

CARERS AND CAREGIVERS

Caregivers' work satisfaction and individualised care in care settings for older people

Riitta Suhonen, Andreas Charalambous, Minna Stolt, Jouko Katajisto and Markku Puro

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 (Sahyoun *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, Burtson & 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). Muntlin *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, Burtson & 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 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 (α) 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 α -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 α -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 α -values and the customary level of α -values above of 0.70 (Nunnally & Bernstein 1994) was used to accept the reliability of an instrument. Where

probability values were computed p -values of <0.05 were considered statistically significant.

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, SD 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) ($r = 0.303$, $p < 0.01$). 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 ($t = -0.96$, $p = 0.339$), Professional Status ($t = 1.06$, $p = 0.290$), 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

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

Sum variable	Scale options	Number of items	Mean	SD	Min	Max	Converted means	Cronbach's alpha
Support of Patient Individuality (ICS-A)	1-5	17	4.18	0.58	1.88	5.00	83.68	0.93
Clinical Situation (Clin A)	1-5	7	4.32	0.57	1.71	5.00	86.42	0.86
Personal Life Situation (Pers A)	1-5	4	3.90	0.85	1.00	5.00	78.09	0.85
Decisional Control (Dec A)	1-5	6	4.21	0.63	1.50	5.00	84.20	0.84
Individuality in care provided (ICS-B)	1-5	17	4.16	0.56	1.71	5.00	83.11	0.92
Clinical Situation (Clin B)	1-5	7	4.35	0.52	1.86	5.00	86.97	0.85
Personal Life Situation (Pers B)	1-5	4	3.92	0.77	1.00	5.00	78.37	0.75
Decisional Control (Dec B)	1-5	6	4.09	0.69	1.17	5.00	81.74	0.86
Knowing the Person (IC-KNOW)	1-4	13	2.91	0.38	1.92	4.00	72.64	0.71
Resident Autonomy (IC-AUTONOMY)	1-5*	15	2.63	0.38	1.60	4.27	52.60	0.72
Staff-to-Resident Communication (IC-COMMUNICATION-SR)	1-4	7	2.73	0.35	1.71	4.00	68.21	0.63
Staff-to-Staff Communication (IC-COMMUNICATION-SS)	1-4	11	3.10	0.40	2.00	4.00	77.39	0.80
IWS total	1-7	44	4.30	0.57	2.43	6.34	61.40	0.86
Pay	1-7	6	2.71	1.04	1.00	6.00	39.34	0.76
Professional status	1-7	7	5.41	0.69	2.71	7.00	77.18	0.50
Autonomy	1-7	8	4.77	0.88	2.50	6.88	68.05	0.70
Organisational policies	1-7	7	3.68	0.91	1.14	6.14	52.58	0.69
Task requirements	1-7	6	3.70	0.90	1.33	7.00	52.79	0.64
Interaction	1-7	10	4.88	0.82	2.56	6.80	69.67	0.71
Nurse-Nurse	1-7	5	5.31	0.89	1.50	7.00	75.89	0.53
Nurse-Physician	1-7	5	4.45	1.14	1.00	7.00	63.48	0.76

*Reversed scale options.

Table 2 Spearman's rho correlations between the study variables

Variables	1	2	3	4	5	6
1 Support of Patient Individuality (ICS-A)						
2 Individuality in the Care Provided (ICS-B)	0.751**					
3 Knowing the Person (IC-KNOW)	0.387**	0.440**				
4 Resident Autonomy (IC-AUTONOMY)	-0.401**	-0.493**	-0.562**			
5 Staff-to-Resident Communication (IC-COMMUNICATION-SR)	0.372**	0.290**	0.374**	-0.304**		
6 Staff-to-Staff Communication (IC-COMMUNICATION-SS)	0.404**	0.397**	0.404**	-0.430**	0.511**	
7 IWS total	<u>0.303**</u>	<u>0.235**</u>	<u>0.592**</u>	-0.021	<u>0.607**</u>	<u>0.686**</u>
8 Pay	0.028	-0.007	0.046	-0.210**	0.004	-0.013
9 Professional status	0.144*	0.160**	0.193**	-0.235**	0.215**	0.277**
10 Autonomy	0.228**	0.275**	0.392**	-0.449**	0.233**	0.352**
11 Organisational policies	0.181**	0.272**	0.252**	-0.454**	0.069	0.310**
12 Task requirements	0.111	0.159**	0.266**	-0.436**	0.130*	0.179**
13 Interaction	0.103	0.127*	0.232**	-0.262**	0.123*	0.185**

*Correlations is significant at the 0.05 level (two-tailed).

**Correlations is significant at the 0.01 level (two-tailed).

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).

Discussion

Generally, the findings support the initial hypothesis that perceptions of work satisfaction are positively associated

Table 3 Comparison of nurses' work satisfaction in different care settings for older people

Care settings	Primary healthcare	Nursing	Sheltered	Home	F (df)	p-value
	In-patient ward	Homes	Housing	Care		
Sum-variables	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		
Support of Patient Individuality (ICS-A-Nurse)	4.14 (0.64)	4.05 (0.62)	4.28 (0.56)	4.40 (0.35)	5.57 (3) α	0.001
Individuality in Care Provided (ICS-B-Nurse)	4.09 (0.61)	4.00 (0.57)	4.31 (0.43)	4.38 (0.44)	7.43 (3) #	< 0.001
Knowing the Person (IC-KNOW)	2.83 (0.37)	2.92 (0.39)	3.01 (0.34)	2.88 (0.39)	2.23 (3) #	0.085
Resident Autonomy (IC-AUTONOMY) obs reversed scale	2.74 (0.46)	2.67 (0.35)	2.55 (0.30)	2.51 (0.36)	4.53 (3) #	0.004
Staff-to-Resident Communication (IC-COMMUNICATION-SR)	2.72 (0.30)	2.74 (0.40)	2.79 (0.35)	2.69 (0.23)	0.77 (3) α	0.514
Staff-to-Staff Communication (IC-COMMUNICATION-SS)	2.99 (0.36)	3.13 (0.41)	3.11 (0.40)	3.14 (0.40)	2.07 (3) #	0.105
IWS total	4.24 (0.60)	4.30 (0.56)	4.25 (0.50)	4.38 (0.59)	0.68 (3) #	0.564
Pay	2.94 (0.97)	2.67 (1.06)	2.87 (0.98)	2.57 (1.11)	1.58 (3) #	0.195
Professional status	5.34 (0.75)	5.36 (0.62)	5.37 (0.73)	0.68 (0.68)	1.50 (3) #	0.216
Autonomy	4.53 (0.89)	4.83 (0.86)	4.72 (0.81)	4.92 (0.98)	2.20 (3) #	0.088
Organisational policies	3.47 (0.95)	3.73 (0.97)	3.62 (0.83)	3.85 (0.80)	1.83 (3) #	0.142
Task requirements	3.70 (0.91)	3.73 (0.93)	3.73 (0.92)	3.58 (0.85)	0.37 (3) #	0.775
Interaction	4.87 (0.83)	4.85 (0.83)	4.69 (0.85)	5.06 (0.78)	1.68 (3) #	0.172

Brown-Forsythe.

#ANOVA: one-way analysis of variance, degrees of freedom.

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 α -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 α -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 α -value ($\alpha = 0.86$ total) but for the sub-scales Professional Status and Nurse-to-Nurse Interaction both α -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 focussed 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

- Abbey J, Abbey B, Bridges P, Elder R, Lemcke P, Liddle J & Thornton R (2006) Clinical placements in residential aged care facilities: the impact on nursing students' perception of aged care and the effect on career plans. *Australian Journal of Advanced Nursing* 23(4), 14–19.
- Al-Hussami M (2008) A study of nurses' job satisfaction: the relationship to organizational commitment, perceived organizational support, transactional leadership, transformational leadership and level of education. *European Journal of Scientific Research* 22, 286–295.
- Alkema GE, Reyes JY & Wilber KH (2006) Characteristics associated with home- and community-based service utilisation for Medicare managed care consumers. *Gerontologist* 46, 173–182.
- Brown Wilson C & Davies S. (2009) Developing relationships in long term care environments: the contribution of staff. *Journal of Clinical Nursing* 18, 1746–1755.
- Burtson PL & Stichter JF (2010) Nursing job environment and nurse caring: relationship among motivational factors. *Journal of Advanced Nursing* 66, 1819–1831.
- Caspar S & O'Rourke N (2008) The influence of care provider access to structural empowerment on individualized care in long-term-care facilities. *Journals of Gerontology Series B: Psychological Sciences & Social Sciences* 63B, S255–S265.
- Castle NG, Degenholtz H & Rosen J (2006) Determinants of staff job satisfaction of caregivers in two nursing homes in Pennsylvania. *BMC Health Services Research* 24, 60.
- Chappell NL, Reid RC & Gish JA (2007) Staff-based measures of individualized care for persons with dementia in long-term care facilities. *Dementia* 6, 527–547.
- Charalambous A, Katajisto J, Välimäki M, Leino-Kilpi H & Suhonen R (2010) Individualised care and the professional practice environment: nurses' perceptions. *International Nursing Review* 57, 500–507.
- Chenoweth L, Jeon YH, Merlyn T & Brodaty H (2010) A systematic review of what factors attract and retain nurses in aged and dementia care. *Journal of Clinical Nursing* 19, 156–167.
- Cohen-Mansfield J & Jensen B (2005) The preference and importance of bathing, toileting and mouth care habits in older persons. *Gerontology* 51, 375–385.
- Cohen-Mansfield J & Parpura-Gill A (2008) Practice style in the nursing home: dimensions for assessment and quality improvement. *International Journal of Geriatric Psychiatry* 23, 376–386.
- Courtney M, Tong S & Walsh A (2000) Acute-care nurses' attitudes towards older patients: a literature review. *International Journal of Nursing Practice* 6, 62–69.
- Edvardsson D, Fetherstonhaugh D, McAuliffe L, Nay R & Chenco C (2011) Job satisfaction amongst aged care staff: exploring the influence of person-centered care provision. *International Psychogeriatrics* 5, 1–8.
- Estes C, Biggs S & Phillipson C (2003). *Social Theory, Social Policy and Aging*. Open University Press, Milton Keynes.
- ETENE (2008). *Old Age and Ethics of Care*. Report of the National Advisory Board on Health Care Ethics (ETENE). http://www.etene.fi/c/document_library/get_file?folderId=18388&name=DLFE-668.pdf (11 September 2011).
- Flanagan NA (2006) Testing the relationship between job stress and satisfaction in correctional nurses. *Nursing Research* 55, 316–327.
- Flinkman M, Leino-Kilpi H & Salanterä S (2010) Nurses' intention to leave the profession: integrative review. *Journal of Advanced Nursing* 66, 1422–1434.
- Florin J, Ehrenberg A & Ehnfors M (2005) Patients' and nurses' perceptions of nursing problems in an acute care setting. *Journal of Advanced Nursing* 51, 140–149.
- Foley M, Lee J, Wilson L, Young Cureton V & Canham D (2004) A multi-factor analysis of job satisfaction among school nurses. *Journal of School Nursing* 20, 94–100.
- Forma L, Rissanen P, Aaltonen M, Raitanen J & Jylhä M (2011) Dementia as a determinant of social and health service use in the last two years of life 1996–2003. *BMC Geriatrics* 11, 14. doi:10.1186/1471-2318-11-14.
- Goldman A & Tabak N (2010) Perception of ethical climate and its relationship to nurses' demographic characteristics and job satisfaction. *Nursing Ethics* 17, 233–246.
- Hall P, Weaver L, Gravelle D & Thibault H (2007) Developing collaborative person-centred practice: a pilot project on a palliative care unit. *Journal of Interprofessional Care* 21, 69–81.
- Hasson H & Arnetz JE (2008) Nursing staff competence, work strain, stress and satisfaction in elderly care: a comparison of home-based care and nursing homes. *Journal of Clinical Nursing* 17, 468–481.
- Hertzberg F, Mausner B & Snyderman B. (1959) *The Motivation to Work*, 2nd edn. John Wiley and Sons, New York.
- Jirovec MM & Templin T (2001) Predicting success using individualized scheduled toileting for memory-impaired elders at home. *Research in Nursing & Health* 24, 1–8.
- Kassner E & Bertel RW (1998) *Midlife and older Americans with disabilities: who gets help?* A chart book. <http://research.aarp.org/il/d16883.midlife.l.html> (31 March 2011).
- Kloster T, Høie M & Skår R (2007) Nursing students' career preferences: a Norwegian study. *Journal of Advanced Nursing* 59, 155–162.
- Kovach CR, Cashin JR & Sauer L (2006) Deconstruction of a complex tailored intervention to assess and treat discomfort of people with advanced dementia. *Journal of Advanced Nursing* 55, 378–388.
- Kovach CR, Simpson MR, Reitmaier AB, Johnson A & Kelber ST (2010) Do personality traits predict work outcomes of certified nursing assistants? *Research in Gerontological Nursing* 3, 253–261.
- Kovner CT, Mezey M & Harrington C (2002) Who cares for older adults? Workforce implications of an aging society. *Health Affairs* 21, 78–89.
- Kwak C, Chung BY, Xu Y & Eun-Jung C (2010) Relationship of job satisfaction with perceived organizational support and quality of care among South Korean nurses: a questionnaire survey. *International Journal of Nursing Studies* 47, 1292–1298.

- Lake ET & Friese CR (2006) Variations in nursing practice environments: relation to staffing and hospital characteristics. *Nursing Research* 55, 1–9.
- Lauver DR, Ward SE, Heidrich SM, Keller ML, Bowers BJ, Brennan PF, Kirchoff KT & Wells TJ (2002) Patient-centered interventions. *Research in Nursing & Health* 25, 246–255.
- Leka S & Jain A. (2010) *Health Impact of Psychosocial Hazards at Work: An Overview*. World Health Organization. http://whqlibdoc.who.int/publications/2010/9789241500272_eng.pdf (24 January 2011).
- McNeese-Smith D (2001) Staff nurse views of their productivity and non-productivity. *Health Care Management Review* 26(2), 7–19.
- Moser K (1997) Commitment in organizations. *Psychologies* 41, 160–170.
- Mulrow CD, Gerety MB, Kanten D, Cornell JE, DeNino LA, Chiodo L, Aguilar C, O'Neil MB, Rosenberg J & Solis RM (2004) A randomized trial of physical rehabilitation for very frail nursing home residents. *JAMA the Journal of the American Medical Association* 271, 519–24.
- Muntlin A, Gunningberg L & Carlsson M. (2006) Patients' perceptions of quality of care at an emergency department and identification of areas for quality improvement. *Journal of Clinical Nursing* 15, 1045–1056.
- Murphy K (2007) A qualitative study explaining nurses' perceptions of quality care for older people in long-term care settings in Ireland. *Journal of Clinical Nursing* 16, 477–485.
- National Center for Health Statistics (2005) *Health, United States, 2005. With Chartbook on Trends in the Health of Americans*. National Center for Health Statistics, Hyattsville (MD).
- Nunnally JC & Bernstein IH (1994). *Psychometric Theory*, 3rd edn. McGraw-Hill, New York.
- OECD (2004). *Towards High-Performing Health Systems*. OECD Health Project. Organisation for Economic Co-operation and Development OECD Publications 2, Paris, France (Publication Services).
- O'Rourke N, Chappell NL & Caspar S (2009) Measurement and analysis of Individualized Care Inventory responses comparing long-term care nurses and care aides. *Gerontologist* 49, 839–846.
- Powell JS (2010) The power of global aging. *Ageing International* 35, 1–14.
- Powell JS & Leedham C (2009) Post-industrial society and ageing in a global world: the demographic context of social welfare 2009. In *The Welfare State in Post-Industrial Society* (Powell JL & Hendricks J eds). Springer, New York, NY, pp. 141–159.
- Purdy N, Spence Laschinger HK, Finegan J, Kerr M & Olivera F (2010) Effects of work environments on nurse and patient outcomes. *Journal of Nursing Management* 18, 901–913.
- Radwin LE & Alster K (2002) Individualised nursing care: an empirically generated definition. *International Nursing Review* 49, 54–63.
- Radwin LE, Carbal HJ & Wilkes G (2009) Relationships between patient-centred cancer nursing interventions and desired health outcomes in the context of the health care system. *Research in Nursing & Health* 32, 4–17.
- Rakich JS, Longest BB & Darr K (1985). *Managing Health Services Organizations*, 2nd edn. W.B. Saunders Co, Philadelphia, PA.
- Rakowski W, Ehrich B, Goldstein MG, Rimer BK, Pearlman DN, Clark MA, Velicer WF & Woolverton H (1998) Increasing mammography among women aged 40–74 by use of a stage-matched, tailored intervention. *Preventive Medicine* 27, 748–756.
- Ross F, Smith E, Mackenzie A & Masterson A (2004) Identifying research priorities in nursing and midwifery service delivery and organisation: a scoping study. *International Journal of Nursing Studies* 41, 547–558.
- Ruggiero JS (2005) Health, work variables and job satisfaction among nurses. *Journal of Nursing Administration* 35, 254–263.
- Sahyoun NR, Pratt LA, Lentzner H, Dey A & Robinson KN (2001) *The Changing Profile of Nursing Home Residents: 1985–1997*. Aging Trends No. 4. National Center for Health Statistics, Hyattsville (MD).
- Schnelle JF, Cruise PA, Alessi CA, Al-Samarrai N & Ouslander JG (1998) Individualized night time incontinence care in nursing home residents. *Nursing Research* 47, 197–204.
- Slater P, McCormack B & Bunting B (2009) The development and pilot testing of an instrument to measure nurses' working environment: the Nursing Context Index. *Worldviews on Evidence-Based Nursing* 6, 173–182.
- Stamps P (1997) *Nurses and Work Satisfaction. An Index for Measurement*, 2nd edn. Health Administration Press, Chicago, IL.
- Stamps P (2001) *Scoring Workbook for the Index of Work Satisfaction®*. Market Street Research Publications, Amherst, MA.
- Suhonen R, Välimäki M & Leino-Kilpi H (2008) A review of outcomes of individualised nursing interventions on adult patients. *Journal of Clinical Nursing* 17, 843–860.
- Suhonen R, Välimäki M & Leino-Kilpi H (2009) The driving and restraining forces that promote and impede the implementation of individualised nursing care: a literature review. *International Journal of Nursing Studies* 46, 1637–1649.
- Suhonen R, Gustafsson M-L, Katajisto J, Välimäki M & Leino-Kilpi H (2010a) Individualised Care Scale-Nurse version: a Finnish validation study. *Journal of Evaluation in Clinical Practice* 16, 145–154.
- Suhonen R, Gustafsson M-L, Katajisto J, Välimäki M & Leino-Kilpi H. (2010b) Nurses' perceptions of individualised care. *Journal of Advanced Nursing* 66, 1035–1046.
- Suhonen R, Gustafsson M-L, Lamberg E, Välimäki M, Katajisto J & Leino-Kilpi H (2010c). A theory of individualised nursing care – professional practice environment and nurse autonomy as parts of the theory. *Hoitotiede*, 22, 184–194 (in Finnish, English abstract).
- Suhonen R, Papastavrou E, Efstathiou G, Lemonidou C, Kalafati M, Antunes da Luz MD, Idvall E, Berg A, Acaroglu R, Sendir M, Kanan N, Sousa VD, Katajisto J, Välimäki M & Leino-Kilpi H (2011) Nurses' perceptions of individualised care: an international comparison. *Journal of Advanced Nursing* 67, 1895–1907.
- Takase M, Kershaw E & Burt L. (2001) Nurse–environment misfit and nursing practice. *Journal of Advanced Nursing* 35, 819–826.
- Teeri S, Leino-Kilpi H. & Välimäki M (2006) Long-term nursing care of elderly people: identifying ethically problematic experiences among

- patients, relatives and nurses in Finland. *Nursing Ethics* 13, 116–129.
- Tellis-Nayak V (2007) A person-centered workplace: the foundation for person-centered caregiving in long-term care. *Journal of the American Medical Directors Association* 8, 46–54.
- U.S. Census Bureau (2009) *An Aging World: 2008*. <http://www.census.gov/prod/2009pubs/p95-09-1.pdf> (2 June 2011).
- Utriainen K & Kyngäs H (2009) Hospital nurses' job satisfaction: a literature review. *Journal of Nursing Management* 17, 1002–1010.
- Weisman CS, Alexander CS & Chase GA (1980) Job satisfaction among hospital nurses: a longitudinal study. *Health Services Research* 15, 341–364.
- WHO (2004). *Towards Age-Friendly Primary Health Care*. World Health Organisation, Paris. <http://whqlibdoc.who.int/publications/2004/9241592184.pdf> (19 March 2009)
- WHO (2006) *Working Together for Health*. The World Health Report 2006. World Health Organization, Geneva, Switzerland.
- WHO (2007) *People-Centred Health Care*. A Policy Framework: World Health Organisation. WHO Press, Geneva, Switzerland.
- WHO (2008) The World Health Report 2008: Primary Health Care, Now More Than Ever. Switzerland. http://www.who.int/whr/2008/whr08_en.pdf (17 May 2009).
- Wilson D & Neville S (2008) Nursing their way not our way: working with vulnerable and marginalised populations. *Contemporary Nurse* 27, 165–176.
- WMA (2008). *WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects*. Adopted by the 59th WMA General Assembly, Seoul, Korea, October 2008 <http://www.wma.net/en/30publications/10policies/b3/> (22 June 2011)
- Zangaro GA & Soeken KL (2005) Meta-analysis of the reliability and validity of Part B of the Index of Work Satisfaction across studies. *Journal of Nursing Measurement* 13, 7–22.
- Zimmerman S, Williams CS, Reed PS, Boustani M, Preisser JS, Heck E & Sloane PD (2005) Attitudes, stress and satisfaction of staff who care for residents with dementia. *Gerontologist* 45, 96–105.

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