseline in 2003 of 1.5 million (National Center for Health Statistics 2005) to three million by 2030 (Sahyun et al. 2001).

The increase in the number of older people who are living in nursing homes and other long-term care institutions has put additional strains on the nursing workforce in these settings (Kovner et al. 2002) and there are reports of difficulties in recruiting and retaining suitable, qualified nursing staff both nationally (Kassner & Bertel 1998, Al-Hussami 2008) and internationally (e.g. Abbey et al. 2006, Kloster et al. 2007). As the numbers of people who wish to live in these institutions increase there will be a further, concomitant strain on the capacity and ability of these institutions to deliver appropriate care.

Previous studies have pointed out that work satisfaction is low in nurse professionals working in care settings for older people (Castle et al. 2006, Kovach et al. 2010) and the work has been reported to be unpopular, with professional challenges and clinical experiences often given as reasons for dissatisfaction (Kloster et al. 2007). Unsurprisingly, there is an international shortage of nurses especially in the older person and dementia care sectors (Chenoweth et al. 2010). These three issues, work dissatisfaction, the unpopularity of work in care settings for older people and the resulting nurse shortage threaten the provision of safe healthcare (Ruggiero 2005) and make the ability to recruit and retain caregivers one of the major challenges healthcare organisations face (Leka & Jain 2010).

Factors related to recruitment and retention have been shown to be related to the activities of the organisation and the organisational climate (Takase et al. 2001, Castle et al. 2006, Hasson & Arnetz 2008, Kwak et al. 2010), the quality of care (Castle et al. 2006, Burton & Stichler 2010, Kwak et al. 2010) and nurses’ desire to deliver patient-centred or individualised nursing care (e.g. Zimmerman et al. 2005, Tellis-Nayak 2007, Edvardsson et al. 2011). However, there is little known about the factors associated with work satisfaction or the opposite, dissatisfaction, for nurses working in care settings for older people (Castle et al. 2006). Even less is known about nurses’ perceptions of individuality of care in these care settings (Suhonen et al. 2009) and their association with nurses’ work satisfaction (Charalambous et al. 2010).

Background

It has been reported that patient care and patient outcomes and outcomes of nursing care, nursing staff and organisational outcomes are affected by the context where care is delivered (e.g. Suhonen et al. 2009, Purdy et al. 2010). This makes the organisational context an important and powerful, though variable factor affecting clinical practice and outcomes. In the organisational context reported factors that affect nurses’ work include, the working environment, the level of work satisfaction (Lake & Friese 2006, Suhonen et al. 2009, Purdy et al. 2010) and the association between a favourable working environment and the provision of individualised care (e.g. Charalambous et al. 2010). An acceptance of these findings leads to the notion that the foundation for person-centred care-giving is a person-centred work place (Hall et al. 2007, Tellis-Nayak 2007). Considering this through the lens of practice development, improvements in the care quality through the development of individualised care, may require improvement in the environments where patients and staff interact (OECD 2004, WHO 2006) and the establishment of individualised care as an organisational imperative. However, although the importance of individualised nursing care (e.g. Cohen-Mansfield & Jensen 2005, Kovach et al. 2006) and its effectiveness in producing positive outcomes for both patients (Suhonen et al. 2008) and caregivers (Lake & Friese 2006, Tellis-Nayak 2007) has been clearly reported, it has not been integrated into health care development plans (OECD 2004, Wilson & Neville 2008). This makes individualised care one of the most important research and organisation priorities in the health care service (Ross et al. 2004).

Individualised care

Individualised care is defined by an acknowledgement that all patients are different and require potentially different
interventions to meet their individual needs (Radwin & Alster 2002). Nurses using individualised care work with individual patients to determine the interpersonal approach to care and the associated nursing interventions (Lauver et al. 2002). Individualised nursing care is a process that encourages personally devised health-improving behaviours (Rakowski et al. 1998, Suhonen et al. 2009) to achieve positive patient outcomes (Suhonen et al. 2008, Radwin et al. 2009) such as the improvement of patients’ functional ability (Mulrow et al. 2004) and improved urinary incontinence (Schnelle et al. 1998, Jirovec & Templin 2001). The management of patients’ individuality in this way facilitates the development of a deeper understanding of user perspectives, is needed for the further development of health care and health policies (e.g. WHO 2004, 2008) and meets the ethical obligations of health care (e.g. ETENE 2008).

Additionally, stakeholders assert that individualised care is essential for the realisation of health care quality (e.g. OECD 2004, WHO 2007) and is one attribute of high quality nursing care when associated with desired health outcomes (Florin et al. 2005, Murphy 2007). However, it has been found that care, in settings for older people, does not take individuality into account (Alkema et al. 2006, Teeri et al. 2006, Wilson & Neville 2008) and even limits patient choice and involvement in decision making (Murphy 2007). Muntil et al. (2006) found that more than 20% (n = 200) of the patients in an emergency department perceived that nurses showed only a low interest in their life situation and a review by Courtney et al. (2000) reported that many ‘attitudes reflect ageist stereotypes and knowledge deficits that significantly influence registered nurses’ practice and older patients’ quality of care’. In the acute setting this reduction of quality of care includes older patients’ experiences of decreased independence, limited decision-making possibilities, increased probability of developing complications, poor consideration of age-related needs, limited health education and sometimes social isolation (Courtney et al. 2000).

Work satisfaction

The importance of work satisfaction in health care was acknowledged in the 1980s (Weisman et al. 1980). The reason for its importance in organisations is the association between work satisfaction, staff turnover (Castle et al. 2006, Hasson & Arnetz 2008, Flinkman et al. 2010) and performance (Takase et al. 2001, Kwak et al. 2010). Nursing staff turnover results in high costs to hospitals and may affect care quality which makes the examination of work satisfaction, as an antecedent variable affecting care quality, highly relevant. Work satisfaction has received extensive attention by researchers around the world resulting in different definitions and understandings of the concept. Although it may be difficult to encapsulate the meaning of work satisfaction, most commonly, the concept is described as the extent to which employees like their jobs (Rakich et al. 1985). In a review of the literature Utriainen and Kyngäs (2009) found reasons for dissatisfaction were easier to determine than satisfaction in a practical setting and it is thought that work satisfaction arises primarily from the work itself (Hertzberg et al. 1959). In a similar, though not identical understanding, Stamps (1997) defined six factors related to work satisfaction: pay, autonomy, task requirements, organisational policies, interaction and professional status.

Work satisfaction and dissatisfaction have been typically studied in acute hospitals (e.g. Foley et al. 2004, Utriainen & Kyngäs 2009) and work satisfaction appears to have a positive effect. The literature shows that those who are satisfied with their work tend to report low levels of work-related stress (Foley et al. 2004, Flanagan 2006) and burnout (Foley et al. 2004, Kwak et al. 2010) and less of them report their intention to leave their job (Foley et al. 2004). Work dissatisfaction has been found to be associated with an increased absence from work (Castle et al. 2006, Hasson & Arnetz 2008), low quality of care (Castle et al. 2006, Burton & Stichler 2010, Kwak et al. 2010), poor delivery of care (Takase et al. 2001, Kwak et al. 2010) and lethargy with reduced organisational commitment (Moser 1997).

The association between individualised care and work satisfaction

There is little direct evidence for an association between individualised care and work satisfaction. In the acute care setting positive perceptions of the quality of care and the atmosphere at work have been reported to increase work satisfaction (Goldman & Tabak 2010) and, in nursing homes, Castle et al. (2006) found that those nurses who perceived they delivered high quality care were more satisfied with their work. Since the delivery of individualised care has been considered an indicator of quality of care (Florin et al. 2005, Murphy 2007) and associations between the quality of care and work satisfaction have been reported, indirectly, it is argued that individualised care is associated with work satisfaction. Zimmerman et al. (2005) found that a person-centred attitude is related to nurses’ (n = 154) satisfaction and other evidence shows that adopting a person-centred approach to nursing alters the work environment and increases work satisfaction (Tellis-Nayak 2007, Slater et al.
2009). However, only a few studies have focussed on this association which requires some clarification. Edvardsson et al. (2011) found that perceived person-centred care provision was significantly associated with work satisfaction in nurses who work with older people in residential homes ($n = 297$). In this study, person-centred care provision explained nearly half of the variation in work satisfaction and the largest independent influence on this was individualised care. The authors concluded that supporting staff in providing person-centred care can enhance work satisfaction and might facilitate attracting and retaining nurses in residential care homes. These findings reiterate a need to shift the focus of care from completing care tasks and following organisation-centred routines to providing high quality, person-centred care that enhances the individual lives of each resident and improves work satisfaction.

As work satisfaction is a complex concept and there appears to be at least an association between nurses’ work satisfaction, recruitment and retention and individualised care, there may be a specific correlation between work satisfaction and individualised care which is unknown currently. A more complete understanding of the association between the work satisfaction of nurses and their provision of individualised care may facilitate the improvement of work environments and employment cultures and an increase in nursing interventions that meet the individual needs of patients and the improvement of the employment culture. This current study is a response to this gap in the knowledge.

Aims and objectives

The aim of this study was to examine the association between caregivers work satisfaction and individualised care by comparing their perceptions of individualised care and work satisfaction in different care settings for older people. It was hypothesised work satisfaction is positively associated with perceptions of individualised care.

Methods

Design, settings and sample

An exploratory and correlational survey design, using self-completed questionnaires, was employed to collect data from all caregivers ($n = 263$, response rate 71%) working in care settings for older people in five municipalities (six types of organisations) in one health care area in Finland between 11 May–14 June 2010. The caregivers included registered nurses (RN), licensed practical nurses (LPN), home helpers and nurses aids ($n = 375$). The organisations, divided into four groups, were health centre hospitals (primary health care centres and in-patient wards), nursing homes and sheltered housing with 24-h assistance, sheltered housing (residential homes offering health-related services) and home health care.

Measures

The level of provision of individualised health care was captured using two measures, the Individualised Care Scale (ICS-Nurse) and the Individualised Care Instrument (ICI). The level of work satisfaction was captured using the Index of Work Satisfaction Scale (IWS, Part B). In addition, the following socio-demographic information was requested from the participants: age, gender, the length of work experience, highest education (school level, college level, bachelor’s degree, other), work role, type of job (full time, part time, casual) and type of organisation.

The Individualised Care Scale (ICS-Nurse; Suhonen et al. 2010a,b, 2011) is a two-part instrument developed in Finland and it assesses nurses’ perceptions of individualised patient care. The instrument has 34 items with five point Likert-type scale (1 = strongly disagree–5 = strongly agree with a neutral midpoint). The two parts, (ICS-A-Nurse and ICS-B-Nurse) measure the support of patient individuality in specific nursing activities and the perceptions of individuality in care provision respectively. Each part has three sub-scales: Clinical Situation (Clin A and B), Personal Life Situation (Pers A and B) and Decisional Control over Care (Dec A and B). All the items are positively worded so that a higher score represents higher perceptions of individualised care and has been validated having Cronbach’s alpha ($\alpha$) coefficients, ICS-A-Nurse (ICS-B in parenthesis) of 0.88 (0.90) with the sub-scales ranging from 0.72–0.83 (0.73–0.84) (Suhonen et al. 2010a).

The Individualised Care Instrument (ICI) (Chappell et al. 2007, Caspar & O’Rourke 2008, O’Rourke et al. 2009) was developed in Canada for the measurement of individuality in clinical practice. The domains of individuality assessed by this scale are: Knowing the Person, Patient/Resident Autonomy, Staff-to-Patient/Resident Communication and Staff-to-Staff Communication. The ‘Knowing the Person’ (IC-KNOW) sub-scale uses a Likert-type, four-point scale for 13 questions which refer to the ways that nurses obtain information about their patients and nurses’ perceptions of how well they know their patients. The scale is also positively worded.

The Patient/Resident Autonomy (IC-AUTONOMY) sub-scale is a negatively worded five-point frequency scale ranging from Very Frequently ($=1$) to Never ($=5$) and has 15 items relating to the thoughts and feelings that people sometimes have about patients or residents as care attendants.
in long-term care facilities. Caregivers choose a statement which best describes their thoughts and feelings about their ability to provide care at the facility they work. Caregivers are advised to rate each item based on how they generally feel about the topic. The Staff-to-Resident Communication (IC-COMMUNICATION-SR) sub-scale is a positively worded four point frequency scale (1 = never, 2 = sometimes, 3 = often and 4 = always) and has seven items which assess the different forms of communication used in the last 7 days between staff members and residents. Finally, the Staff-to-Staff communication (IC-COMMUNICATION-SS) sub-scale is a positively worded four-point frequency scale (1 = Never, 2 = Sometimes, 3 = Often and 4 = Always) which has 11 items assessing the different forms of communication between staff members used in the last 7 days. Although the ICI is free of copyright restrictions the author was informed about its use in this study.

The Index of Work Satisfaction Part B (IWS; Stamps 1997, 2001) was developed in the United States of America (USA) for the measurement of nurses’ work satisfaction and consists of 44 items on a seven point Likert-type scale (1 = strongly disagree, 7 = strongly agree). The scale requests the respondent’s opinion about work satisfaction in their current employment. In the 44 items there are six sub-scales: Pay (six items, three negatively worded items), Autonomy (eight items, three negatively worded), Task Requirements (six items, three negatively worded), Organisational Policies (seven items, three negatively worded), Professional Status (seven items, three negatively worded) and Interaction (10 items, five negatively worded). The interaction sub-scale is divided into two separate variables: Nurse–Nurse Interaction and Nurse–Physician Interaction. In this study the scores for the positively worded items were reversed so that average scores for the sub-variables could all be found by counting the individual item scores and dividing the count by the number of items.

The IWS, especially Part B, has been widely used and has proven reliability and validity. The \( z \)-value has been reported to be 0.82 for the total scale and 0.52–0.81 for the sum variables (Stamps 1997). Zangaro and Soeken (2005) conducted a meta-analysis about the studies that have used the IWS and reported an average \( z \)-value of 0.78 for the total IWS. Additionally, a principal component analysis provided a six factor solution explaining 52% of the variance in work satisfaction (Stamps 1997).

Data collection and ethical considerations

Ethical approval was obtained from the administrator and medical officer of the health care area and directors of the social services in each municipality. The same authority provided access to the research sites. The researchers used the principles in the Declaration of Helsinki (WMA 2008) to protect the rights of the participants before, during and after the completion of the study. Due to the nature of this study special attention was paid to safeguarding of the participants’ integrity, anonymity, voluntary participation and their right to withdraw from the study at any time.

Each of the sites had a named contact person who provided detailed written and verbal information to the potential participants who, on showing an interest, were asked for their oral informed consent. The data collection period was 4 weeks and a reminder was sent to the participants through their work place after 2 weeks. Completed questionnaires were returned in sealed envelopes to letter boxes in the participating wards. The return of the completed questionnaires was evidence of informed consent.

Statistical analysis

The data were analysed using the SPSS 16.0 (SPSS Inc., Chicago, IL, USA). Descriptive statistics (frequencies, percentages, means and standard deviations, minimum and maximum) were calculated for the sample characteristics, items and sum-variables. As the scale options in the three questionnaires used differed, the mean scores were converted to a 0–100 scale for ease of assessment. Sum-variables were formed by calculating the item scores and then dividing the total score by the number of items in the scales. Spearman’s correlation coefficients were calculated for the sub-scales to demonstrate possible associations between work satisfaction and individualised care. One-way analyses of variance (ANOVA, \( F \)-statistics, degrees of freedom with \( p \)-value with Tukey’s HSD post hoc multiple comparisons) were used to compare caregivers’ perceptions in different care settings for older people. If the Levene’s test of homogeneity of variances was violated the Brown–Forsythe robust test of equality of means was used and the post hoc comparisons were computed using Tamhane’s test.

Multiple regression analyses were computed to examine the extent the single IWS sub-scales explained perceptions of individualised care from the ICS-Nurse-B results. The explanatory power of predictor variables (\( R^2 \)) and the importance of individual predictors in the analysis with the standardised regression (beta) coefficients were inspected. Additionally, the internal consistency reliability of the sub-scales was computed obtaining \( z \)-values and the customary level of \( z \)-values above of 0.70 (Nunnally & Bernstein 1994) was used to accept the reliability of an instrument. Where
Results

Respondents
The mean age of the respondents was 44 years (SD 11, range 19–64) and most of them were females (99%, n = 260). The average lengths of work experience reported was 15 years (SD 10, range 0–43) and most were in full-time employment (94%) followed by part-time (5%) or only certain days (1%). About two thirds were licensed practical nurses (67%) and one quarter was registered nurses (24%). Some were home helps (4%) and others were nurse aids (5%). The nurses worked in: primary health care centres and in-patient wards (24%), nursing homes and sheltered housing with 24-h assistance (39%), sheltered housing residential homes offering health-related services (17%) and home health care (20%).

Individualised care
The participants reported high levels of individualised care supporting patients’ individuality through specific activities (mean 4.18, SD 0.58) and holding strong perceptions in relation to individuality in care provision generally (ICS-B-Nurse, mean 4.16, SD 0.56). In the ICS-A-Nurse, the Clinical Situation (Clin A) sub-scale showed the highest mean value (4.32, SD 0.57) and the Personal Life Situation (Pers A) sub-scale the lowest (mean 3.90, 0.85). For the ICS-B-Nurse the Clinical Situation (Clin B) sub-scale also showed the highest mean value (4.35, SD 0.52) and the Personal Life Situation sub-scale (Pers B) the lowest (mean 3.92, 0.77).

In the ICI scale the highest mean was measured for the sub-scale Staff-to-Staff Communication (mean 3.10 out of 4, SD 0.40). The lowest mean score was found in the Resident Autonomy sub-scale (mean 2.63 out of 5, SD 0.38). However, this sub-scale was scored with a reversed scale (Table 1).

Work satisfaction
The average work satisfaction score for the IWS in the sample was 4.30 (SD 0.57) (Table 1). Caregivers were most satisfied with their Professional Status (mean 5.41, SD 0.69), Interaction (mean 5.31, SD 0.89) and Autonomy (mean 4.77, SD 0.88). They were least satisfied with Pay (mean 2.75, SD 1.04), Organisational Policies (mean 3.68, SD 0.91) and Task Requirements (mean 3.70, SD 0.90) (Table 1).

Work satisfaction in association with individualised care
A statistically significant correlation was found between caregivers’ perceptions about the Support of Individuality (ICS-A-Nurse) and caregivers’ Work Satisfaction (IWS total) ($r = 0.303$, $p < 0.001$). Similarly, caregivers’ perceptions of Individuality in Care Provision (ICS-B-Nurse) were statistically significantly correlated with the IWS ($r = 0.235$, $p < 0.01$). Three out of the four domains of the ICI were positively associated with Work Satisfaction (IWS): Knowing-the-Person ($r = 0.592$, $p < 0.001$), Staff-to-Resident Communication ($r = 0.607$, $p < 0.01$) and Staff-to-Staff Communication ($r = 0.686$, $p < 0.01$) (Table 2).

In the multiple regression analysis the model for the association between Work Satisfaction (IWS) and perceptions of Individualised Care (ICS-B-Nurse) was statistically significant ($F = 4.69$, df = 7, $p < 0.001$). However, in the sub-scales only two were statistically significant: Pay ($t = -0.96$, $p = 3.39$), Professional Status ($t = 1.6$, $p = 0.290$), Autonomy ($t = 2.02$, $p = 0.044$), Organisational Policies ($t = 2.56$, $p = 0.011$), Task Requirements ($t = 0.28$, $p = 0.779$) and Interaction ($t = 0.33$, $p = 0.739$) which explained 11.5% ($R = 0.339$, $R^2 = 0.115$) of the dependent variable changes. The Autonomy and Organisational Policies sub-scales were therefore the most significant predictors of caregivers’ perceptions of individualised care.

Comparison of individualised care and work satisfaction in older people care settings
Analysis using the Brown–Forsythe robust test of equality of means revealed statistically significant differences in caregivers’ perceptions of the support of patient individuality through specific nursing activities ($p = 0.001$). Significant differences were found between staff working in home care and those working in primary health care in-patient wards ($p = 0.035$) and between staff working in home care and those working in nursing homes ($p < 0.001$) (Table 3). ANOVA revealed statistically significant differences in caregivers’ perceptions of individuality in the care they provided ($p < 0.001$). Post hoc comparisons showed differences between caregivers working in home care and those in primary health care in-patient wards ($p = 0.019$), between those in home care and nursing homes ($p < 0.001$) and finally, between those in sheltered housing and nursing homes ($p = 0.01$). Using the ICI, the only significant differences in caregivers’ perceptions in care settings for older people were found in the sub-scale Resident Autonomy (IC-AUTONOMY), where the scores of caregivers working in home care were high compared with those working in primary health care.
Carers and caregivers

Work satisfaction and individualised care

Table 1  Descriptive results on the ICS, ICI and IWS scales

<table>
<thead>
<tr>
<th>Sum variable</th>
<th>Scale options</th>
<th>Number of items</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Converted means</th>
<th>Cronbach’s alpha</th>
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<tbody>
<tr>
<td>Support of Patient Individuality (ICS-A)</td>
<td>1–5</td>
<td>17</td>
<td>4.18</td>
<td>0.58</td>
<td>1.88</td>
<td>5.00</td>
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<td>Clinical Situation (Clin A)</td>
<td>1–5</td>
<td>7</td>
<td>4.32</td>
<td>0.57</td>
<td>1.71</td>
<td>5.00</td>
<td>86.42</td>
<td>0.86</td>
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<tr>
<td>Personal Life Situation (Pers A)</td>
<td>1–5</td>
<td>4</td>
<td>3.90</td>
<td>0.85</td>
<td>1.00</td>
<td>5.00</td>
<td>78.09</td>
<td>0.85</td>
</tr>
<tr>
<td>Decisional Control (Dec A)</td>
<td>1–5</td>
<td>6</td>
<td>4.21</td>
<td>0.63</td>
<td>1.50</td>
<td>5.00</td>
<td>84.20</td>
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<tr>
<td>Individuality in care provided (ICS-B)</td>
<td>1–5</td>
<td>17</td>
<td>4.16</td>
<td>0.56</td>
<td>1.71</td>
<td>5.00</td>
<td>83.11</td>
<td>0.92</td>
</tr>
<tr>
<td>Clinical Situation (Clin B)</td>
<td>1–5</td>
<td>7</td>
<td>4.35</td>
<td>0.52</td>
<td>1.86</td>
<td>5.00</td>
<td>86.97</td>
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<tr>
<td>Personal Life Situation (Pers B)</td>
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<td>3.92</td>
<td>0.77</td>
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<td>5.00</td>
<td>78.37</td>
<td>0.75</td>
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<tr>
<td>Decisional Control (Dec B)</td>
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<td>4.09</td>
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<td>1.17</td>
<td>5.00</td>
<td>81.74</td>
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<td>Knowing the Person (IC-KNOW)</td>
<td>1–4</td>
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<td>2.91</td>
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<td>1.92</td>
<td>4.00</td>
<td>72.64</td>
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<td>Resident Autonomy (IC-AUTONOMY)</td>
<td>1–5*</td>
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<td>1.60</td>
<td>4.27</td>
<td>52.60</td>
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<td>Staff-to-Resident Communication (IC-COMMUNICATION-SR)</td>
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<td>1.71</td>
<td>4.00</td>
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<td>1–4</td>
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<td>3.10</td>
<td>0.40</td>
<td>2.00</td>
<td>4.00</td>
<td>77.39</td>
<td>0.80</td>
</tr>
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</table>

Table 2  Spearman’s rho correlations between the study variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Support of Patient Individuality (ICS-A)</td>
<td>0.75**</td>
<td></td>
<td></td>
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<td>2 Individuality in the Care Provided (ICS-B)</td>
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<td>0.44**</td>
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<tr>
<td>3 Knowing the Person (IC-KNOW)</td>
<td>0.38**</td>
<td>0.56**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Resident Autonomy (IC-AUTONOMY)</td>
<td>-0.40**</td>
<td>-0.56**</td>
<td>-0.30**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Staff-to-Resident Communication (IC-COMMUNICATION-SR)</td>
<td>0.37**</td>
<td>0.37**</td>
<td>0.51**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Staff-to-Staff Communication (IC-COMMUNICATION-SS)</td>
<td>0.40**</td>
<td>0.40**</td>
<td>0.51**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 IWS total</td>
<td>0.30**</td>
<td>0.23**</td>
<td>0.59**</td>
<td>-0.021</td>
<td>0.60**</td>
<td>0.68**</td>
</tr>
<tr>
<td>8 Pay</td>
<td>0.028</td>
<td>0.07**</td>
<td>0.046</td>
<td>-0.210**</td>
<td>0.004</td>
<td>0.013</td>
</tr>
<tr>
<td>9 Professional status</td>
<td>0.14**</td>
<td>0.16**</td>
<td>0.19**</td>
<td>-0.235**</td>
<td>0.21**</td>
<td>0.27**</td>
</tr>
<tr>
<td>10 Autonomy</td>
<td>0.22**</td>
<td>0.27**</td>
<td>0.39**</td>
<td>-0.449**</td>
<td>0.23**</td>
<td>0.35**</td>
</tr>
<tr>
<td>11 Organisational policies</td>
<td>0.18**</td>
<td>0.27**</td>
<td>0.25**</td>
<td>-0.454**</td>
<td>0.06**</td>
<td>0.31**</td>
</tr>
<tr>
<td>12 Task requirements</td>
<td>0.11**</td>
<td>0.15**</td>
<td>0.26**</td>
<td>-0.436**</td>
<td>0.13**</td>
<td>0.17**</td>
</tr>
<tr>
<td>13 Interaction</td>
<td>0.10**</td>
<td>0.127**</td>
<td>0.232**</td>
<td>-0.262**</td>
<td>0.123**</td>
<td>0.185**</td>
</tr>
</tbody>
</table>

*Correlations is significant at the 0:05 level (two-tailed).
**Correlations is significant at the 0:01 level (two-tailed).

Discussion

Generally, the findings support the initial hypothesis that perceptions of work satisfaction are positively associated care in-patient wards ($p = 0.006$). However, no differences were found in the caregivers’ perceptions of work satisfaction generally or in any of the sub-scales between the different types of institutions (Table 3).

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with perceptions of individualised care. Positive statistical correlations were found in the majority of sub-scales assessing individuality and work satisfaction. Negative correlations were found between Resident Autonomy and Work Satisfaction (total and individual scores) because the ICI-Autonomy sub-scale uses reversed scale options (Table 1).

The level of individualised care was assessed as high in all the care settings studied. However, in these results, statistically significant differences were found between the settings, with the home care setting claiming the highest levels of individualised care and the nursing homes the lowest. This means that, in this study, individualised care in long term care in-patient wards was perceived to be higher than in nursing homes. This is surprising, as previously, a lack of attention to individuality in long-term care in-patient wards has been reported (Alkema et al. 2006, Teeri et al. 2006, Wilson & Neville 2008). However, this finding is based solely on nurses’ perspectives and shows the need for a closer examination of the working environment, the organisation of nursing work and staffing levels as these have been found to effect on the delivery of individualised care (Brown Wilson & Davies 2009, Suhonen et al. 2009). Additionally, future studies should include patients’ perspectives as these may differ from those of caregivers.

The level of work satisfaction was also reported higher in this study, compared with previous studies conducted in care settings for older people (Castle et al. 2006). In this study, a positive relationship was found between the caregivers’ perceptions about the support of individuality (ICS-A-Nurse) and caregivers’ work satisfaction, as well as caregivers perceptions of individuality in the care provided (ICS-B-Nurse) and work satisfaction. This is in line with previous studies where nurses felt that outcomes of teaching and caring for individuals are rewarding and contribute to productivity at work (McNeese-Smith 2001). In addition, three out of the four individual domains of the ICI were positively associated with work satisfaction: Knowing the Person, Staff-to-Resident Communication and Staff-to-Staff Communication. These results confirm the previously suggested association between individualised care and work satisfaction (Tellis-Nayak 2007, Edvardsson et al. 2011) which, until now, has not been clearly reported. Developing this theme, our analyses show that in the IWS, Autonomy and Organisational Policies were the most significant predictors of caregivers’ perceptions of individualised care. This is aligned with previous evidence that individualised care is associated with nurses’ autonomy at work (Tellis-Nayak 2007, Caspar & O’Rourke 2008, Suhonen et al. 2010c), care performance, organisational policies, organisation of nursing work and the working environment (Cohen-Mansfield & Parpura-Gill 2008, Suhonen et al. 2009).
Limitations and methodological considerations

Although a total sampling strategy was used it was only employed to sample one heterogeneous group of care givers of different grades from different organisations in one healthcare area in Finland. This limits the international generalisability of the study even though the response rate (71%) was good. In the multiple regression analysis, surprisingly, only two statistically significant predictors were found. The inspection of the distributions of the residuals shows residuals that are not normally distributed suggesting that the model does not perfectly fit and further indicating that the associations are not necessarily linear or that there may be outliers in the data.

The data were collected using validated instruments. The overall ability of the ICS-A and ICS-B scales to assess individualised care is high with $\alpha$-values of 0.93 (total) and 0.92 (total), respectively. The Personal Life Situation (Pers B) sub-scale was the lowest ($\alpha = 0.75$). The ICI, also demonstrated acceptable $\alpha$-values ($\alpha = 0.71$ total) with the exception of the Staff-to-Resident Communication sub-scale ($\alpha = 0.63$). Finally the IWS also demonstrated an acceptable $\alpha$-value ($\alpha = 0.86$ total) but for the sub-scales Professional Status and Nurse-to-Nurse Interaction both $\alpha$-values were found to be below the acceptable levels at 0.50 and 0.53, respectively. These results are consistent with previous studies evaluating the internal consistency of these scales (Stamps 1997, 2001, Chappell et al. 2007, Suhonen et al. 2009, Charalambous et al. 2010).

Conclusions

The results in this study revealed a positive correlation between the work satisfaction (dependent variable) and the independent variables: Support of Patient Individuality, Individuality in the Care Provided, Knowing the Person, Staff-to-Staff Communication and Staff-to-Resident Communication. These findings provide empirical evidence for the research hypothesis, suggesting that strategies designed to enhance the provision of individualised care could be focused on aspects relating to work satisfaction.

High levels of individuality of care and a moderate level of work satisfaction were reported in the sample. This finding is positive and provides evidence for a higher level of quality of the working environment in care settings for older people than has previously been found. There is now a need for a further examination of the working environment, the organisation of care giving work and staffing levels in nursing homes and long-term care institutions to explore the nature of these associations and contradictions.

 Recommendation for future research

This study design should be replicated with larger numbers and include a focused sample of e.g. nurses working in nursing homes so that perceptions of individualised care and work satisfaction can be compared with caregivers in the other care settings for older people. In addition, it would be useful to examine the factors that might affect caregiver perceptions of these concepts. Studying caregivers with different cultural backgrounds would also provide a more complete understanding of individualised care, work satisfaction and their relationship. The purpose of such a study would be to investigate how work satisfaction is perceived to influence the provision of individualised care by caregivers in other countries compared with caregivers in Finland. There is also a need to examine older people’s perceptions of individualised care as comparators to the caregivers’ assessments.

Relevance to clinical practice

The assessment of caregivers’ work satisfaction is a valuable tool for nurse managers who wish to measure and improve individualised care and patients’ outcomes. This may require the incorporation of the individualised care assessment in care settings for older people as a means to improve clinical practice and to develop the skills of the workforce. Improved work satisfaction will facilitate the provision of a better quality of care for older people and will also help caregivers to stay committed to their work in care settings for older people.

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Contributions

Study design: RS, AC, MS, MP; data collection and analysis: RS, JK, MS and manuscript preparation: RS, AC, MS, JK, MP.

Conflict of interest

There is no conflict of interest.
References


Carers and caregivers


patients, relatives and nurses in Finland. *Nursing Ethics* 13, 116–129.


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