Nöjdhet och skillnader inom brukarorienterad äldreomsorg

Doktorsavhandlingar vid Göteborgs universitet
ISSN: 1101-718X Avhandling/Göteborgs universitet, Psykologiska institutionen
ISRN: GU/PSYK/AVH—324—SE Printed in Sweden
ISBN: 978-91-982353-9-5
http://hdl.handle.net/2077/40893
Tryckt av Ineko, Göteborg, Sverige, 2015

DEGREE OF DOCTORATE IN PSYCHOLOGY

ABSTRACT

Kajonius, P. J. (2015). *An Inquiry into Satisfaction and Variations in User-Oriented Elderly Care.* Department of Psychology, University of Gothenburg, Sweden

The foundation for this thesis is an ongoing discussion about quality in Swedish elderly care: Which are the most important factors that contribute to elderly care in terms of satisfaction among older persons, and what are the primary reasons for their differences?

Aims. The principal aim was to examine *what* determines satisfaction with elderly care in home care and nursing homes, using the perspective of older persons (Studies I and II). The secondary aim was to analyze *why* these determinants differ, using the perspective of care workers, managers, and observers (Studies III and IV).

Methods. *Study I* analyzed aggregated statistical data from the level of municipalities and districts (N = 324) based on the Swedish elderly care quality reports "Open Comparisons", while *Study II* analyzed individual data based on the original ratings in the annual, nationwide elderly surveys (N = 95,000). *Study III* describes field observations and interviews with care workers and managers in two municipalities, one with a high rating for user satisfaction and one with an average rating. *Study IV* describes investigations in these two municipalities concerning their organizing principles and departmental-level management climate.

Results. The results relating to the principal aim showed that process factors (such as respect, information, and influence) are related considerably more closely than structural factors (such as budget, staffing levels, and training levels) to satisfaction with care. Other process factors (such as treatment, safeness, staff and time availability) were also able to alleviate person factors (such as health, anxiety, and loneliness). Moreover, the results relating to the secondary aim showed that differences in user-oriented elderly care are mainly due to interpersonal factors between the caregiver and the older person. Care workers, however, reported that other factors (such as organizing principles and leadership support) influence the quality of the care process. Overall, older persons who receive home care generally report higher satisfaction with care than those in nursing homes, and feeling less safe. It may be that differences in the process of aging explain this.

Value. This thesis shows that satisfaction with elderly care can be largely explained by psychological quality at the individual level. The sizes of structural resources and organizing principles at the municipal level have minimal effect (< 5%). The thesis also presents a theoretical multiple-level *Quality Agents Model* to explain the sources of differences in satisfaction with care, and it presents recommendations for elderly care practices. A renewed focus on the psychology of satisfaction may contribute to the development of quality in elderly care.

Keywords: elderly care, quality, structure, process, satisfaction, user-oriented care

SAMMANFATTNING PÅ SVENSKA

Bakgrunden för denna avhandling är nöjdhet inom svensk äldreomsorg. Det dominerande förhållningssättet inom både privat och offentlig omsorg är det individanpassade sättet, även kallad brukarorientering, vilket kännetecknas av att den äldre personens behov och önskemål är det centrala i verksamheten. Idag når allt fler personer en hög ålder och förväntningarna från de äldre själva och deras anhöriga anses som allt viktigare. Nöjdhet utifrån den äldres perspektiv är idag en av de viktigaste kvalitetsindikatorerna inom äldreomsorgen. För att fortsatt kunna upprätthålla en hög nivå i framtiden behövs mer kunskap om vilka faktorer som påverkar graden av nöjdhet och förståelse om varför skillnader uppstår.

Det första syftet med avhandlingen var att undersöka *vad* som genererar nöjdhet i äldreomsorgen ur de äldres perspektiv, i hemtjänsten och på äldreboenden. Data från Socialstyrelsens rikstäckande rapport Öppna Jämförelser om äldres erfarenheter av äldreomsorg utgjorde underlag för statistiska analyser: *Studie I* utgick från omsorgskvalitet i termer av struktur och process och inkluderade alla Sveriges 324 kommunenheter med resultat på kommun-nivå. Resultaten visade att strukturella faktorer (budget, personaltäthet och personalens utbildningsnivå) visade svaga eller inga samband, medan process faktorer (erfarenheter av respekt, information och äldres inflytande) uppvisade starka samband med omsorgsnöjdhet. *Studie II* baserades på de äldres individuella svar (N = 95,000) och analyserade hur omsorgsprocessen samspelade med de äldres egna egenskaper. Process faktorer (erfarenheter av bemötande, trygghet, personal- och tidstillgång) hade ett starkare samband med nöjdhet, jämfört med individuella faktorer (hälsa, ångest och ensamhet). Vidare påvisades att effekten av de äldres upplevda ensamhet kunde motverkas genom trygghet och ett bra bemötande. Äldre personer med hemtjänst kände sig i allmänhet mer nöjda än äldre personer i äldreboende, men upplevde också mindre trygghet, vilket troligen beror på skillnader i åldrandets progress.

Det andra syftet med avhandlingen var att förstå *varför* omsorg varierar i kvalitet och vad som kännetecknar en framgångsrik organisation i äldreomsorgen. Till *Studie III* utvaldes två likvärdiga kommuner gällande storlek och geografiskt läge för observationsbaserade fältstudier, varav en var högre rankad och en mer genomsnittlig utifrån Socialstyrelsens årliga nöjdhetsundersökningar. I varje kommun observerades och intervjuades medarbetare och chefer om vad som kunde förklara skillnader i omsorgsprocessen. Resultaten påvisade att omsorgsvariation på individ-nivå kunde delas in i fem teman: uppgiftsfokus, personfokus, påverkan, samarbete och tidsanvändning. En teoretisk modell togs fram som syftade till att förklara variation inom brukarorienterad äldreomsorg utifrån flera nivåer (den äldre, medarbetaren, enheten, förvaltningen och kommunen). *Studie IV* eftersträvade att identifiera principer i de två kommunerna som kännetecknar framgångsrikt organiserad äldreomsorg. Resultaten ifrån förvaltningsnivån påvisade tre kännetecknande drag för verksamheten med högre äldre-nöjdhet: 1) omsorgen organiserades utifrån behoven hos den äldre personen och inte lika mycket utifrån verksamhetens behov, 2) rekrytering och utbildning strävade mot att ta in och skapa självständiga medarbetare, 3) vid uppkomna

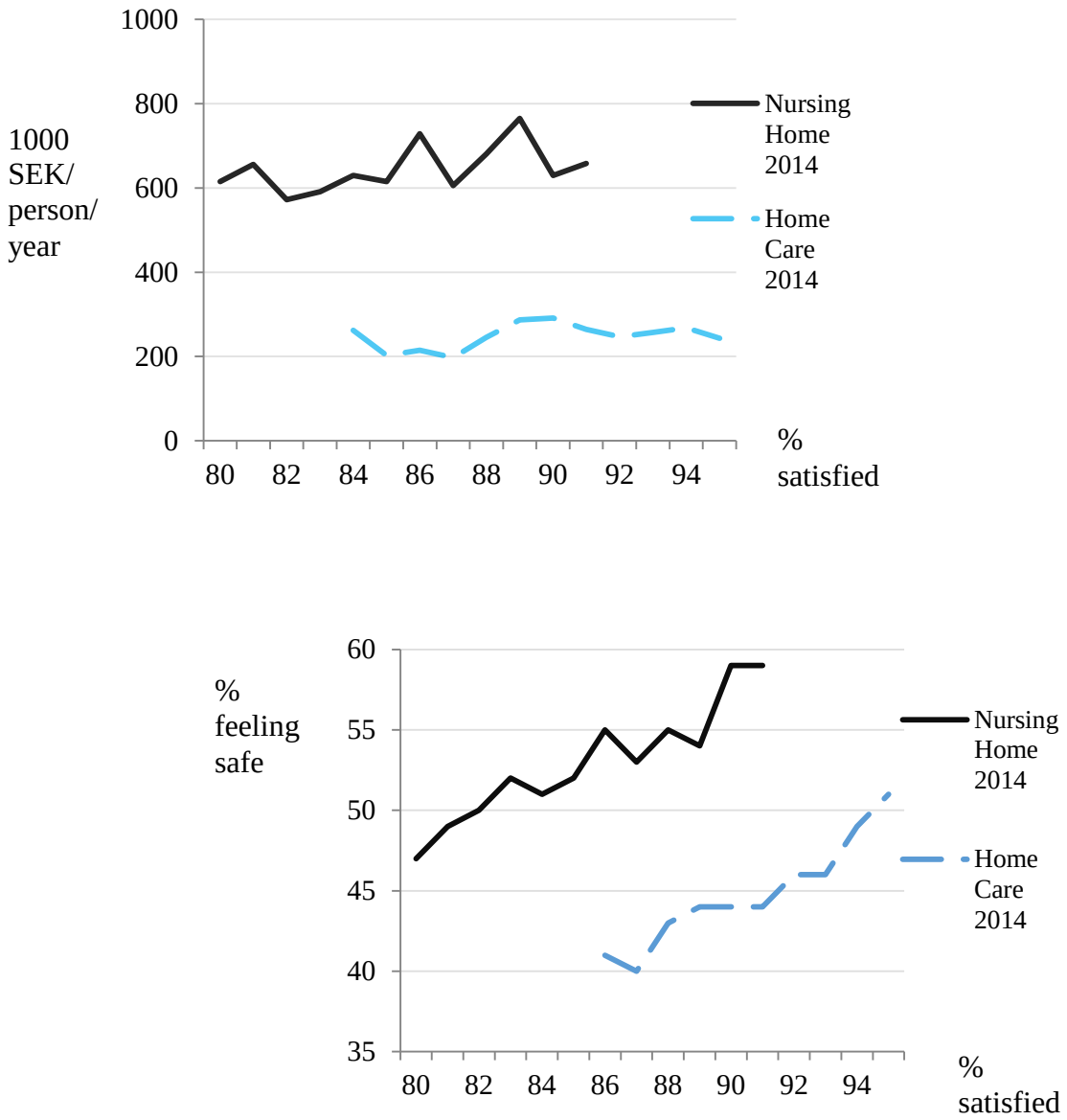
problem hade uppdraget prioritet över regler och strukturer. Den mer framgångsrika förvaltningen kännetecknades av ett arbetsklimat präglat av motivation och flexibilitet, medan det arbetsklimatet i den andra förvaltningen kännetecknades mer av att göra saker rätt.

Slutsatsen ifrån avhandlingen är att nöjdhet med äldreomsorg i Sverige till stor del kan förklaras ur ett psykologiskt perspektiv genom äldre personers uppfattning om omsorgsprocessen (bemötande och trygghet), och endast i liten mån (< 5%) genom storleken på strukturella resurser eller hur man organiserar omsorgen. Detta har konstaterats ifrån flera perspektiv: Den äldres perspektiv, genom statistiska data; ifrån medarbetare och ledningsperspektiv, genom intervjuer; och genom strukturerade observationer ifrån ett observatörsperspektiv. Avhandlingen sökte också expandera teoribildning och inspirera framtida forskning genom att lägga fram en socialpsykologisk modell tänkt att kunna förklara variationer i brukarorienterad omsorg (Studie III). Denna kan praktiskt utgöra ett verktyg i äldreomsorgen, såväl som i andra service-orienterade yrken. Kritiska implikationer och rekommendationer för ledande befattningar och andra forskare läggs fram i diskussionsdelen. Huvudtesen i denna avhandling är att nöjdhet med äldreomsorg formas starkast i relationen mellan medarbetaren och den äldre.

Petri J. Kajonius, Department of Psychology, University of Gothenburg, P.O. Box 500, SE 405 30 Gothenburg, Sweden. E-mail: petri.kajonius@psy.gu.se

Graphical Abstract

The graphical summary depicts the main theme of the thesis – satisfaction with elderly care is more closely related with the caring relationship (lower graph) than organizational resources (upper graph).



Abstract figure. The upper graph shows the weak association between a measure of organizational structure (the average municipal budget, measured in thousands of SEK/older person /year) and overall satisfaction with care (measured as the average percentage of satisfied older persons in a municipality, which was the main outcome variable). The lower graph shows the strong positive association between an interpersonal process (experience of safeness with care measured as the percentage older persons feeling safe) and overall satisfaction with care (measured as the percentage of satisfied older persons). The data have been taken from all of Sweden's municipalities and districts in 2014 (N = 324). The graphs show also that home care is less expensive, and that those who receive such care have lower feelings of safeness, and higher satisfaction with care.

Private Note

One challenge for applied psychology as it moves further into the 21st century is to keep improving its hundred-year-old tradition of scientific methodology while maintaining its focus on pivotal aspects of the human experience. This thesis focuses on one inevitable domain of all our lives: aging. My objective has been to gain insight into the complexity of the human mind in terms of satisfaction with elderly care, viewed from a psychological perspective.

On a personal note, after several years of demanding statistical studies and intensive reading in state-of-the-art psychology research, I am just starting to grasp the profound difficulties of attempting to describe the world. Neither statistical rigor using data with nearly 100,000 respondents, nor extended in-depth interviews with national experts in the field, have come close to "carving the joints of nature itself". From an ontological and epistemological standpoint, the philosophical school 'Quietism' may have the best solution. This viewpoint calls for no conclusions on the part of the observer, and claims that everything that is said about the world is on some level untrue, false, or lacking in nuance. This thesis cannot escape this fate and should be seen as a collection of analyses and observations, whose conclusions are best left for the future.

Posing hard questions and utilizing some of the best statistical tools for finding a signal in society's stochastic noise, while attempting to write advanced papers in a cogent manner, has been my personal challenge of a life-time. Nevertheless, it has also been one of the most captivating and interesting periods I have experienced, and I have met with critical and brilliant colleagues I never knew existed, some of whom are presumably reading this. This thesis' moment in time is already fleeting, but what endures is the insight that I am more prepared than ever to be entertained by existence itself.

Petri J. Kajonius
September 11th, 2015, University of Gothenburg, Sweden.

Acknowledgements

Thanks to my supervisor and collaborator Associate Professor Ali Kazemi for the hard work in initializing the much-accredited project and for maintaining a passion for conscientious and impactful research for the benefit of both academia and society.

Also, gratitude is directed towards mentors and role models of great academic stature such as Professors Boo Johansson, Leif Strömwall, and Anders Biel, as well as the invigorating doctoral colleagues and skilled lecturers, such as Valgeir Thorvaldsson and Karl Ask, at the Department of Psychology, Gothenburg, Sweden.

Thanks to the municipalities involved in the studies for graciously granting our research group access to their organizations.

In addition, acknowledgments to the University of Skövde for providing a second office and motivated research assistants, who demonstrated high-quality work in the project, and to University West, Trollhättan, for showing needed moral support.

This research was enabled by a supported grant 2012-1200 to Ali Kazemi, University of Skövde, from the Swedish Research Council for Health, Working Life and Welfare, FORTE (previously FAS), and financial support from the municipality of Skövde, Sweden.

Preface

This thesis includes the following papers, which are referred to in the text by Roman numerals:

Study I. Kajonius, P. J., & Kazemi, A. (In Press). Structure and process quality as predictors of satisfaction with care. *Health & Social Care in the Community*, 10.1111/hsc.12230.

Study II. Kajonius, P. J., & Kazemi, A. (In Press). Safeness and treatment mitigate the effect of loneliness on satisfaction with elderly care. *The Gerontologist,* 10.1093/geront/gnu170.

Study III. Kajonius, P. J., & Kazemi, A. (In Press). Advancing the Big Five of user-oriented care and accounting for its variations. *International Journal of Health Care Quality Assurance.*

Study IV. Kajonius, P. J., Kazemi, A., & Tengblad, S. (In Press). Organizing principles and management climate in high-performing municipal elderly care. *Leadership in Health Services.*

Selected studies referenced which support the thesis:

Kajonius, P. J., & Kazemi, A. (2014). Rankning av Sveriges kommuners äldreomsorg i Öppna jämförelser. *Socialmedicinsk tidskrift, 91*(4), 323-331.

Kazemi, A., & Kajonius, P. J. (2015a). User-oriented elderly care: A validation study in two different settings using observational data. *Quality in Ageing and Older Adults, 16*(3), 140-152.

Word list

- Home care (Swedish “hemtjänst”) - also known as assisted care at home; home help; assisted living.
- Nursing home (Swedish “äldreboende”) - also known as institutionalized care; special housing; long-term facility; full service living; accommodated living; residential care home.
- Older persons (Swedish “äldre”) - also known as aging individuals; older generation; older adults; mature persons.
- User-oriented care (Swedish “individanpassad omsorg”, “brukarorientering”) - also known as individualized care; client-centered care; person-oriented care.

1. The Context of the Thesis

This doctoral thesis in applied psychology was motivated by public interest in Swedish elderly care. As more persons reach old age and the proportion of older persons increases, expectations of well-being and satisfaction with elderly care also increase. It has been estimated that 25% of the population in Sweden will be 65 years or older in 2050, compared with 14% today, and 8% in the 1950s (United Nations, 2001). Most societies in Europe and the industrialized world are attempting to improve elderly care services. In the light of these demographic changes (Malmberg, 2011; Thorslund, 2010), the importance of understanding how to maintain and continue to improve elderly care is one of the critical challenges for our times (Szebehely & Trydegård, 2012).

Sweden has long been among the best places to grow old in Europe, as measured by self-reported levels of satisfaction, good health, and overall quality in elderly care (Genet et al., 2011; National Board of Health & Welfare, 2012). Sweden is known for its generously financed public welfare system, its nationwide equality (Olsen, 2013), and for spending the highest proportion of its GNP on elderly care of all countries in Europe (Damiani et al., 2011; Theobald, 2003). The process that now dominates both private and public elderly care services is called individualized care, also known as user-oriented care. This approach considers the older person's satisfaction to be one of the most important quality measurements. This thesis will examine how to provide the best possible elderly care for the older generation, where "best" is measured in terms of the older person's satisfaction. The thesis will analyze determinants of care satisfaction and explore differences in the care process.

1.1. The Quest for Satisfaction

The National Board of Health and Welfare oversees quality in Swedish municipalities, which have a responsibility to provide high-quality elderly care. The Board suggests that the older resident is viewed as a unique individual, with individual needs and desires, not just a person in the collective care of society. Modern elderly care in the 21st century is to be user-oriented and not system-oriented (Kitwood, 1997). This focus on the older person has come to be the guideline for improving elderly care (National Board of Health & Welfare, 2014). This approach, known as "user-oriented elderly care", regards the satisfaction of the older person to be a central indicator of quality (Stewart, 2001). It has been suggested that quality ratings in elderly care should always include the older persons' satisfaction (Williams, Straker, &

Applebaum, 2014). It is becoming the norm to include the older person's perspective by asking the older person about his or her satisfaction with care, and the results are commonly used in national elderly surveys (e.g., National Board of Health & Welfare, 2014). All older persons in Sweden receiving care, both at home through home care services and in institutions such as nursing homes, receive a written questionnaire every year that includes the question: "*How satisfied are you overall with the care you receive?*". Older persons like to be asked about their personal satisfaction (Little et al., 2001). The introduction of new public management policies further emphasizes that the citizen is a customer who requires satisfaction (Bergman, Lundberg, & Spagnolo, 2012). Satisfaction with care may be the most pragmatic measurement currently in use, and comprises the sum of the subjective experiences of the older person. This makes it interesting and societally relevant in psychology research.

The use of only a few short questions on satisfaction to establish the quality of elderly services has been much criticized (Meinow, Parker, & Thorslund, 2011). However, the reliability and validity of results on satisfaction obtained in this way are sufficiently high (Lyubomirsky, King, & Diener, 2005), and many studies on quality have confirmed the importance of subjective evaluations (Fung, Lim, Mattke, Damberg, & Shekelle, 2008). National authorities subscribe to the latter view and are looking for scientific information on which to base their political decisions. It appears that assessments of older persons' subjective experiences are here to stay, and should be considered by the scientific community.

1.2. Swedish Elderly Care

Sweden has a regionally based, publicly operated and financed, universal system of elderly care. It was the responsibility of the regional councils to implement policy and provide elderly care until 1992, at which point the responsibility for elderly care was transferred to the municipalities. The intention was to place the decision-making process closer to the citizens. The start of this reform coincided with an economic recession, and, in combination with innovations in care technology, this resulted in the decentralization of elderly care services (Johansson, 1997). A few years after the reform, several trends could be seen, such as increasing inequality in accessibility, as well as in costs, and the quality of care, and a general lack of public discussion (Thorslund, Bergmark, & Parker, 1997). Today, both the public and the research community are engaged in a more informed debate (Meagher & Szebehely, 2013). The annual national elderly surveys have been an important part of this development. In addition, the introduction of privately operated care organizations has sparked renewed interest in the definition of quality and how satisfaction with care is achieved (Bergman et al.,

2012). A bill passed by the Swedish parliament, Act on System of Choice in the Public Sector (2008:962), gives older persons the right to choose between caregiving organizations in 88% of all Swedish municipalities – only 37 out of 324 municipalities and districts have decided to not to implement this right (National Board of Health and Welfare, 2014). The perspective of many municipalities and privately operated elderly care organizations is that the older person is a customer. A renewed interest in user-oriented satisfaction has increasingly become a highly relevant research subject matter and municipalities compare their results with those of others (Kajonius & Kazemi, 2014).

A criticism following these trends is that the decentralized idea to allow municipalities to develop the care enterprise in accordance with regional preconditions has often led to municipalities following current national societal trends (Trydegård & Thorslund, 2010). Another criticism is that municipal autonomy, together with privatization, has increased the requirements for documentation and burdensome quality controls (Öhlén, Forsberg, & Broberger, 2013). A third criticism is directed towards the depiction of Swedish elderly care and that the Swedish model is a generous and equal role model for publically provided care in Europe. Family-based care still constitutes a substantial part of Swedish elderly care (Lyons & Zarit, 1999; Sundström, Malmberg, & Johansson, 2006). In addition, Swedish elderly care is costly, and the annual budget allocated for elderly care per user is growing. It is now the highest in Europe (National Board of Health & Welfare, 2012; 2014).

Elderly care in Sweden today is provided by 290 municipalities and 34 municipality districts (National Board of Health & Welfare, 2012). There are two commonly distinguished main sectors in elderly care: Assistance at home (which is known as “home care” in the work presented here) and institutionalized care (known as “nursing home care”). In 2012, which is the first year that the data used in the thesis cover, approximately 160,000 older people in Sweden were assisted in their homes by home care services. Another 92,900 were serviced in institutionalized care in various types of nursing homes – these include special dementia units (29,900), full-service living units (9,900), and short-term residences (3,800) (National Board of Health & Welfare, 2012). An estimated 50% of home care users eventually move from home-assisted care to institutionalized care (Bravell, Berg, Malmberg, & Sundström, 2009). Both sectors, therefore, are interesting from a research standpoint, since they play different roles in the continuous aging process.

1.3. The Setting of Psychology

The endeavor of this thesis was to utilize input from several fields and disciplines, with the purpose of a balanced contribution to applied psychology with an elderly care context. Figure 1 illustrates how the subject of the thesis, satisfaction with care, is related to several fields of psychology. *Social psychology* is considered to be the unifying thread through the thesis, with multiple levels of analysis and perspectives from older persons, care workers, managers, third-party observers, and care organizations. *Gerontology* is the discipline that provides the context of the aging person, while *work psychology* and *managerial psychology* focus on performance in a user-oriented enterprise.

Satisfaction with care concerns the perceptions, subjective experiences, and inherent dispositions of the participants, and justifies a psychological approach to the subject. The evaluation of user-oriented elderly care is subjective in its nature (*how* one is perceived to carry out treatment, *how* information is perceived, and *how* the interaction with the older person is experienced). A complex social and psychological process is involved in making a person satisfied (Chung-Yan, 2010). For instance, the impact of an individual's pre-existing characteristics, such as anxiety, has implications for a range of evaluations (see a review by Donaldson & Ko, 2010). Another example is the impact of social relationships on satisfaction (Fagerström et al., 2007; Hellström, Andersson, & Hallberg, 2004). Some of the most reliable predictors of user satisfaction are psychological: Perception of equity, expectations and disconfirmation of expectations, and level of affect (see the review by Szymanski & Henard, 2001). The premise for the thesis is that research on determinants and differences in satisfaction with elderly care can be understood and explained proficiently from a psychological perspective.

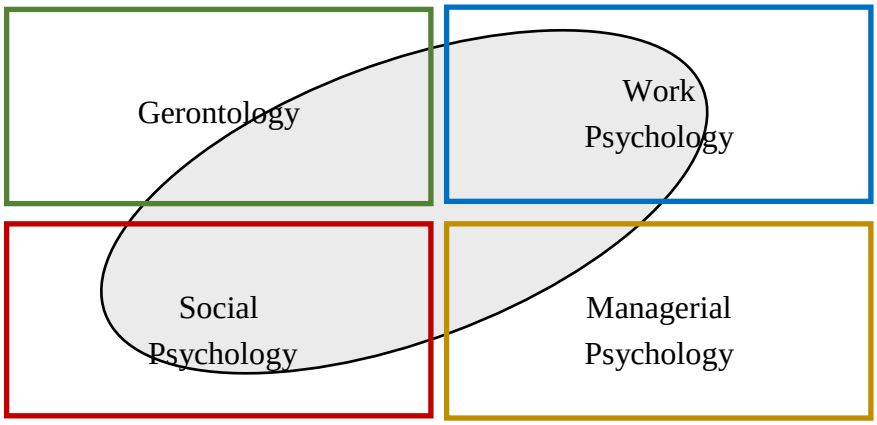


Figure 1. The grey ellipse depicts how the thesis subject, user satisfaction with care, overlaps to various degrees with several fields in the behavioral sciences.

2. Theories and Previous Research

2.1. User Satisfaction

Satisfaction is a multifaceted phenomenon, involving both social and psychological dimensions (Chung-Yan, 2010). Structural aspects (such as budget), process aspects (such as the availability of skilled personnel), and the properties of the older person (such as condition of health) are possible predictors of user satisfaction (Fredrickson, 2005; Lyubomirsky, Sheldon, & Schkade, 2005). A review of 50 studies on user satisfaction (including studies of customer satisfaction) by Szymanski and Henard (2001) showed that the primary antecedents for satisfaction were: 1) equity, 2) disconfirmation of expectations, 3) expectations, 4) performance, and 5) level of affect, in order of importance. In other words, care satisfaction depends on more than care performance. When respondents evaluate the quality of elderly services, they also estimate their own level of affect, their expectations, the fulfillment of expectations, and the equity level in the relationship with the caregiver.[1] The premise is that in today's public management market there is a freedom to choose, and that makes it evermore important to understand and explore the mechanisms of customer satisfaction.

However, it has been questioned whether the older person can be regarded as an independent user of societal services. A Swedish study has shown that one third of older persons above 77 years of age are cognitively impaired and that 88% have some form of cognitive or sensory problems or are unable to go outside their homes (Meinow et al., 2011). However, the end-user of a care service is the older person, which makes the subject of satisfaction of utmost importance.

Elderly care is a relationship. The perspective of user-oriented care is the dominant quality perspective in contemporary elderly care (Kajonius & Kazemi, 2014). User-orientation is regarded to be the focusing on the older person with his or her wants and needs. This can be traced back to a tradition of the humanistic perspective (Rogers, 1961), and is related to the modern care approach of "knowing the person/knowing the patient" (Kitwood, 1997). User-oriented care consists of the interaction between the caregiver and the older person, as well as the background, life history, and previous relationships of the older person (McCormack, 2004). This view was supplemented by Titchen (2004), who added the framework of a caregiver's critical and skilled companionship. In other words, user-oriented

[1] These studies have similarities with studies of healthcare, summarized in a meta-analysis of 221 studies by Hall and Dornan (1988). This showed that humaneness is the most important factor for satisfaction in healthcare.

care should be seen as an interactive interpersonal relationship that aims to facilitate the highest personal satisfaction and to provide regulatory support.

This view has been criticized for being overly naïve and not recognizing how the institution and the caregivers actively shape the social situation, often at the expense of the older persons' autonomy (Fjær & Vabø, 2013). However, successfully implemented user-oriented care is conducive of a diversity of expressions, including the satisfaction of both older persons and staff (Edvardsson, Fetherstonhaugh, McAuliffe, Nay, & Chenco, 2011).

Elderly care is like being at home. An important aspect of user-oriented care is the feeling of being safe and at ease, which is captured by the sense of being at home (Edvardsson, Sandman, & Rasmussen, 2005).[2] Home is considered to be the safe base, and satisfaction is considered to be optimized at home. A study on home caregivers reported that care quality can be measured as the degree to which home-like environments for the elderly are reproduced (Murphy, 2007). Successful elderly care attempts to replicate the home environment with respect to comfort, autonomy, and relationships (Welford, Murphy, Wallace, & Casey, 2010). Relieving loneliness by encouraging a relationship with the caregiver in the context of a home-like and safe environment is a recurring theme (Edvardsson et al., 2005). Most people have not spent their lives by themselves, but surrounded by family and friends. Making elderly care feel like home is the goal when attempting to increase the satisfaction of older persons (Falk, Wijk, Persson, & Falk, 2013). In other words, a part of satisfaction in elderly care is found in meaningful relationships in the safeness of a home-like environment.

2.2. Structure and Process in Care Satisfaction

Many researchers have searched for a theoretical framework to provide generalizable categories of quality that will be useful for the evaluation of elderly care (see, for example, Schneider & Lieberman, 2001). One of the most influential models in the care sciences is

[2] Several instruments are available to establish the degree to which a user-oriented approach has been employed. Most attempts to measure user-oriented care make use of the older person's perspective, trying to capture the experiences from the point of view of the receiver of the care (Edvardsson & Innes, 2010). Coyle and Williams (2001), for example, reported the dimensions of personalization, approachability, and respectfulness. Another frequently used instrument for measuring individualized care is the PDC scale (Person-Directed Care), which consists of 64 items (White, Newton-Curtis, & Lyons, 2008). Factor analysis of the PDC scale demonstrated five latent dimensions of user-oriented care: knowing the person, comfort care, autonomy, personhood, and support relations. Another commonly used instrument to describe individualized care is the ASCOT (Malley et al., 2012), which measures several dimensions that are similar to those of the National Board of Health and Welfare's elderly surveys (such as influence, comfort, meal times, safeness, social participation, activities, and respect). There is still a lack of consensus on the theoretical base behind user-oriented care scales.

Donabedian's model (1988). This model categorizes care quality in terms of *structure*, *process* and *outcome*. Structural aspects of care involve financing, buildings, instruments, medical supplies, documentation, and personnel, while process aspects involve the way care is carried out, in terms of respect, information, influence, treatment, and safeness. Finally, outcome includes all the effects of care, such as health, behavior, knowledge, and – of particular interest for this thesis – satisfaction. Older persons' overall experience is considered to be a key outcome variable in healthcare (Closs & Tierney, 1993). The Donabedian model has been a starting point for much institutionalized care in modern societies (Brook & McGlynn, 1996), and it has been used also in Swedish settings (Fahlström & Kamwendo, 2003). However, there is a scarcity of research that examines the relative effects of structure and process for the experience of quality of care by older persons (Kunkel, Rosenqvist, & Westerling, 2007). Donabedian's model has been frequently used in research on the quality of care in hospitals, but has not been used as frequently within elderly care (Hearld, Alexander, Fraser, & Jiang, 2008). Analyzing care quality in terms of structure and process has been used also in qualitative research (Forbes-Thompson & Gessert, 2005). Senić and Marinković (2012) reported that the relationship between the professional and patient has the strongest impact on patient satisfaction. The more time and the more concern the professional caregiver invests, the higher the compliance and satisfaction among older persons (Fleishman, 1997).

Donabedian's model has not been used to analyze specifically older persons' satisfaction with elderly care. Modern elderly care is ultimately the product of both the structure of an institution and the care process. Knowing the relative contributions of these categories may facilitate understanding and policy development in elderly care.

2.3. Older Persons and Care Satisfaction

The properties of older persons, such as deteriorating health, increasing anxiety, and increasing loneliness, may affect ratings of care satisfaction. Self-estimated ratings from older people concerning the care they receive are affected by their aging conditions. The severity of health problems, for example, is negatively correlated to the satisfaction of relationships with personnel (Otani, Waterman, & Claiborne Dunagan, 2012). The more ill the patients are, the more likely they are to disapprove of the care process. Furthermore, personal self-esteem and anxiety affect perceptions, including the evaluation of treatment, loneliness and health status (Larrabee, Engle, & Tolley, 1995; McMullin & Cairney, 2004). Personal feelings and predispositions affect the perception and evaluation of care services. Person and process are, however, not easy to disentangle. The influence of the person is often the most active *before* a

situation occurs; through selecting the caregiving organization, for example, or actively manipulating the personnel or care process. Longitudinal research has shown that both the person and the process contribute significantly: half of the variance in the experience of satisfaction depends on personal characteristics, such as levels of anxiety, and the other half depends on unspecified situational factors (see the meta-analysis by Heller, Watson, & Ilies, 2004).

A useful theoretical perspective on this matter is that of "person *versus* situation" from social psychology, which postulates two primary sources of influence (Funder, 2008; Mischel, 2009) on any behaviors: The ultimate question is whether the individualities of a person (such as his or her personality traits, temperament, or personal values) have the greatest effect, or the external properties of a situation (such as colleagues, relationships, or process qualities).[3] With the advent of behavioral genetics, several studies have demonstrated that the properties of the person make substantial and stable contributions to all types of behavior, and this observation has been labeled as 'the first law of genetics' (Plomin, DeFries, Knopik, & Neiderhiser, 2013). Personality is regarded as the most important predictor of many life outcomes (such as subjective well-being) (see the review by Roberts, Kuncel, Shiner, Caspi, & Goldberg, 2007).

Drawing on these findings, the premise for this thesis is that the older person's satisfaction with care is affected by both personal characteristics and the care process. The thesis investigates their relative importance, and how they are related. No previous study has quantified these factors, measured against satisfaction with care. Knowing their relative importance will advance our understanding of the role of the personal aging condition in satisfaction with care.

2.4. Organizing Care Satisfaction

The goal of an elderly care organization is to aid elderly peoples' everyday life and well-being, while guided by the specific needs and desires of the older person (Mead & Bower, 2000). User-oriented care can be considered to be the interaction between the older person and the care process. The care organization exists to facilitate this process. Figure 2

[3] During the 1970s and 1980s, the research community believed that the impact of the person could never have strong effects across situations ($r > .30$), and the conclusion was that the person is only marginally relevant (Mischel, 2009). However, the major journals in the field (Personality and Social Psychology Review, Personality and Social Psychology Bulletin, Journal of Personality and Social Psychology, and Social Psychological and Personality Science) have in the last fifteen years published and reported what seems to be an emerging consensus that the person influences the situation much more than previously thought.

shows that the elderly care process starts with the older person experiencing deteriorating physical health and increasing mental anxiety (general worry), which translates into a predicament for the individual, and ultimately the need of assistance. This progressive experience of vulnerability can be captured by measuring feelings of loneliness (Aartsen & Jylhä, 2011). This can be achieved simply by asking the older person whether he or she feels alone (Boomsma, Willemsen, Dolan, Hawkley, & Cacioppo, 2005). Loneliness is, furthermore, directly related to overall satisfaction, and to the level of safe treatment (Kane & Kane, 2001; Mann, Birks, Hall, Torgerson, & Watt, 2006; Routasalo & Pitkala, 2003). The more unprotected a person feels, the less satisfied he or she is with the elderly care situation (Aartsen & Jylhä, 2011). Figure 2 suggests that safeness is a vital mediator for satisfaction in elderly care.

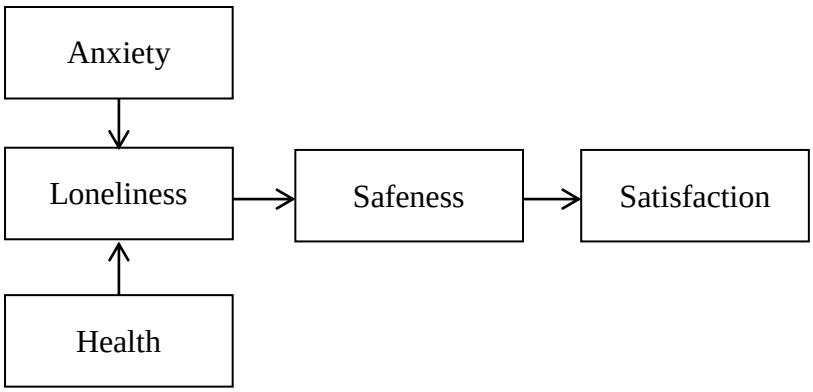


Figure 2. The thesis' postulated relationship between person-based variables and overall satisfaction as being mediated by the care process (measured by the level of safeness). In other words, the user-oriented care process of safeness should start when the predicament of failing health and increasing anxiety shows in the vulnerability of loneliness.

Management and organizational climate. Being effective as an elderly care organization hinges on the management being able to create and transmit working principles throughout the care organization (National Board of Health & Welfare, 2009). Previous research has described a positive relationship between management and the employees in an efficient organization, and shown that the relationship should be characterized by trust, cooperation, commitment, and responsibility (Hällsten & Tengblad, 2002). The field of work psychology distinguishes between the organizational culture and the organizational climate (Schneider, Ehrhart, & Macey, 2011). The culture is the sum of the values and objectives that

exist in an organization, whereas the climate is the sum of the feelings, thoughts and behaviors, among the persons in the organization (Katz & Kahn, 1978; Kuenzi & Schminke, 2009). In other words, a psychological climate is constituted by the shared perceptions that govern relationships within an organization (Koys & De Cotiis, 1991). A model that is frequently used to characterize organizations describes three types of climate: the *affective*, *cognitive*, and *instrumental* climates (Ostroff, 1993). The performance of organizations is correlated with the dominant climate type (Clarke, 2006). The climate and the well-being among employees are also linked (Schneider & Snyder, 1975), and the climate may, in turn, predict customer satisfaction (Schneider & White, 2004; Zohar, 2000). These relationships are present in Swedish elderly care settings (Dackert, 2010). The relationship between a workplace climate and organizational performance can be mediated by management (Mayer, Nishii, Schneider, & Goldstein, 2007; Parry & Proctor-Thomson, 2002), which is of particular interest for this thesis. The thesis is based on the assumption that the leadership is important in setting the stage for successful elderly care organizations.

2.5. Self-estimating Care Satisfaction

Understanding and interpreting the mechanisms behind self-ratings of satisfaction is one of the challenges for this thesis (Jylhä, 2009; Lyubomirsky, Sheldon et al., 2005). For instance, one crucial question is whether the elderly surveys reveal actual differences in services or differences in how people rate services (influenced by individual characteristics or other factors not related to the service itself). Self-ratings in health extend beyond the subject of evaluation. Jylhä (2009) described self-rating as a multi-step process: 1) a personal, subjective evaluation, 2) comparison with similar people of the same age, and 3) comparison with what can be generally expected, socially and culturally. This model suggests that several psychological reference points are activated when any type of subjective evaluation is carried out. A mental dimension (such as the level of anxiety) and a physical dimension (such as the experience of health) come into play in self-rated evaluations. Furthermore, a social dimension (such as experience of support, both from loved ones and professional caregivers) also comes into play, as does a cultural dimension (such as comparing with the society at large). This line of thinking in multiple levels, using multiple reference points, is compatible with what is known about "successful aging" (Nosraty, Enroth, Raitanen, Hervonen, & Jylhä, 2015), which is a theoretical model that acknowledges the complexity behind the rationalization of reaching a mature age. The theory of multiple reference points put forward by Jylhä (2009) implies that we draw on many sources of input, beyond our actual experience,

when we estimate how satisfied we are with a service. For example, older Swedes report better physical health and psychological well-being than their European counterparts. This may not be because Swedish municipalities offer the best performance in elderly care: it may be that people in general *estimate* that they have better care than people in other countries (Jylhä, 2009). In a similar way, it is possible that municipalities with a high rating for satisfaction have better satisfied elderly people than municipalities who receive a lower rating, or that the elderly simply give a higher rating. The advancement in satisfaction in elderly care in this thesis builds in part on Jylhä's (2009) model of the psychology behind estimating self-rated health.

The work presented here set out to investigate the impacts of structure, process, and person-based factors in satisfaction with care, and to analyze why some of the predictors with greatest impact differ within and between care organizations. This is of interest not only for those who make policy in elderly care, but also for those involved in providing elderly care, and for those interested in the psychology of satisfaction.

3. Present Research and Methods

The overall research aims advanced in this thesis were, first, to establish *what* predicts satisfaction with elderly care and, second, to explore *why* the predictors with most impact vary. The first aim was explored in Studies I and II and used the older person's perspective, based on nationwide samples from elderly surveys. The second aim was explored in Studies III and IV and used care workers' and managers' perspectives, based on interviews, and third-party perspectives based on observations.

3.1. Research Purpose

First aim: predictors of satisfaction. The first aim of this thesis posed the research question: "What predicts older persons' satisfaction with care?". The work attempted to explain what and how satisfaction with care is generated. Study I used municipality-level data, comparing the impact of the care process (how care was performed, in terms of the older person's influence, information, and respect) to structural resources (what resources were spent, in terms of budget, number of staff, and training levels), on older persons' satisfaction with care. Donabedian's (1988) theoretical quality model was utilized for this purpose. Study II used the original, individual-level raw data from the elderly surveys, comparing the impact of the care process (in terms of treatment, safeness, staff availability, and time availability) to the older person's aging conditions (in terms of health, anxiety, and loneliness), against the older person's satisfaction with care. The theoretical approach behind the second study was the "person *versus* situation" perspective from social psychology (Funder, 2008; Mischel, 2009), which in this case translated into the interaction between the older persons and their care environment.

Second aim: reasons for variations in the care process. The second aim, building on the first aim, posed the research question: "Why do variations occur in the care process?". The challenge was to further our understanding of sources of variation in elderly care and the reasons that some organizations are more successful than others. Study III used interviews with care workers in two selected municipalities and observations focused on the interactions between care workers and older persons. The purpose was to establish reasons for variations in satisfaction with elderly care from the perspective of the care workers, the unit managers, and third-party observers. The theory behind this attempt was Jylhä's (2009) reference points' theory, which suggests that multiple levels are at play when self-rated evaluations are carried out. Study IV, building on the results from Study III, made use of interviews with higher

departmental managers and observations in manager meetings in both municipalities to further our understanding of the influence of management and organization. The theory behind this study was the psychological climate in workplaces (Ostroff, 1993), viewed as a precursor to care service performance.

3.2. Research Methods

Material. The body responsible for quality control and information about municipalities' performance in Sweden is the National Board of Health and Welfare. A report called "Open Comparisons" has been published every year since 2007 with publicly available data on how elderly care is performing. This report is highly respected (Lindgren, 2012). A number of indicators of quality are reported, drawing from a selection of databases, including a nationwide survey in which older persons are asked about their perceptions and experiences of home care services and institutionalized care. This questionnaire is the result of collaboration between the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions, while Statistics Sweden is responsible for collecting the data in an ethically approved way. The national survey data are made publicly available only on an aggregated municipality mean level, while the individual data must be applied for. These data sets are the foundation of the statistical analyses in this thesis.

Sample. The sample (N = 95,000) represented older persons in all municipalities and districts in Sweden (N = 324). 61,600 people with home care responded out of 89,400 (69% response rate), while 33,400 living in nursing homes responded out of 61,500 (54% response rate). In home care, N = 39,699 were women (65%) and N = 17,988 men (29%); N = 51,550 (84%) were Swedish-born and N = 5,946 (10%) foreign-born. In nursing homes, N = 21,893 were women (66%) and N = 9,180 men (27%); N = 28,392 (85%) were Swedish-born, and N = 2,546 (8%) were foreign-born. Not all percentages reach a total of 100% due to missing data.

With the second aim of understanding the sources of user-oriented care variation, two medium-sized municipalities, with a population of around 50,000, in geographical proximity were selected.[4] The first municipality (Municipality 1) was known for its good results in the national elderly surveys, both in assisted home care and institutionalized nursing homes

[4] Ten expert interviews (with, for example, CEOs of private care organizations, heads of department for municipal organizations, politicians, and professors) were conducted by the thesis author, and were the starting point and pilot study for the thesis, with the intention to understand what is considered quality in elderly care, and to provide clues on how to proceed with appropriate research questions.

(Kajonius & Kazemi, 2014). The second municipality (Municipality 2) was chosen as an example of an average municipality (National Board of Health and Welfare, 2012; 2013; 2014). Table 1 summarizes the user-oriented process characteristics in terms of the percentages of satisfied older persons in the two municipalities.

Table 1.

User-oriented Indicators for Selected Municipalities 2012-2014

User indicator	Municipality 1			Municipality 2			All
Home care	2012	2013	2014	2012	2013	2014	2014
Overall satisfaction	94	95	95	89	93	91	91
Influence	72	70	76	58	67	63	60
Respect	90	88	90	81	91	85	87
Information	89	-	76	68	67	-	-
Treatment	82	85	86	72	78	71	77
Safeness	57	59	57	40	51	41	45
Nursing homes							
Overall satisfaction	88	91	90	84	86	85	84
Influence	72	75	80	56	61	64	61
Respect	87	88	86	83	81	79	80
Information	57	75	-	46	61	-	-
Treatment	69	70	70	55	64	58	59
Safeness	56	58	53	49	56	54	51

Note. All numbers represents the percentages of satisfied older persons.[5] The column with all municipalities includes $N = 324$.

[5] Municipality differences were generally small. For instance, the indicator Treatment in Home care for 2012 (82 vs. 72), using individual level data reported a Cohen's $d = .27$ (when converted into a biserial correlation, $r = .13$), $t(600) = 3.2$, $p < .001$.

Statistical data. The structural data (such as budget, staffing, and training) were available through supplementary registry data in Open Comparison 2012. The process data and the person variables were available from the national elderly surveys. The questionnaire is provided in the Appendix in its original size and form, and the subsequent numbers refer to their location in the questionnaire: In summary, the structural variables measured were budget, number of staff, and training levels (Study I); the process variables in Study I were respect (Question 19), influence (Question 12), information (Question 11), while in Study II they were treatment (Question 17), safeness (Question 20), staff availability and time availability (Question 10); and the person variables were health (Question 1), anxiety (Question 2), and loneliness (Question 24). Items that related to overall evaluations were preferred, such as "*Do the staff usually treat you well?*" (Question 17). In contrast, specific practicalities such as "*Do you receive help going to the bathroom to the extent you need?*" (Question 15) were not included. The main dependent variable was satisfaction with care (Question 28), which was posed as: "*How satisfied or not satisfied are you with the overall elderly care*?". The majority of items were answered on 5-point scales, ranging from "Very satisfied" (5) to "Very dissatisfied" (1), also with the option, "No opinion/I don't know". Some items were reversed, and some items were on 3-point scales, "Very often" (3) to "Not at all" (1).

Field data. Impressions of the care process, focusing on the interaction between caregiver and older person, were logged in the field observations. Access to the units was available at all times for a period of approximately 2 weeks. Observations were conducted on 36 days (12 days in Municipality 1 and 24 days in Municipality 2). Home care services were followed in both municipalities for a combined total of 12 days and nursing homes for 24 days. Observations were made in four home care units and six nursing homes. Seventeen interviews were recorded in Municipality 1 and 24 in Municipality 2 (18 of these were made with management and 23 with care workers). During visits by the researchers, care workers on duty were followed in the everyday activities, or observations were made in public places such as the TV-room or the kitchen. The care process was recorded without intruding and questions were not asked in close proximity to a particular occurrence. Between observation sessions, interviews were held to gain a deeper understanding of the context and challenges of the care process. Interviews were held also with the positions of department nursing home manager, department home care manager, quality manager, head of unit, and departmental head manager, in both municipalities. An open semi-structured interview guide was used

containing general questions on user orientation, the organizations, and overall reflections on care satisfaction.

Ethics. This research was approved by the National Ethics Committee in Sweden. The observational data were made anonymous without retraceable references to individual care workers or older persons. The care workers' participation in interviews was voluntary and anonymous. No older persons were interviewed, and informed consent was obtained by care managers and care workers before entering an older person's home (in home care) or room (in nursing homes). Research notes took place openly and those who led various meetings were informed about the research, with the stated purpose of describing municipal elderly care on all levels.

3.3. General Limitations

Participant bias. The response rate was 69% for home care and 54% for nursing homes in the Open Comparison data used for Studies I and II. The low response rate may mean that the results are not representative. General reviews of non-responders have shown that they share certain characteristics, such as lower socio-economic status, inferior health (Galea & Tracy, 2007), and a higher mortality risk (Kelfve, Thorslund, & Lennartsson, 2013). However, studies by the same author show also that differences may not be large enough to affect generalizability (Kelfve, Lennartsson, Agahi, & Modig, 2015). Another limitation concerns elderly people with dementia. Such patients (and others) use proxies such as loved ones or care workers, which might skew the representativeness of the sample (Meinow et al., 2011). We do not know the degree to which the opinions of the older persons themselves are being expressed. In home-based care, 24% said they had received help responding to the questions, while in nursing homes the number who received help was as high as 61%. Also, when using help, close relatives most often completed the questionnaires, and it is not known how relatives (compared with other proxy persons) affect the reliability of the answers. Alternative interpretations of the results may be possible, which is discussed further below.

Self-ratings. Epidemiological studies based on self-reporting must face the question of reliability and validity. Respondents might simply not be truthful, or might give normative answers with social desirability in mind. The issue with self-reporting is mostly of concern when non-ability performance is measured, which is the case in this thesis (Ones, Viswesvaran, & Reiss, 1996). When asked for evaluations, respondents might, for example, exaggerate positive aspects in order to relieve their caregivers or loved ones, or they might exaggerate negative aspects in order to provoke change. They might also not answer the

question directly, but be influenced by cues beyond the actual moment, as discussed by Jylhä (2009). However, support for the continued use of self-rating scales is generally found. A review of 125 meta-studies, for example, based on 800 samples in a wide range of psychological questionnaires showed that the validity of self-reporting is dependable and similar to that of neighboring sciences such as medicine (Meyer et al., 2001).

Self-ratings are, furthermore, the primary instrument used to indicate health and anxiety, and to determine the personal aging condition. One of the thresholds for being eligible for elderly care is low self-rated health and/or high self-rated anxiety, which is a part of an evaluation process handled by municipal case officers with the aim to establish the degree of assistance rights. Physical and mental hindrances are the main predictors for receiving home care, according to the Swedish National study on Aging and Care (SNAC) (Meinow, Kåreholt, & Lagergren, 2005). Rating one's own health has conceptual and predictive validity (Jylhä, 2009), and is robust against cross-cultural differences (Jylhä, Guralnik, Ferrucci, Jokela, & Heikkinen, 1998).

Quantitative method. The two most popular effect size measurements used in psychology, Pearson's bivariate correlation coefficient (*r*) and Cohen's standardized mean-difference (*d*), are reported in Studies I and II. A rule of thumb when transforming between Pearson's *r* and Cohen's *d* is that a value of $r = .10$ is equal to $d = .20$, and that $r = .30$ is equal to $d = 0.7$ (Cohen, 1992). Occasionally, the sizes of associations are reported as "small", "medium", or "large", which are subject to interpretation. Use of the label "medium" was here based on the largest meta-analysis in social psychology (Richard, Bond, & Stokes-Zoota, 2003), where the average effect over a hundred years of research (among 25,000 studies) was $r = .21$. This was confirmed by Hemphill (2003), who reported that the middle third of all reported effects in psychology are between $r = .20$ and $r = .30$. A third confirmation of the interpretation of the term "medium" is a recent study that was based on 147,328 effect sizes within work psychology and organizational psychology, which established the average effect to be around $r = .20$ (Bosco, Aguinis, Singh, Field, & Pierce, 2015).

Qualitative method. A potential limitation of the second aim of the thesis, reported in the qualitative Studies III and IV, is the observer effect (Denzin & Lincoln, 2011). This describes the phenomenon of participants modifying their behaviors and acting differently when they know that they are being studied. To reduce the effects of social desirability, the purpose of the study was stated to be an attempt to describe (not evaluate) everyday practices in elderly care services. A second potential validity concern is the dependability and

credibility of the observers themselves (Morse, Barrett, Mayan, Olson, & Spiers, 2008). One way in which the effects of bias and prior expectations were counteracted was that another researcher revisited the organizations six months after the first collection, conducted new interviews, and compared the information collected. The material was regularly discussed during data collection. As a final verification strategy, research assistants conducted a number of pilot observations together and then separately, and compared their experiences of data collection. In this way, the observation and recording procedures were calibrated to ensure the best possible consistency in the observation procedures. The peer debriefing sessions that were held are believed to help combat bias, and are regarded as the equivalent of objectivity in quantitative research (Patton, 1999).

3.4. Thesis Limitations

The outcome variable. Satisfaction with care is an imperfect dependent variable from a statistical standpoint. First, it is skewed towards the high end of the scale, which implies an asymmetric distribution, and is not optimal for regression analyses. However, it was still within recommended limits in the work reported here (skewness < 2.0; Field, 2013). A normal distribution is required for linear statistical analyses to be possible, although some argue that a normal distribution is not a requirement when sample sizes are large (approaching thousands), such as in the present studies (Lumley, Diehr, Emerson, & Chen, 2002). A second variable limitation is that the original Likert scale on overall satisfaction with care may not be an interval scale at all, but rather an ordinal scale. In other words, we do not know the qualitative differences between scoring, for instance, 3 and 4 on the original satisfaction scale, or 4 and 5. Ordered logistic regression instead of linear regression is, thus, an alternative approach. However, this was not used in the work presented here, since the results were highly similar.[6]

Another limitation is that two different measurements of overall satisfaction with care were used in the thesis: one on the municipal level (reporting the proportion of satisfied older persons) in Study I, and one on the individual level (reporting the true means) in Study II. Nevertheless, the correlations between the results gained for satisfaction in the two studies was on average very high (r = .90). A last issue with the dependent variable is that it was not built from an assembled index, but consisted of one item, lacking a reported internal

[6] Several tests were performed with non-parametric methods, and they gave identical results to those reported in the studies. For instance, attempting a log10-transformation (with skewness close to 0) of the outcome variable yielded the same results. Similarly, using Spearman's rho correlation, instead of Pearson's correlation, also gave the same results.

consistency or test-retest coefficient. If such an item were to be systematically misunderstood, conclusions and interpretations could be skewed. However, research on single items, as seen in neighboring fields such as personality psychology, has shown the usefulness of short scales; both regarding reliability and validity (see Yarkoni, 2010, who comprised 203 scales into 181 items with retained scoring capacity). After much deliberation, a decision was made to use the only global question in the national surveys: "*How satisfied are you with the care you receive?*".

Self-rating short scales. The risk of Common Method Variance (CMV) was an issue when working to achieve the first aim of the thesis, to develop predictors for satisfaction with care (Spector, 2006). This threat arises when both independent and dependent variables have the same source, in this case the same older person who completes the questionnaire. It is possible in this case that some of the statistical relationships are due to the style of response of the participants. One example of this is acquiescence, the tendency to agree with the questions, which inflates the relationships. Large questionnaires, however, may not suffer much from CMV, and thus it may not affect the conclusions (cf. Moorman & Podsakoff, 1992; Rorer, 1965). Indeed, since some items are reversed and the questions cover a wide range of topics, acquiescence may instead act as an error term, and may decrease correlations rather than inflating them. If common method variance affected the current data sets, all variables would be slightly correlated (cf. Boswell, Boudreau, & Dunford, 2004), which was not the case.

Another limitation of the self-rated short scales arises from the fact that the National Board of Health and Welfare does not use aggregated indices. A single one-item index, for instance, could easily be misunderstood by certain individuals or groups of individuals. However, one-item scales are becoming more popular and are showing sufficient robustness in statistical analyses (see, for example, Jylhä, 2009, on self-reported health, and Gogol et al., 2014, on affective constructs).[7] Attempting to measure person-related characteristics such as well-being, health, and attitudes is effective, even with only very few questions (see the brief-scale study by Thalmayer, Saucier, & Eigenhuis, 2011). When asking about subjective well-being with one item, for instance, the one-year test-retest reliability is adequate, as it is greater than .50 (cf. Fujita & Diener, 2005). Nevertheless, type II errors (underestimating or missing a

[7] One example of a very short scale is to ask people "Are you a narcissist?". This question has a similar predictive validity as the original 40-item Narcissism questionnaire (Konrath, Meier, & Bushman, 2014).

true effect) are more common with short scales (Credé, Harms, Niehorster, & Gaye-Valentine, 2012).

Understanding effects. Another often overlooked limitation concerns the understanding of researchers of the statistical effect sizes calculated during the statistical analyses. The term "effect" describes the statistical impact of a predictor on a dependent variable. The implications and real-life impact of a medium effect size of Pearson's correlation (r = .20) can be can be illustrated in several ways: First, depicting the impact of the coefficient in a biserial relationship, such as flipping a coin with two outcomes, changes the probability from 50/50 to 40/60 (Rosenthal, 1991). Second, using the effect to address the size of explained variance, r = .20 squared provides the amount of accounted variance in the variables in the relationship (4%). Third, predicting a latent third variable that is connected to an apparently bivariate relationship, which is often what the researcher is looking for, would provide that 20% of the variance is explained (D'Andrade & Dart, 1990; Ozer, 1985; Trafimow, 2015). A common example of this would be quantifying the variance in the latent *g*-factor (general intelligence) from the relationship between an IQ measurement and academic grade performance (Johnson, 2011; Ozer, 2007). Fourth and last, an effect of r = .20 could be understood by considering two groups that are compared, such as one that has received an intervention while the other functions as a control. In this case Cohen's d is usually preferred over Pearson's r. If the effect of the intervention is r = .20 (which corresponds to d = .40), approximately 68% of the participants in the intervention group score higher on the outcome variable than the mean value in the control group (Cohen, 1992).

In addition, the results in the studies are sometimes formulated as *effects* or *impacts*, or described as "explaining variance". This formulation is used since it represents theoretical propositions in the relationships. However, no causality can be inferred from this since these are not experimental studies. Also, confidence intervals are intentionally not reported here for reasons of parsimony, since the standard errors deviated less than .01 from the estimates, due to the large sample sizes.

3.5. Study Limitations

Operationalization. In the first study, the variables respect, information and influence constituted the process factors, and were measured on an aggregated municipal level, while in the second study, the variables safeness and treatment constituted the process factors, and

were measured on the individual level. The implication from this is that the relative impact from the process factors on satisfaction with care cannot be compared between the studies.[8] Structural variables were not available on the individual level. Also, the purpose of Study II was to explore the countering effects on individual aging conditions in particular, and to study additional process variables such as interpersonal treatment and feelings of safeness. In Study I, the measurement combined the percentages of *very satisfied* and *satisfied* older persons, while in Study II the data consisted of raw mean scores.[9] The first study aimed at quantifying the general impact of structure and process factors on a municipal level, using the theoretical structure-process model; while the second study aimed at studying the specific individual level, with the theoretical person-situation paradigm. Since the studies cannot be compared, these approaches are to be regarded as complements, and provide a broader picture of elderly care.

Omitted variable bias. The posited associations revealed by the statistical Studies I and II may have alternative explanations, if some variables were not included in the analyses. For instance, the associations between process variables and satisfaction may be partly due to overlapping constructs due to their subjective, psychological nature; while associations between structure variables and satisfaction may depend on a number of omitted controls (such as socio-economic status, share of immigrants, north-south cultural differences, urban-rural differences, or private-public elderly care differences). Also, the variables used in Study I were not used in Study II, not even as control variables. This was deliberate, since the studies had different theoretical outsets (Studies I and II were based on Donabedian's model while Studies III and IV were based on the person-situation paradigm). Another difficulty was the different levels of analyses (aggregated municipal and individual level, respectively).

Interacting variables. Another limitation in the studies was the potential complexity of interaction between variables, which was not taken into account. In Study I, no interaction terms were introduced, due to the statistical and theoretical dissimilarities between process and structure variables. In Study II, however, an interaction term was introduced into a polynomial quadratic regression model, multiplying the person variable loneliness and the process variable safeness, in order to analyze moderating effects. Theoretical reasoning leads us to believe that personality and process psychology go hand in hand (Rauthmann, Sherman, Nave, & Funder, 2015 analyze how the construals of situations depend on personality).

---

[8] The mean correlation between the different process variables used in Studies I and II was $r = .45$.
[9] The correlations between the two ways of measuring process variables in the two studies were high ($r = .90$).

Cross-sectional data. Epidemiological studies that inquire about people's health or other experiences through self-rated surveys are useful in the sense that they tend to treat all groups in a population in a similar way, thus compensating for some of the statistical disturbances. However, it may be difficult to interpret such studies, since the effects of cohorts, time spans, and characteristics of subgroups are missed. This tends to oversimplify the descriptive analysis of the sample, and might report statistical relationships that are not representative for all respondents. Also, not being able to control for the characteristics of non-responders in large surveys is an issue for representativeness and thus limits generalization.

Outliers. To ensure a fair comparison of the associations in municipalities, we conducted analyses both with and without outliers. (An "outlier" is defined as a data point located greater than 2.5 standard deviations from the mean, in a normal distribution). Including outliers did not alter the conclusions. When the main purpose was to compare municipalities, such as in a supplementary study (Kajonius & Kazemi, 2014), all the three large urban regions, Stockholm, Gothenburg, and Malmoe, were omitted, as well as municipalities in which fewer than 100 persons have responded. When the purpose was to establish general relationships in a model, all data were included, since no municipalities were included in the Open Comparison that had fewer than 30 responses. In addition, the datasheets from Open Comparison gave a value of zero, which we interpreted as missing data, since we believed that it was not possible that there would be 0% for any variable relating to either process or structure.

Reliability. In contrast to the data-driven studies I and II, Studies III and IV were based on qualitative observations and interviews. Study III made use of research assistants who had no insight into the overall project aims or any expected results. This was on purpose, to secure a more unbiased data collection. However, the first author conducted the observations and interviews in Study IV, which took place at the relevant departments in each selected municipality, which might render comparisons problematic. A mitigating feature was that this data collection took place in the beginning of the research project, before the thesis and expectations of results had started to materialize. Either way, in hindsight, some impressions might have been different if only research assistants had been used throughout the entire qualitative data collection.

A further limitation of the qualitative studies was the unknown dependability and credibility of qualitative observations. Interviewer effects and the transference of expectations

were counteracted by using semi-structured interviews and observational guides. Another issue was the use of several research assistants, who both separately and together collected the data and who afterwards could compare and discuss materials and the interpretation of experiences. This is both an advantage for accuracy, since any deviant perceptions probably conformed to those of the other observers, but may also be a disadvantage for the representativeness, since a desire for conformity probably led to some impressions remaining unrecorded. Overall, the project had many points of reference and opportunities for validation (including, for example, the use of several methods, a large range of data, several different types of informants, and the use of several perspectives), which strengthens the thesis.

4. Summary of Results

The first aim – to understand the most important predictors for satisfaction with care – was investigated in Studies I and II. The second aim – to understand the influences behind variations in the most important predictors – was investigated in Studies III and IV.

4.1. Result Study I – Budget and Satisfaction

The purpose of Study I was to compare structure factors (extent of care resources) and process factors (how care is performed) in relation to older persons' satisfaction with care. For example, if a municipality were to prioritize staffing and spending on elderly care, while not succeeding in providing influence for the older persons in nursing homes, would this have a greater impact on satisfaction with care than the policy of a thrifty municipality, which succeeds in providing a highly evaluated care process? The national elderly survey from 2012 was analyzed on an aggregated municipal level, including all of Sweden's municipalities (N = 324). Donabedian's model (1988) with structure, process, and outcome was used to model the relationships. Process was operationalized in terms of perceptions of respect, information, and influence, which all had a strong relationship with satisfaction with care; while structure was operationalized in terms of budget per capita, budget per elderly person, number of personnel, and care workers' level of training, and had non-significant relationships with satisfaction with care.

Process variables accounted for much of the difference in satisfaction with care, while structural variables did not. The only structural variable that presented any correlational relationship with satisfaction with care was the level of staffing in nursing homes. In other words, the more staff a municipality had in its nursing homes, the more satisfied the older persons were. However, a further analysis of this structural impact by a hierarchical two-step regression analysis, depicted in Figure 3 (first, number of personnel, and second, experience of treatment), demonstrated that this impact from staffing was fully mediated by process variables.

The conclusion from Study I is that the two categories, structure and process, together explain over half of the difference in satisfaction with care in both home care and nursing home care, and that process variables contributed the greatest part. In other words, the more the older persons felt respected, informed, and able to influence their life situation, the more they were content with the care they received. Study I also contributed to testing current

theories, by demonstrating that Donabedian's model (1988) is useful in the context of contemporary Swedish elderly care.

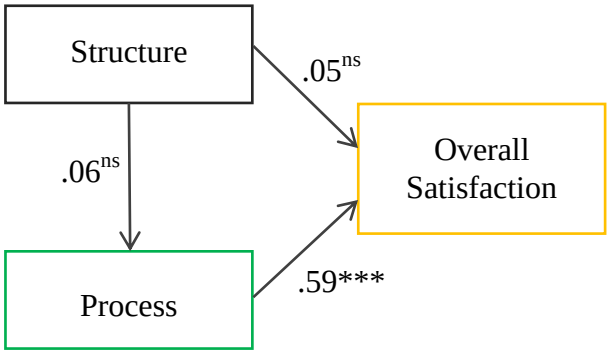


Figure 3. The research model behind Study I (*N* = 324 municipalities and districts), showing the regression relationships between structure (number of personnel, step 1) and process (treatment, step 2) in satisfaction with nursing home care, based on Donabedian (1988). ns = non-significant. *** $p < .001$.

The relationship between the financial resources spent by a municipality and satisfaction with care was surprisingly weak, and is shown in a correlational diagram with Swedish municipalities in Figure 4. The municipal structure in terms of money spent per older person in nursing homes in 2012 (which ranged from SEK 300,000 to SEK 900,000) has no relationship with the percentage of older persons in the municipality who were satisfied with the care they received (which ranged from 50% to 100%). Indeed, the non-parametric Loess-fit trend line shows that there is a negative relationship between money spent and satisfaction.

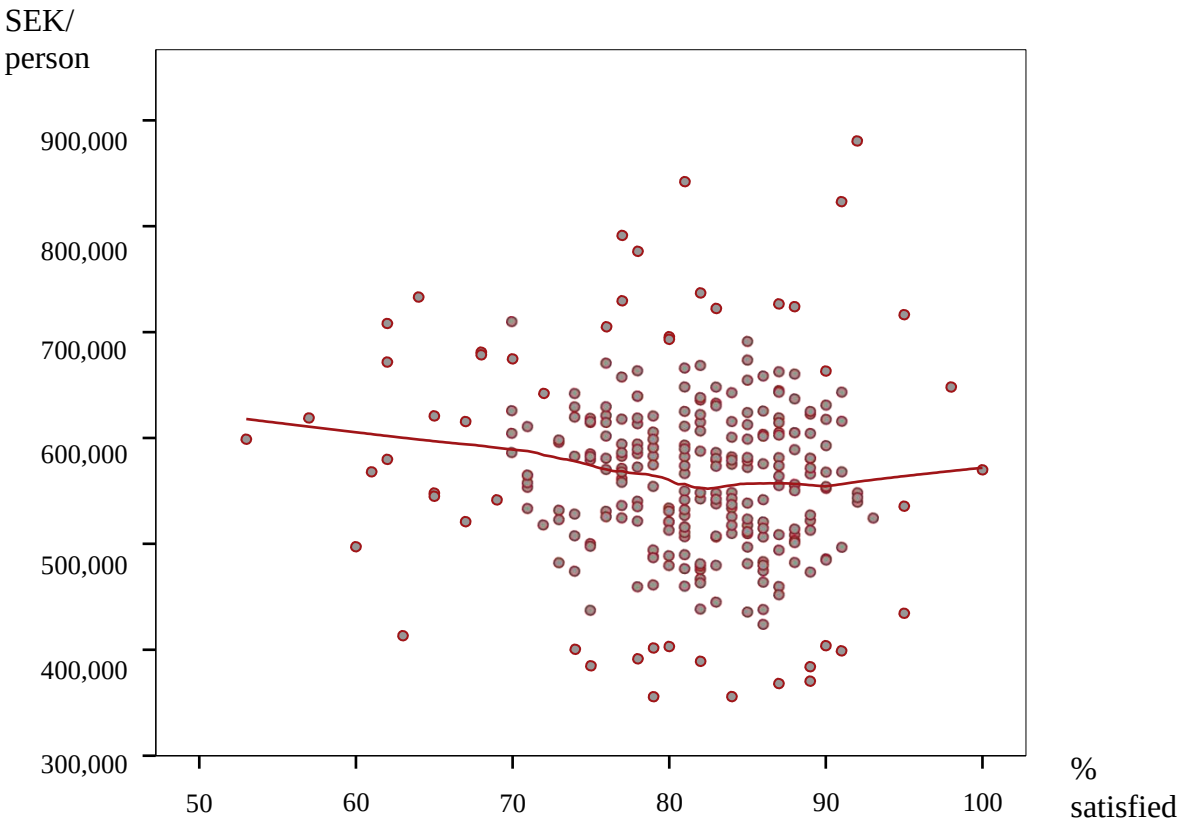


Figure 4. Swedish municipalities represented as dots, including outliers, with data from 2012. The graph shows that the amount of money (SEK) spent per person in nursing homes is not related to the percentage of older persons satisfied with elderly care. A Loess-fit line illustrates the null relationship.

4.2. Result Study II – the Care Process and Personal Conditions

The purpose of Study II was to extend the theoretical model from Study I and expand our understanding of the care process by investigating the individual-level data from the national elderly survey (*N* = 95,000). The first objective was to compare the relative impacts from process factors and personal variables on satisfaction with care. The theoretical background was the person *versus* situation dilemma from social psychology (Funder, 2008), which could be summarized as: In any given situation, do the individual properties (in this case level of anxiety) of the involved person, or the characteristics of the situation (in this case the nature of the user-oriented care process) predict a given outcome more accurately (Mischel, 2009)? The result, as seen in Figure 5, is that an individual factor, mental anxiety, accounted for a smaller part than a process factor, experience of treatment, in explaining the difference in satisfaction with care.

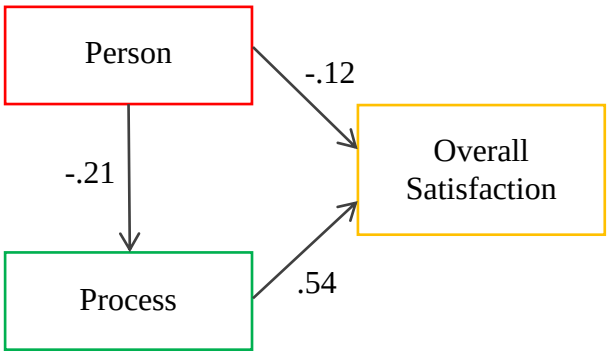


Figure 5. The research model behind Study II on individual older persons assisted with elderly care. Person = Mental anxiety. Process = Treatment experiences. *N* = 78,538. All estimates are significant ($p < .01^{-6}$).

The second objective was to determine whether successful user-oriented care can moderate personal variables in alleviating the aging condition. The theory illustrated by Figure 2 suggests that the user-oriented care process starts with the predicament of failing health and increasing anxiety, which in turn creates the vulnerable condition of loneliness, and thus the need of assistance. Figure 6 depicts the result of Study II and the interplay between the person variable *loneliness* (scaled 1-3) and the process variable *safe environment* (1-5) in

predicting satisfaction with care (1-5). The curvilinear relationship between personal loneliness and satisfaction with care, as moderated by the process variable safeness, was analyzed with the help of a quadratic regression model[10]. Safeness had a greater impact than loneliness, as seen in Figure 6 by the steeper slope, and the higher satisfaction (comparing color bands). Moreover, the figure reveals the accentuating lowering of satisfaction when low process safeness is coupled with high personal loneliness.

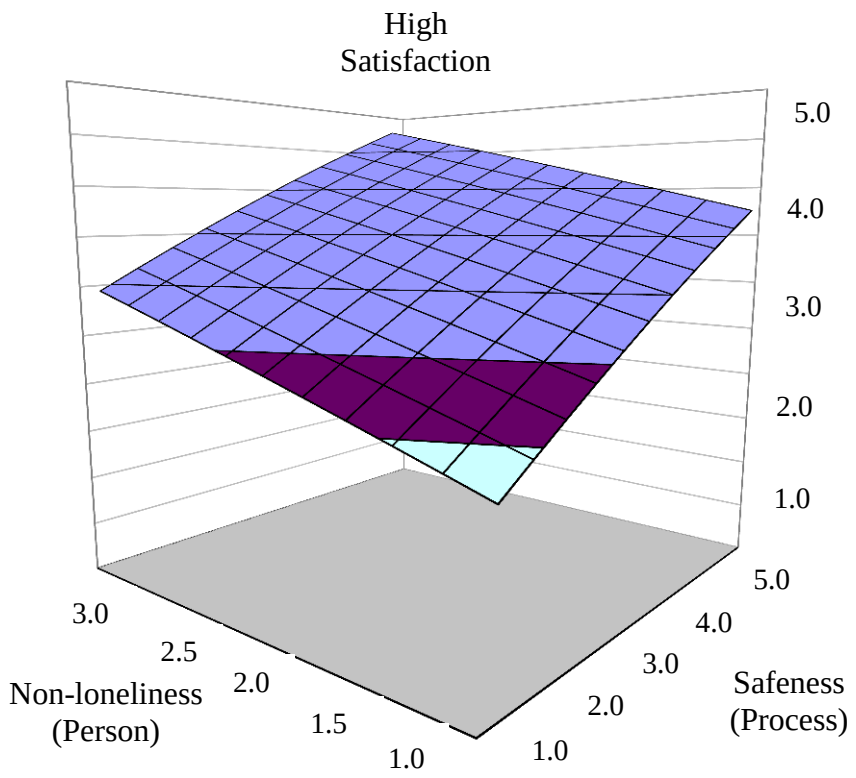


Figure 6. The interplay between the older person's feelings of loneliness (left X-axis) and a safe user-oriented care environment (right X-axis) on satisfaction with care (the accelerating decline in satisfaction related to loneliness and low safeness), as depicted by the color bands.

The third objective was to analyze the impact of user-oriented elderly care on the aging condition with the help of Structural Equation Modeling (SEM). The path-analysis in Figure 7

[10] (Safeness) x (Loneliness) x (Safeness)^2 x (Loneliness)^2 x (Safeness x Loneliness) = Satisfaction with Care

(based on the theory illustrated in Figure 2) shows that the process factors, *treatment* and *safeness*, play important roles in mediating the relationship between personal loneliness and satisfaction with care. The figure shows how *anxiety* was negatively related to health (the lower the health, the higher the anxiety) and positively to *loneliness*. Furthermore, *loneliness* in turn was negatively related to overall satisfaction with care, but this depended on the experiences of *safeness* and *treatment*, which largely alleviated the relationship (Figure 7). In other words, process factors, when successfully implemented, can act as counterbalances to an older persons' predicament of loneliness, thus reducing the impact of loneliness on satisfaction. In conclusion, how the older person perceives his or her health, anxiety, and loneliness, all play a role in determining satisfaction with care, but not as much as the evaluation of how one feels treated and how safe one feels.

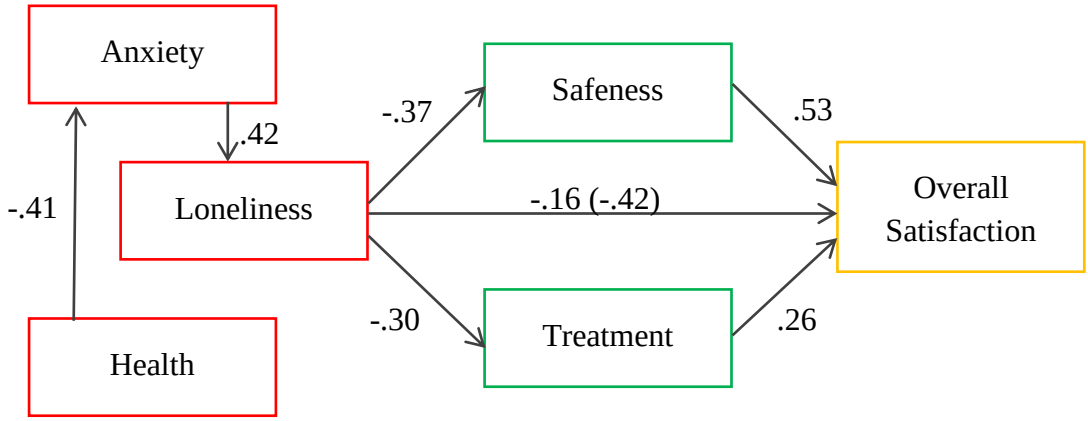


Figure 7. The extended integrated person-process path model of Study II showing how Swedish nursing homes alleviate the aging condition on the individual level (N = 19,097). Red boxes represent person variables and green boxes process variables, while the yellow box is the outcome variable. All regression coefficients were significant, $p < .01^{-6}$, and confidence intervals are within .01 of the values.

4.3. Result Study III – Quality Agents Model

The purpose of Study III was to explore the reasons why the user-oriented care process, which Studies I and II had revealed to be the most powerful predictor, varies. The perspective in Study III shifted from the older person to the persons most involved in delivering care, the care workers. The annual rankings in the national elderly surveys indicated that there are differences between municipalities, even though the differences tend to be statistically small (Kajonius & Kazemi, 2014). The objectives were to describe user-oriented care differences and to determine the reasons for these differences.

Study III established a framework for understanding user-oriented differences, in the form of a Big Five Model. The model summarizes five themes that were found by thematic analysis, based on observations both in home care and nursing homes. The five factors were: 1) Task, 2) Person, 3) Affect, 4) Cooperation, and 5) Time (abbreviated T-PACT). We suggest that these constitute the qualitatively distinguishable features of user-oriented elderly care. The model's taxonomy was subsequently validated by measuring the same factors with quantitative observational methods in a supplementary study (Kazemi & Kajonius, 2015a).

The second and main result of Study III was that a number of complex challenges in the care organization affect the care process. The Quality Agents Model (Figure 8) summarizes the material collected during interviews and observations, and models the various levels and perspectives encountered when explaining differences in care. In other words, differences were perceived to originate also from levels beyond the interpersonal level, such as the level of support from the care unit manager, or the departmental level in the municipality. It was suggested that even the attitudes of the town and national regulations affect satisfaction ratings.

One of the ideas behind the Quality Agents Model is that the self-rated evaluations made by older persons reflect not only the sources of actual differences in the interpersonal care process, but also the psychological input from all levels in the care organization. This theory is founded on previous work on self-rated health by Jylhä (2009), and extends this work. Examples of psychological input from other levels than the interpersonal are social disturbances by temporary patients in the nursing home (care-unit level) or the sentiment in the community due to, for example, declining jobs and economy (town level). Biased media coverage on elderly care is an example of a national-level influence. Whether real or perceived, the differences in the care process can be understood from an overall system perspective, as depicted in the Quality Agents Model (Figure 8), and this model may be a

useful tool for understanding the psychology of satisfaction. The implications of the model are discussed later in the thesis.

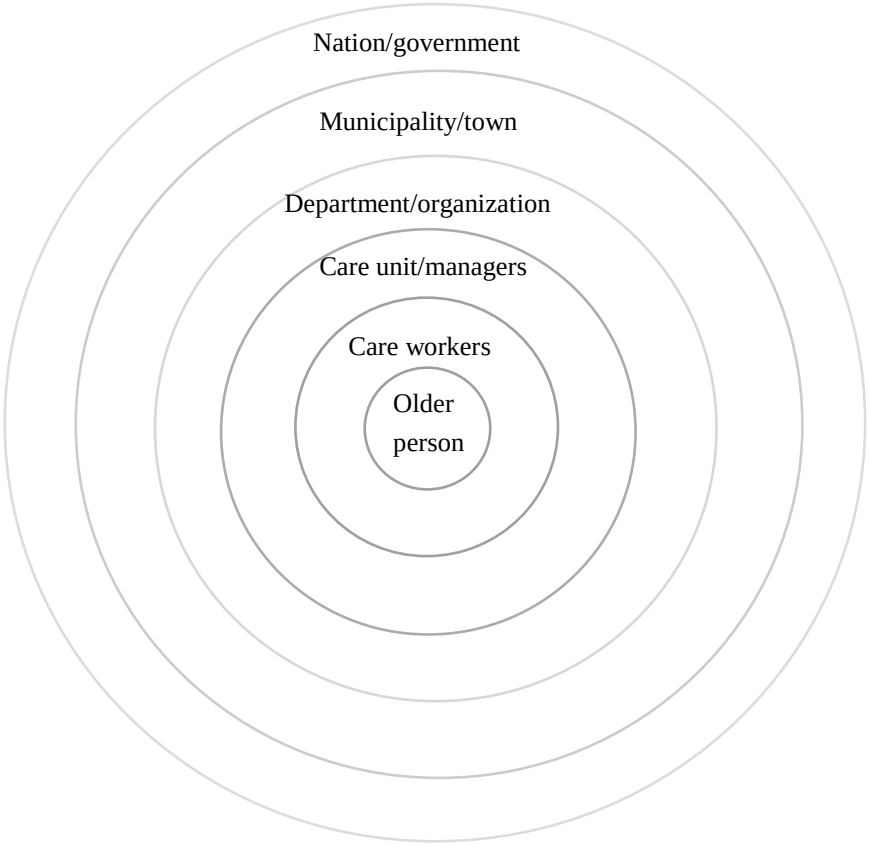


Figure 8. The Quality Agents Model, derived from observations and interviews with care workers. The circles depict the reference points in the levels of the care organization that are perceived to impact the care process. A central idea of the Quality Agents Model is that the closer the level is to the older person in focus, the larger the impact it has on evaluation

4.4. Result Study IV –Differences in Organizing Care

Study IV was intended to extend the results of Study III by examining one level of the care organization that many care workers and managers found important – the level of municipal departmental management. Also, stimulated by a study by Kazemi and Kajonius (2015b) that used multi-level modeling analysis (MLM), we intended to explore qualitatively the differences in user-oriented care satisfaction that arose from belonging to different municipalities. Some municipalities are better at supplying user-oriented satisfaction than others, according to the older persons' ratings, and we decided that this "municipality effect" needed to be explained. Difference at levels beyond the interpersonal level may help to explain what influences care process satisfaction, or what influences the satisfaction ratings given by older persons. Studies of the higher management level in the municipalities studied in Study III would provide clues about what distinguishes a highly successful care organization from a less successful one, and expound on the possibilities of improving elderly care from a managerial perspective.

Participation in managers' meetings and interviews with managers revealed differences in leadership work climate and in organizational principles. Thematic analysis was used to group the results of Study IV into three perspectives: 1) the views of the older persons, 2) the views of the employees, and 3) the views of the mission of the organization. The work climate and organizational principles differed between the two municipalities within each of these perspectives (Schneider et al., 2011) and Table 2 summarizes these differences. The more successful municipality exhibited more of what in Ostroff's taxonomy (1993) is known as the *affective/supportive* dimension, which in this study was expressed by the concept of the older needy person being the reason for the organization. The second dimension, *cognitive/autonomous,* also distinguished the more successful municipality, and relates to the concept of allowing the employees to be creative and self-achieving professionals. Finally, the third dimension, *instrumental/structural*, was interpreted as relating to rigid structures in terms of tasks and formal procedures, which was the most notable feature of the average municipality.

The conclusion from Study IV is that the organization and climate at the top departmental level (two levels beyond the interpersonal relationship in the Quality Agents Model, as seen in Figure 8) can contribute to differences in user-oriented elderly care between the two municipalities. Furthermore, and more importantly, care organizations can be characterized by their organizational principles and work climate at the management level.

Table 2.

Relationships between Organizational Climate and Principles in Elderly Care

Organizational climate		Organizational principles	
Category type	Perspective	High-success municipality	Average-success municipality
Affective (supportive)	Older person	End-users are fellow citizens with needs	End-users are older clients with preferences
Cognitive (autonomous)	Co-worker	Co-workers are team colleagues in mission	Co-workers are part of the organization
Instrumental (structural)	Mission	The mission has priority over structure	Rules and roles guide the mission

Note. The three category types are based on Ostroff (1993) and Schneider et al. (2011).

4.5. Additional Results

This section presents the most relevant additional findings that support the main thesis. We have analyzed whether demographic subgroups such as social class (socio-economic status) affect the analyses of satisfaction with care. Such an effect would emphasize the importance of person-related variables. Being born in Sweden (N = 51,600) had only a small positive effect on satisfaction with care (d = 0.18), compared with being born outside Sweden (N = 6,000). A follow-up multiple regression model with satisfaction with care regressed onto three demographic variables (birthplace, educational level, and socio-economic status) showed that the variance that was accounted for was minimal, 0.4%.[11] In other words, being born in Sweden was a weak predictor, while educational level and socio-economic status had no effect. We concluded that demographic factors have only minimal effects on the results.

One of the important aims of elderly care is to recreate and maintain a home-like environment. Additional analyses of the national survey data showed that the older persons living at home (N = 51,400) have a higher satisfaction with care (d = 0.33) than older persons living in nursing homes (N = 22,400). Figure 9 shows how the relationship between satisfaction with care and safeness is moderated by care setting (home care or nursing home). The lower the experience of safeness, the lower the overall satisfaction, and this effect is even more pronounced in nursing homes. Moreover, just as previously seen in the thesis' introductory graphical abstract, the overall experience of satisfaction is higher in home care than in nursing homes while, interestingly, safeness is lower. Home-care users also reported higher anxiety than people living in nursing homes, which may explain some of the differences in safeness. Furthermore, an exploratory analysis showed that the older persons living alone (N = 46,200) have significantly lower satisfaction with care (d = -.26) than those living with someone (N = 13,700).

These findings confirm the importance of viewing elderly care in terms of social relationships, and are further discussed in Kazemi and Kajonius (2015a), where user-oriented care based on quantitative observations is compared between home care and nursing homes.

[11] ($F(3, 47957) = 59.23$, $p < 0.001$)

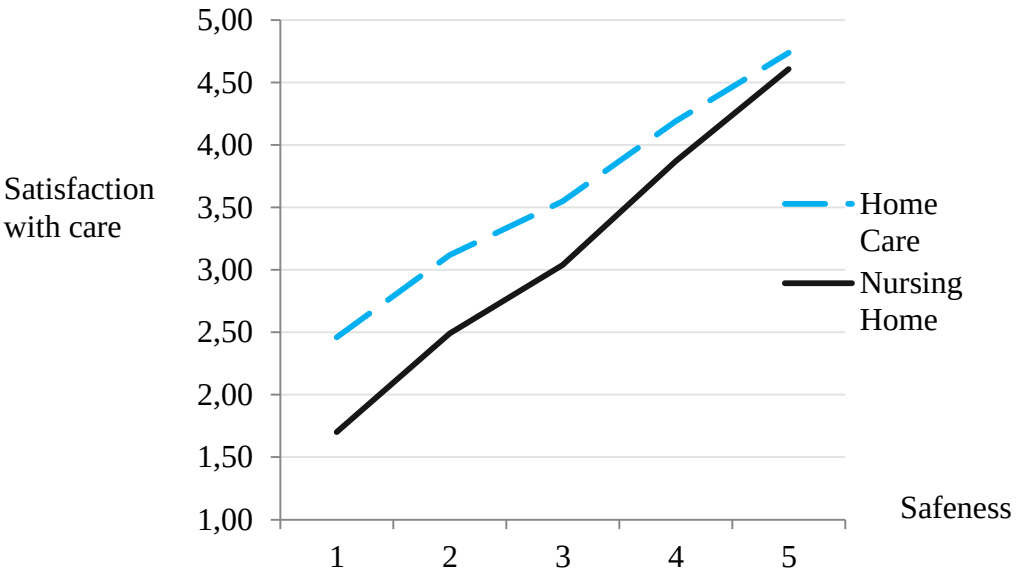


Figure 9. The individual-level results (*N* = 73,800) of satisfaction with care related to experiences of safeness, classified according to care sector. Satisfaction is higher at home with assisted care than it is for those staying in a nursing home, and this gap widens when safeness is lower.

Another question of practical importance is the extent to which municipalities can influence satisfaction. The amount of variation that can be accounted for by belonging to a certain municipality plays a role in confirming the reasoning behind the Quality Agents Model from Study III – that the older person is influenced by other factors than the experienced care at the interpersonal level. We have used a multi-level model (MLM) that separates the individual from the municipal level. The intra-class correlation (ICC), which measures the percentage of similarity between observations that can be explained by the belonging to the same municipality, shows that only 2% of the difference in process variables in home care and 5% of the difference in nursing homes can be attributed to belonging to certain municipalities. We conclude that belonging to a particular municipality has only a very small effect beyond the effects on the interpersonal level (Kazemi & Kajonius, 2015b).[12]

[12] However, a value of approximately .05 (as in nursing homes), even though considered small (Field, 2013), may be significant (cf. Meyer et al., 2001).

5. General Discussion

The first aim of the work presented here was to determine what predicts satisfaction with care. The results of Studies I and II show that interpersonal process factors such as information, influence, respect, treatment, and safeness are better predictors of satisfaction with care than structural factors such as budget and training, and better than personal factors such as anxiety and health. The second aim was to determine why predictors of satisfaction differ. The results of Studies III and IV show that differences in the user-oriented process factors are perceived to be related to multiple levels in the care organization, and that municipalities with different satisfaction results have different organizational principles and managerial climates. This is the first time that user-oriented elderly care has been analyzed with respect to satisfaction with care using a large, national sample, and shows that the aging condition can be alleviated. The overall finding was that the relationship between care worker and older person is the most important factor for explaining older persons' satisfaction with care.

5.1. Interpreting Satisfaction with Care

The overall objective of the work presented here was to understand how satisfaction with care is generated. This was achieved with help of statistical analyses of the data sets from the national elderly surveys, both on the individual level and on the municipal level. The results from Study I suggest that elderly care may not need a higher budget: it needs better interpersonal skills. However, the cross-sectional design of the studies does not allow longitudinal conclusions. In other words, the former large budgets or other municipality structural factors may be the reason that interpersonal skills today are strongly related to satisfaction. Also, controls for potentially mediating variables, such as demographic and other municipality characteristics, were not included in the analyses (Davey, Johansson, Malmberg, & Sundström, 2006), which limits the validity of conclusions about the lack of impact of structural variables. Furthermore, interactions between structure and process variables, which may have provided additional interpretations, were not exhaustively explored, as discussed previously and more below under "Limitations".

With these caveats in mind, the results support the notion that what are known as "hygiene factors" (Sachau, 2007) have been taken care of in Swedish elderly care. Hygiene factors are the basic needs of, for example, treatment and safety. A lack of basic hygiene factors makes people *dissatisfied*. In contrast, motivational factors, which reflect the

psychological needs of, for example, a social life and self-fulfillment, make people *satisfied*. Swedish municipalities have greater structural resources than other European nations, and it is possible that structural effects have reached a ceiling and cannot account for more variation. Thus, process factors may now be more important than ever for satisfaction (Wagner et al., 2010), as improvements in the values of structural variables have taken satisfaction as far as they can.

Study II showed that the care process, as expressed in the user-oriented behaviors of creating safeness and providing treatment by care personnel, can counteract the impact of the personal aging condition (loneliness) on satisfaction with care. Support for this interpretation comes from studies that show that satisfaction is higher and loneliness lower in Sweden than in Mediterranean countries (Sundström, Fransson, Malmberg, & Davey, 2009). This result also implies that satisfaction with care lies to a certain extent in the hands of the care workers, and the way in which they act on the interpersonal level. However, the individual aging condition (health, anxiety, and loneliness) also has an effect, even though these factors do not predict satisfaction with care as accurately. The importance of the individual condition is the essence of needing elderly care (Figure 2), and it characterizes the end of life (Bravell, Malmberg, & Berg, 2010). Even small individual differences make the everyday care experience unique. Despite the promising results that show that the care process has a profound effect, elderly care does not take away the individuality of the older person; it only relieves the impact of the aging condition.

The aging progression. The results also showed that satisfaction with care differs between care settings (home care or nursing home care). Those receiving home care were more satisfied and felt less safe. This is probably due to differences in personal aging progression, rather than in how the care is carried out (Figure 2). Aging generally begins with deterioration in health, which is followed by an increase in anxiousness, and this is the period at which the home-care services come into the picture. As the aging process continues with its characteristic decline in physical mobility and increase in loneliness, the time has come to move into a nursing home. The difference between a receiver of home care and a person in a nursing home may be that the latter experiences lower anxiety. This leads to a feeling of safeness, which is underscored by the availability of round-the-clock care. In contrast, overall satisfaction is likely to be higher as long as one lives at home, and experiences the feelings of being socially active and in control, as reported in the supplementary results section. It is possible that the differences between the results from different care settings are

methodological artifacts, to a certain extent. It is known, for example, that relatives help to answer the elderly surveys to a greater extent in nursing homes, and that the non-response rate is higher.

5.2. Interpreting Variations in Care

The other objective of the work presented here was to understand why the care process varies – what causes the different results in the yearly elderly surveys. Multiple perspectives were employed to answer this in terms of care workers, managers, and third-party observers. A theoretical analysis based on the material collected resulted in the Quality Agents Model, Figure 8, which shows how differences are influenced by multiple levels of the care organization. Study IV presents differences in management climate and organizational principles between municipalities, and confirms the validity of the model. The problem posed by media and the public opinion is that the care process differs depending on municipality (Lindgren, 2012). The work presented here, however, shows that variations in the care process mostly occur within municipalities (within-group), and not between municipalities (between-group) (Kajonius & Kazemi, 2014). Our field observations show that most, if not all, care workers enjoy meeting the older persons and meet their needs skillfully. The bulk of variation in the care process occurs due to random contingencies, such as the personalities of care workers and temporary challenges that the care units are facing. Differences between municipalities and between elderly care units are not large or systematic. These qualitative impressions are supported by supplementary studies that further quantified the between-municipality variance to be as little as 2% in home care and 5% in nursing home care. This would indicate that most of the variance takes place within municipalities (Kazemi & Kajonius, 2015a; Kazemi & Kajonius, 2015b).

From a psychological perspective, the Quality Agents Model suggests an extended and alternative explanation of differences in the care process between municipalities in the national surveys. It might simply be that the differences in ratings express municipality differences in user-oriented care on the interpersonal level, and that such factors as department managerial skills and work climate affect the care process. However, it is also possible that the differences in ratings are an expression of influences from beyond the interpersonal level, which would explain why the present study did not reveal interpersonal differences between municipalities (or care units). Jylhä (2009) suggests that a respondent needs a comparison point, such as another person in a similar situation or another context, when rating a service. Evaluating satisfaction is an intricate process that is influenced by

many factors (for an overview of cognitive satisfaction see Kahneman, 2011). This is also the theory behind the Quality Agents Model. The personal, subjective evaluation of one's experience is only one of many inputs, and an evaluation includes additional contextual levels. These may be other older persons of the same age, or expectations based on comparison with other care units or other towns, and these contextual levels influence the ratings of care experience. The strength of the model is that it acknowledges the many inputs involved in forming an opinion, and provides a tool for the analysis of differences in user-oriented contexts.

Studies III and IV show that organizing around the user (in contrast to organizing around rules and regulations) is a key part of what inspires employees to do great work. The results presented here confirm earlier research in psychological climate (Wilderom & Berg, 2000). The size, age, and type of organization are not strong moderators of the effect of climate effects on performance (Sackmann, 2011), which emphasizes how important the managerial climate is. We expect that successful management leads to a healthy organizational climate and high end-user satisfaction (Schneider & White, 2004). The Quality Agents Model may help to explain this chain of user-oriented service, showing how upper levels in the care organization influence the experiences of the care service performed.

5.3. Result Limitations

It is possible that the validity of the seemingly convincing results from Studies I and II is compromised by variables that have not been considered. The weak association between structural variables and satisfaction, for example, may be affected by several factors, such as socio-economic status, share of immigrants, north-south cultural differences, urban-rural differences, and private-public elderly care differences, that have not been considered (Savla, Davey, Sundström, Zarit, & Malmberg, 2008).[13] Further, the strong association between process variables and satisfaction with care may be due to conceptual overlaps in constructs, since both are subjective and of psychological nature. It is possible, for example, that much of the relationship between anxiety and satisfaction with care revealed by Study II depends on the older person's personality trait *neuroticism,* to give an example of a variable that has not been considered, and of conceptual overlap.

[13] The Open Comparisons supplied one structural variable, the municipal deviation index that attempts to control for a number of demographic factors. When this was used instead of budget per capita, the same conclusion as reported in Study I was reached.

Interaction variables have not been considered in the statistical analyses. The multiplication of variables is usually introduced to determine whether non-linear effects are present, particularly in large samples. There were no theoretical reasons for introducing interaction variables in the analysis presented in Study I, which is based on Donabedian's model (1988), and they were thus excluded for reasons of parsimony. The diverging effects of structure and process further encouraged a parsimonious model in the final report. It is, however, reasonable that structural variables provided the necessary resources for process variables to be longitudinally effective, thus enabling interaction analysis. This is, unfortunately, not possible with the current data. Study II, which is based on a large individual sample, successfully made use of an interaction model in which *loneliness* multiplied by *safeness* was used when predicting satisfaction with care (Figure 6). In other words, the test determined whether *loneliness* coupled with *feeling unsafe* amplified the decline in satisfaction. This was the case.

Studies III and IV presented further qualitative factors in the form of five latent process variables. These were introduced to cover the user-oriented care process and were designed to be conceptually orthogonal (i.e., they have no substantial within-taxonomy overlaps). No analysis of how these factors are intertwined, or how they moderate satisfaction with care was undertaken. To remedy this, we operationalized the factors with quantitative ratings in a supplementary study (Kazemi & Kajonius, 2015a), the results of which show that the process variables overlapped onto two common underlying dimensions of user-oriented care, *task* and *relation*. No interaction terms were further tested in the supplementary study. Study IV should also be subjected to interaction analyses, which may show overlaps or moderations in future research.

Confounding explanations. All the studies were cross-sectional and took place using data for a given year. Thus, no information about chronological effects, such as the long-term impact of the level of financial resources, was available. Study I shows that structural resources had no effect on satisfaction with care in 2012. Cross-sectional studies have the advantage that possible clustering in a population is avoided, while the disadvantages include such effects as missing potential cohort effects and providing too superficial an overall description of the population. As in any large epidemiological survey, certain variables are better explored than others. For example, aggregated municipal process-variable data was compiled in Study I based on the individual answers from older persons, while structural data was taken from census statistics. This may be a problem since process variables, such as

psychological experience-based respect and information from individuals, may have effects on outcomes that differ from those of economic fact-based structure variables, such as cost per inhabitant. This may arise from methodological artifacts, as discussed earlier, or from true psychometric differences in variables. In other words, the differences in effect might partly arise from differences in methods, and not only from factual differences. Epidemiological studies are notorious for the difficulty in revealing conclusive causal relationships, and emphasizes the need for longitudinal studies in future research on the subject.

Data from the two care sectors, home care and nursing home care, were analyzed separately in order to present the challenges facing Swedish elderly care as accurately as possible (Figure 9). However, separating the results into these two care sectors raises the need for further interpretation. For instance, the various phases in the aging process depicted in Figure 2, such as better health related to better overall treatment in home care and lower anxiety related to feeling safe in nursing homes (Study II), may explain some of the differences between care sectors. There may be interplay between structure, process, and person that affects satisfaction with care, and we have done our best to analyze the data at the appropriate level of analysis (individual, care sector, or municipality). Further, the varying nature and levels of data did not allow a comprehensive model that could control for all predictors from the various studies to be developed. This problem was one of the primary reasons for conducting the qualitative studies III and IV, in which more perspectives could be taken into account.

The term "proxy interview" describes the phenomenon of a close relative helping to complete the elderly survey. This may have acted as a confounding factor when analyzing differences. The response rate also may have skewed the representativeness of the results. An exploratory analysis reported a small effect (d = 0.14) in the direction that older persons who had received help with completing the questionnaire were less satisfied with care, than those who completed the questionnaire themselves. This may have been the result of a negativity bias from close relatives who wanted to keep pressure on the institution to improve the situation for their loved one, or it may be the result of the poorer health of those who received help influencing the evaluation of care. In hindsight, we can see that it would have been appropriate to control for proxy interviews in the statistical analyses.

Generalization issues. The generalizability of the results is another concern. It is tempting to call the sample "representative" or at least "comprehensive", since all municipalities in Sweden take part in the surveys, and the data cover a majority of the

population that uses elderly care services. However, a majority of the respondents stated that they had received help in completing the survey. The characteristics of those who received help and those who did not may have differed in several person variables, such as health and level of anxiety, and in several process variables, such as feelings of respect and sufficient information. In hindsight, we can see that it would have been better to divide the sample into those who had received help in completing the survey and those that had not. It is possible that this factor explains some of the differences between home care and nursing homes, and may as mentioned be the underlying cause of the correlation between poorer health and low satisfaction with care. Seeing these facts, it likely that we do not have the full picture of how older persons in Sweden are faring.

Moreover, the generalization of the qualitative studies, especially Study IV, warrants caution. Only two municipalities were analyzed at the level of departmental management and we do not know whether the relationships between organizational climate and principles that we have revealed here will remain valid when more municipalities are included. Study IV should be viewed as a tentative study that explores differences at higher levels in the care organization.

Integration of results. Some of the results from the studies included in the thesis may be incommensurable. The first aim was based only on statistical data, while the second aim was based only on qualitative data. These two aims, together with potentially conflicting methods concerning epistemology, may not complement each other in a constructive manner. For example, Study I analyzed variation in the care process in terms of differences between municipalities (between-group), while Study III concluded that the variation arose from differences within municipalities (within-group). The overall conclusion is that both views probably hold some of the truth. A study (Kazemi & Kajonius, 2015b) showed that up to 5% of the variance arose from differences between municipalities. This could be small enough to miss in the field observations in Study III, while large enough to be detected at the level of municipal departments, in Study IV.

The Quality Agents Model provides another example of difficulties in interpreting the results. Study I implied that real differences exist between municipalities. Study III gave an alternative interpretation: that the differences are the result of psychological input from levels beyond the level that is actually rated. Study IV then showed that differences are affected by differences in management climate and organizational principles, but failed to determine whether such differences affect the level of interpersonal care. The strength of the Quality

Agents Model is that it can ameliorate how care workers do their best in the caring relationship without taking the municipality in which they work into consideration, and how interpersonal user-oriented care still can differ between municipalities. In other words, the model can explain and absorb the results from work to achieve both the first and second aims of the thesis. Despite the study limitations described above, and regardless of which interpretation one subscribes to regarding the cause of differences in the care process, several implications can be derived from the material, allowing several recommendations to be made.

5.4. Implications and Recommendations

Contributions to theory. The work presented here has perhaps for the first time tested user-oriented care against a relevant outcome measure (satisfaction with care), with a large national sample. Also, no previous studies have demonstrated the alleviating effects of safeness and treatment on the aging condition of loneliness. These are two additions to the body of knowledge of elderly care. The results provide for instance explanation to why privately run organizations are often ahead of municipal organizations in satisfaction surveys. It may be that private organizations are quicker to implement a customers' perspective, and therefore have slightly more satisfied older persons, while using less resources (Stolt, Blomqvist, & Winblad, 2011). Moreover, this thesis has illustrated the progression of the aging condition with help of path analysis (Figure 2), and shown how deteriorating health predicts increased anxiety, which predicts loneliness, which in turn relates to satisfaction with care. This result may help relatives and care workers to understand the progression of their elderly dear ones.

We have also tested Donabedian's (1988) proposition on structure, process, and outcome, in this order. In the context of Swedish elderly care, *process* quality has a direct and strong relationship with the outcome *user satisfaction*, even when not taking *structure* into account. In other words, subjective elderly care is more important than objective care. One example of this is how the number of care staff, an objective measure, had a minimal impact (Study I), while the perceived availability of staff, a subjective measure, had a large impact (Study II) on satisfaction with care. We conclude that a psychological interpretation of user-oriented elderly care can be beneficial.

This thesis has also contributed to theory by emphasizing that the end-product of user satisfaction is contextual in nature. A meta-analysis by Szymanski and Henard (2001) showed that psychological predictors, such as perception and own affect (and not only actual service quality), play an important role in determining satisfaction. Furthermore, the care relationship

is influenced by other levels in the care organization than the user-oriented interpersonal level (Figure 8). A central idea of the Quality Agents Model is that the closer the "intervention" is to the person in focus, the larger the impact it has on evaluation. Conversely, the further away the "intervention" is from the person, the lesser the impact it has on evaluation. Even though the level of interpersonal experience is the most important level for satisfaction with care, care organizations can influence satisfaction by the manner in which they organize their enterprise. The results presented here suggest that the psychology of perception can help to understand the mechanisms of user-oriented elderly care.

Contributions to care policy. The way forward for quality improving work is often to prescribe more individualized care, more tailor-made activities, and a greater obligation to document the care given. The results presented here suggest that these are not optimal choices. Additional work with documentation, for example, may take valuable staff time away from the older persons, while there is a temptation for policy makers to show that they are spending resources in the public interest. The results show that satisfaction with care cannot be purchased, at least not for Swedish municipal elderly care in its current state. There may very well be valid reasons for raising the resources for elderly care, and if so, time and staff availability ought to be given priority. Also, municipalities and privately run companies that are already investing in workers and setting aside time for elderly care may be empowered by these results. This is one of the first studies with a nationwide sample that provides empirical evidence for policy makers showing that a focus on larger number of skilled care workers can make a difference. This might encourage a renewed focus on how important relationships are for satisfaction with care.

A supportive work climate may have direct and indirect positive effects throughout the care organization. Increased knowledge about organizational climate and managerial psychology can contribute to achieving better performance. Higher levels of management can be organized in several ways in a care organization, even if the basic interactions between the care workers and the older persons remain much the same. The climate in higher managerial levels is in danger of becoming more governed by duty, regulations and structural inflexibility, given the ongoing political and public pressures that lead to increased demands for quality. Instead, courageous leaders could be part of a climate governed by a focused mission. Decisions made by managers decide the direction of elderly care.

It is worth remembering that satisfaction is also a psychological, stable trait-like construct that is characterized by inherent constancy (Lyubomirsky, Sheldon, et al., 2005).

This is one reason why organizational variables cannot often account for any significant amount of impact. Figure 10 illustrates the constancy of satisfaction with care in Swedish municipalities over 3 years, during which period the costs have steadily increased (Kajonius & Kazemi, 2015c).

Understanding quality rankings. Municipalities today work with restrained budgets but are generally able to provide care that satisfies most people. Indeed, Swedish care may be the best in Europe. However, public opinion is putting pressure onto home care units and nursing homes to further improve satisfaction with care, as do the municipality administrations. One reason for this is a lack of insight into how to interpret the annual rankings published by the National Board of Health and Welfare. A supplementary study has shown that municipalities positioned within 30 ranking positions of each other differ in user-oriented indicators by such small amounts that they lie within the limits of measuring precision (Kajonius & Kazemi, 2014). In other words, quality managers need not despair if their municipality falls 30 positions from one year to the next (Kajonius & Kazemi, 2015c). A fall in ranking by 30 positions corresponds to a handful of older people in the municipality changing from *satisfied* to *neutral*. If a municipality has, for example, 100 respondents, and the degree of satisfaction falls dramatically from 80% to 75% from one year to the next, this means that around five older persons have changed their evaluation. It is equally likely that the change in rating is due to a change in the personal aging condition or random incidents, as it is that it is due to an actual decrease in the quality of elderly care. This implies that care workers and managers are wrong to a certain extent in their belief that differences are affected by higher levels in the care organization. The difference that arises from differences in the municipal organization is minimal (Kazemi & Kajonius, 2015b). Understanding that your care performance does not depend on the municipality for which you work should encourage individual care workers that their work makes a difference in the lives of older persons.

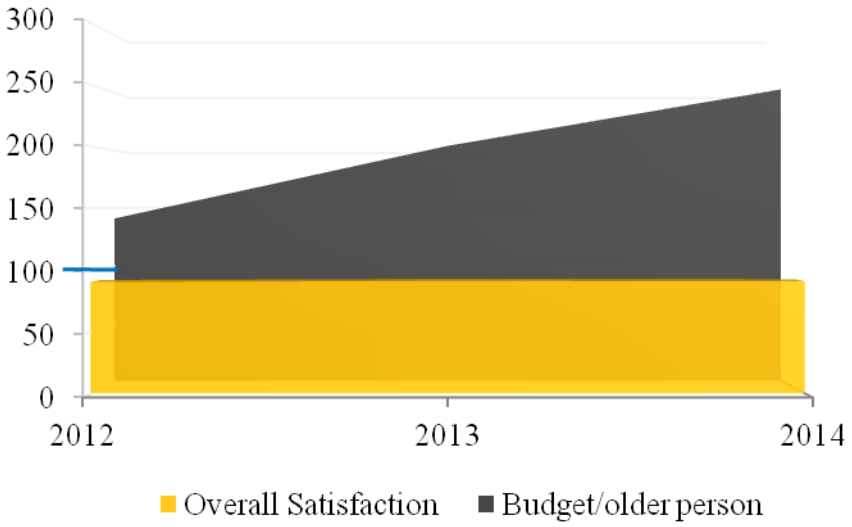


Figure 10. The national average percentage of older persons satisfied with their home care (bottom orange, 0-100%) has been stable around 90%, while the costs for home care have increased (upper dark grey, SEK 100,000-300,000), from an average of SEK 141,000 to 253,000 per older person and year, 2012-2014.

5.5. Future Note

The results presented here can guide employers in the decision whether their strategy for user-oriented care should be to hire additional staff, increase the skills of existing staff, or free existing staff from some of their current duties. Future research may examine whether hiring personnel with certain sets of personality traits can improve perceived safeness and the quality of treatment of older persons, and if employees can be trained in these aspects. The individualized approach in modern elderly care can be refined and implemented more fully, and the best contribution to achieving this may be research into the impact of roles and behavior of care workers. A logical next step is to develop new measurements for national elderly surveys to explain how differences arise, and to replace the currently used weak satisfaction indicators. As discussed above, single-item measurements are not the best basis for the long-term development of a nation's elderly care. New items that minimize the implicit input from sources other than the actual interpersonal care may be implemented in the national surveys, based on a better understanding of the psychology behind satisfaction with care. Sweden still lacks standards for high and low quality within elderly care (Nakrem,

Vinsnes, Harkless, Paulsen, & Seim, 2009), which could be amended by using psychometrically tested variables in future elderly surveys. Future studies may investigate whether the management working climate can function as a mediator for organizational principles and care satisfaction, as suggested by Mayer et al. (2007).

Closing conclusion. We conclude, based on the results presented here, that the most important dimension in satisfaction with elderly care is the relationship between the care worker and the older person. This has been established from several perspectives in the thesis. Two models (Big Five and Quality Agents Model) are provided for use in the advancement of user-oriented care and the understanding of differences in it. The results presented here are relevant for quality developments in all areas of elderly care services, and for other enterprises that employ a user-oriented approach.

References

Aartsen, M., & Jylhä, M. (2011). Onset of loneliness in older adults: Results of a 28 year prospective study. *European Journal of Ageing, 8*(1), 31-38.

Bergman, M. A., Lundberg, S., & Spagnolo, G. (2012). Public Procurement and Non-contractible Quality: Evidence from Elderly Care. *Umeå Economic Studies, No. 846*. Umeå University, Department of Economics.

Boomsma, D. I., Willemsen, G., Dolan, C. V., Hawkley, L. C., & Cacioppo, J. T. (2005). Genetic and environmental contributions to loneliness in adults: The Netherlands Twin Register Study. *Behavior Genetics, 35*(6), 745-752.

Bosco, F. A., Aguinis, H., Singh, K., Field, J. G., & Pierce, C. A. (2015). Correlational Effect Size Benchmarks. *Journal of Applied Psychology*, *100*(2), 431-449.

Boswell, W. R., Boudreau, J. W., & Dunford, B. B. (2004). The outcomes and correlates of job search objectives: searching to leave or searching for leverage?. *Journal of Applied Psychology*, *89*(6), 1083-1091.

Bravell, M. E., Malmberg, B., & Berg, S. (2010). End-of-life care in the oldest old. *Palliative and Supportive Care*, *8*(3), 335-344.

Bravell, M. E., Berg, S., Malmberg, B., & Sundström, G. (2009). Sooner or later? A study of institutionalization in late life. *Aging Clinical and Experimental Research, 21*(4-5), 329-337.

Brook, R. H., & McGlynn, E. A. (1996). Measuring quality of care. *New England Journal of Medicine, 335*(13), 966-970.

Chung-Yan, G. A. (2010). The nonlinear effects of job complexity and autonomy on job satisfaction, turnover, and psychological well-being. *Journal of Occupational Health Psychology*, *15*(3), 237-251.

Clarke, S. (2006). The relationship between safety climate and safety performance: a meta-analytic review. *Journal of Occupational Health Psychology, 11*(4), 315-327.

Closs, S. J., & Tierney, A. J. (1993). The complexities of using a structure, process and outcome framework: the case of an evaluation of discharge planning for elderly patients. *Journal of Advanced Nursing, 18*(8), 1279-1287.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*(1), 155-159.

Coyle, J., & Williams, B. (2001). Valuing people as individuals: Development of an instrument through a survey of person-centredness in secondary care. *Journal of Advanced Nursing*, *36*(3), 450-459.

Credé, M., Harms, P., Niehorster, S., & Gaye-Valentine, A. (2012). An evaluation of the consequences of using short measures of the Big Five personality traits. *Journal of Personality and Social Psychology*, *102*(4), 874-888.

D'Andrade, R., & Dart, J. (1990). The interpretation of r versus r2 or why percent of variance accounted for is a poor measure of size of effect. *Journal of Quantitative Anthropology*, *2*, 47-59.

Dackert, I. (2010). The impact of team climate for innovation on well-being and stress in elderly care. *Journal of Nursing Management*, *18*(3), 302-310.

Damiani, G., Farelli, V., Anselmi, A., Sicuro, L., Solipaca, A., Burgio, A., ... & Ricciardi, W. (2011). Patterns of Long Term Care in 29 European countries: evidence from an exploratory study. *BMC Health Services Research*, *11*(1), 316.

Davey, A., Johansson, L., Malmberg, B., & Sundström, G. (2006). Unequal but equitable: An analysis of variations in old-age care in Sweden. *European Journal of Ageing*, *3*(1), 34-40.

Denzin, N. K. and Lincoln, Y. S. (2011), *The SAGE Handbook of Qualitative Research*, Sage Publications: London.

Donabedian, A. (1988). The quality of care: How can it be assessed. *Jama*, *260*(12), 1743-1748.

Donaldson, S. I., & Ko, I. (2010). Positive Organizational Psychology, behavior and scholarship: A review of the emerging literature and evidence base. *Journal of Positive Psychology*, *5*(3), 177-191.

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*, *23*(8), 1205-1212.

Edvardsson, D., & Innes, A. (2010). Measuring person-centered care: A critical comparative review of published tools. *The Gerontologist*, *50*(6), 834-846.

Edvardsson, D., Sandman, P. O., & Rasmussen, B. H. (2005). Sensing an atmosphere of ease: A tentative theory of supportive care settings. *Scandinavian Journal of Caring Sciences, 19*(4), 344-353.

Fagerström, C., Borg, C., Balducci, C., Burholt, V., Wenger, C. G., Ferring, D., . . . Hallberg, I. R. (2007). Life satisfaction and associated factors among people aged 60 years and above in six European countries. *Applied Research in Quality of life, 2*(1), 33-50.

Fahlström, G., & Kamwendo, K. (2003). Increased physiotherapy in sheltered housing in Sweden: a study of structure and process in elderly care. *Health & Social Care in the Community, 11*(6), 470-476.

Falk, H., Wijk, H., Persson, L. O., & Falk, K. (2013). A sense of home in residential care. *Scandinavian Journal of Caring Sciences, 27*(4), 999-1009.

Field, A. (2013). *Discovering Statistics Using SPSS* (4th Ed.). London: Sage Publishing.

Fjær, E. G., & Vabø, M. (2013). Shaping social situations: A hidden aspect of care work in nursing homes. *Journal of Aging Studies, 27*(4), 419-427.

Fleishman, R. (1997). Non-medical predictors of quality of care of hypertension in elderly patients. *International Journal of Health Care Quality Assurance, 10*(3), 107-116.

Forbes-Thompson, S., & Gessert, C. E. (2005). End of life in nursing homes: Connections between structure, process, and outcomes. *Journal of Palliative Medicine, 8*(3), 545-555.

Fredrickson, B. L. (2005). The broaden-and-build theory of positive emotions. In F.A. Huppert, N. Baylis, & B. Keverne (Eds.), *The Science of Well-Being*, (pp. 217-238). New York: Oxford University Press.

Fujita, F., & Diener, E. (2005). Life satisfaction set point: stability and change. *Journal of Personality and Social Psychology*, *88*(1), 158-164.

Funder, D. C. (2008). Persons, situations and person-situation interactions. In O.P. John, R. Robins & L. Pervin (Eds.), *Handbook of Personality, 3rd ed.*, (pp. 568-580). New York: Guilford.

Fung, C. H., Lim, Y. W., Mattke, S., Damberg, C., & Shekelle, P. G. (2008). Systematic review: the evidence that publishing patient care performance data improves quality of care. *Annals of Internal Medicine, 148*(2), 111-123.

Galea, S., & Tracy, M. (2007). Participation rates in epidemiologic studies. *Annals of Epidemiology, 17*(9), 643-653.

Genet, N., Boerma, W. G., Kringos, D. S., Bouman, A., Francke, A. L., Fagerström, C., ... & Devillé, W. (2011). Home care in Europe: A systematic literature review. *BMC Health Services Research, 11*(1), 207.

Gogol, K., Brunner, M., Goetz, T., Martin, R., Ugen, S., Keller, U., ... & Preckel, F. (2014). "My Questionnaire is Too Long!" The Assessments of Motivational-Affective Constructs with Three-Item and Single-Item Measures. *Contemporary Educational Psychology, 39*(3), 188-205.

Hall, J. A., & Dornan, M. C. (1988). What patients like about their medical care and how often they are asked: A meta-analysis of the satisfaction literature. *Social Science & Medicine, 27*(9), 935-939.

Hearld, L. R., Alexander, J. A., Fraser, I., & Jiang, H. J. (2008). Review: How do hospital organizational structure and processes affect quality of care? A critical review of research methods. *Medical Care Research and Review, 65*(3), 259-299.

Heller, D., Watson, D., & Ilies, R. (2004). The role of person versus situation in life satisfaction: A critical examination. *Psychological Bulletin, 130*(4), 574-600.

Hellström, Y., Andersson, M., & Hallberg, I. R. (2004). Quality of life among older people in Sweden receiving help from informal and/or formal helpers at home or in special accommodation. *Health & Social Care in the Community, 12*(6), 504-516.

Hemphill, J. F. (2003). Interpreting the magnitudes of correlation coefficients. *American Psychologist, 58*(1), 78-80.

Hällsten, F., & Tengblad, S. (2002). *Personalansvar och medarbetarskap-om relationen mellan organisation och medarbetare*. Göteborg: Bokförlaget BAS.

Johansson, L. (1997). Decentralisation from acute to home care settings in Sweden. *Health Policy, 41*, 131-143.

Johnson, W. (2011). Correlation and explaining variance: To square or not to square?. *Intelligence, 39*(5), 249-254.

Jylhä, M. (2009). What is self-rated health and why does it predict mortality? Towards a unified conceptual model. *Social Science & Medicine, 69*(3), 307-316.

Jylhä, M., Guralnik, J. M., Ferrucci, L., Jokela, J., & Heikkinen, E. (1998). Is self-rated health comparable across cultures and genders? *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 53*(3), 144-152.

Kahneman, D. (2011). *Thinking fast and slow*. New York: Macmillan Press.

Kajonius, P. J., & Kazemi, A. (2014). Rankning av Sveriges kommuners äldreomsorg i Öppna jämförelser. *Socialmedicinsk tidskrift, 91*(4), 323-331.

Kajonius, P. J., & Kazemi, A. (2015a). Structure and Process Quality Trends in Swedish Elderly Care. Manuscript submitted for publication.

Kane, R. L., & Kane, R. A. (2001). What older people want from long-term care, and how they can get it. *Health Affairs, 20*(6), 114-127.

Kazemi, A., & Kajonius, P. J. (2015a). User-Oriented Elderly Care: A Validation Study in Two Different Settings Using Observational Data. *Quality of Aging in Older Adults, 16*(3), 140-152.

Kazemi, A., & Kajonius, P. J. (2015b). Variations in User-Oriented Elderly Care: A Multilevel Approach. Manuscript submitted for publication.

Katz, D., & Kahn, R. L. (1978). *The Social Psychology of Organizations*. New York: Wiley.

Kelfve, S., Lennartsson, C., Agahi, N., & Modig, K. (2015). Do postal health surveys capture morbidity and mortality in respondents aged 65 years and older? A register-based validation study. *Scandinavian Journal of Public Health*. In Press. Doi:1403494815575340.

Kelfve, S., Thorslund, M., & Lennartsson, C. (2013). Sampling and non-response bias on health-outcomes in surveys of the oldest old. *European Journal of Ageing, 10*(3), 237-245.

Kitwood, T. (1997). *Dementia Reconsidered: The Person Comes First.* Oxford: Oxford Press.

Konrath, S., Meier, B. P., & Bushman, B. J. (2014) Development and validation of the single item narcissism scale (SINS). *PLoS ONE 9*(8): e103469.

Koys, D. J., & De Cotiis, T. A. (1991) Inductive measures of psychological climate. *Human Relations, 44*(3), 265–285.

Kuenzi, M., & Schminke, M. (2009). Assembling fragments into a lens: A review, critique, and proposed research agenda for the organizational work climate literature. *Journal of Management, 35*(3), 634-717.

Kunkel, S., Rosenqvist, U., & Westerling, R. (2007). The structure of quality systems is important to the process and outcome, an empirical study of 386 hospital departments in Sweden. *BMC: Health Services Research, 7*(1), 104.

Larrabee, J. H., Engle, V. F., & Tolley, E. A. (1995). Predictors of Patient-Perceived Quality. *Scandinavian Journal of Caring Sciences, 9*(3), 153-164.

Lindgren, L. (2012). Öppna Jämförelser - ett styrmedel i tiden eller "Hur kunde det bli såhär?". *FoU i Väst. Rapport 2*:2012.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., ... & Payne, S. (2001). Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. *British Medical Journal, 323*(7318), 908-911.

Lumley, T., Diehr, P., Emerson, S., & Chen, L. (2002). The importance of the normality assumption in large public health data sets. *Annual Review of Public Health, 23*, 151-169.

Lyons, K. S., & Zarit, S. H. (1999). Formal and informal support: The great divide. *International Journal of Geriatric Psychiatry, 14*(3), 183-192.

Lyubomirsky, S., King, L., & Diener, E. (2005). The benefits of frequent positive affect: Does happiness lead to success? *Psychological Bulletin, 131*(6), 803-855.

Lyubomirsky, S., Sheldon, K. M., & Schkade, D. (2005). Pursuing happiness: The architecture of sustainable change. *Review of General Psychology, 9*(2), 111-131.

Malley, J. N., Towers, A. M., Netten, A. P., Brazier, J. E., Forder, J. E., & Flynn, T. (2012). An assessment of the construct validity of the ASCOT measure of social care-related quality of life with older people. *Health and Quality of Life Outcomes, 10*(21), 1-14.

Malmberg, B. (2011). *Global population ageing and migration in Europe (Routledge Studies in the European economy)*. London: Routledge.

Mann, R., Birks, Y., Hall, J., Torgerson, D., & Watt, I. (2006). Exploring the relationship between fear of falling and neuroticism: a cross-sectional study in community-dwelling women over 70. *Age and Ageing*, *35*(2), 143-147.

Mayer, D., Nishii, L., Schneider, B., & Goldstein, H. (2007). The precursors and products of justice climates: Group leader antecedents and employee attitudinal consequences. *Personnel Psychology*, *60*(4), 929-963.

McCormack, B. (2004). Person-centredness in gerontological nursing: an overview of the literature. *Journal of Clinical Nursing*, *13*(1), 31-38.

McMullin, J. A., & Cairney, J. (2004). Self-esteem and the intersection of age, class, and gender. *Journal of Aging Studies*, *18*(1), 75-90.

Mead, N., & Bower, P. (2000). Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science & Medicine, 51*(7), 1087-1110.

Meagher, G., & Szebehely, M. (2013). Long-term care in Sweden: Trends, actors and consequences. In C. Ranci, & E. Pavolini (Eds.), *Reforms in long term care policies in Europe: Investigating institutional change and social impacts*. New York: Springer.

Meinow, B., Kåreholt, I., & Lagergren, M. (2005). According to need? Predicting the amount of municipal home help allocated to elderly recipients in an urban area of Sweden. *Health & Social Care in the Community*, *13*(4), 366-377.

Meinow, B., Parker, M. G., & Thorslund, M. (2011). Consumers of eldercare in Sweden: The semblance of choice. *Social Science & Medicine, 73*(9), 1285-1289.

Meyer, G. J., Finn, S. E., Eyde, L. D., Kay, G. G., Moreland, K. L., Dies, R. R., ... & Reed, G. M. (2001). Psychological testing and psychological assessment: A review of evidence and issues. *American Psychologist, 56*(2), 128-165.

Mischel, W. (2009). From personality and assessment, 1968 to personality science, 2009. *Journal of Research in Personality*, *43*(2), 282-290.

Moorman, R. H., & Podsakoff, P. M. (1992). A meta-analytic review and empirical test of the potential confounding effects of social desirability response sets in organizational behaviour research. *Journal of Occupational and Organizational Psychology*, *65*(2), 131-149.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2008). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 13-22.

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*(3),477-485.

Nakrem, S., Vinsnes, A. G., Harkless, G. E., Paulsen, B., & Seim, A. (2009). Nursing sensitive quality indicators for nursing home care: international review of literature, policy and practice. *International Journal of Nursing Studies, 46*(6), 848-857.

National Board of Health & Welfare (2009). *Öppna jämförelser analys av framgångsfaktorer inom äldreomsorgen – en analys utifrån kommunernas resultat 2009.* [Open Comparisons] Stockholm: Socialstyrelsen.

National Board of Health & Welfare (2012). *Öppna Jämförelser: Vård och Omsorg om Äldre 2012*. [Open Comparisons] Stockholm: Socialstyrelsen.

National Board of Health & Welfare (2013). *Öppna Jämförelser: Vård och Omsorg om Äldre 2013*. [Open Comparisons] Stockholm: Socialstyrelsen.

National Board of Health & Welfare (2014). *Öppna Jämförelser: Vård och Omsorg om Äldre 2014*. [Open Comparisons] Stockholm: Socialstyrelsen.

Nosraty, L., Enroth, L., Raitanen, J., Hervonen, A., & Jylhä, M. (2015). Do Successful Agers Live Longer? The Vitality 90+ Study. *Journal of Aging and Health, 27*(1), 35-53.

Olsen, G. M. (2013). What's 'Left' in the 'Garden of Sweden'? *International Journal of Health Services, 43*(1), 7-30.

Ones, D. S., Viswesvaran, C., & Reiss, A. D. (1996). Role of social desirability in personality testing for personnel selection: The red herring. *Journal of Applied Psychology, 81*(6), 660-679.

Ostroff, C. (1993). The effects of climate and personal influences on individual behavior and attitudes in organizations. *Organizational Behavior and Human Decision Processes, 56*(1), 56-90.

Otani, K., Waterman, B., & Claiborne Dunagan, W. (2012). Patient satisfaction: How patient health conditions influence their satisfaction. *Journal of Healthcare Management, 57*(4), 276-292.

Ozer, D. J. (1985). Correlation and the coefficient of determination. *Psychological Bulletin, 97*(2), 307-315.

Ozer, D. J. (2007). Evaluating effect size in personality research. In R.W. Robins, R.C. Fraley, and R.F. Krueger (Eds.). *Handbook of Research Methods in Personality Psychology*. New York: Guilford.

Parry, K., & Proctor-Thomson, S. (2002). Leadership, culture and performance: The case of the New Zealand public sector. *Journal of Change Management, 3*(4), 376-399.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, *34*(5), 1189-1208.

Plomin, R., DeFries, J. C., Knopik, V. S., & Neiderhiser, J. M. (2013). *Behavioral Genetics,* (6th ed). New York: Worth Publishing.

Rauthmann, J. F., Sherman, R. A., Nave, C. S., & Funder, D. C. (2015). Personality-driven situation experience, contact, and construal: How people's personality traits predict characteristics of their situations in daily life. *Journal of Research in Personality*, *55*, 98-111.

Richard, F. D., Bond, Jr. C., & Stokes-Zoota, J. (2003). One hundred years of social psychology quantitatively described. *Review of General Psychology, 7*(4), 331-363.

Roberts, B. W., Kuncel, N. R., Shiner, R., Caspi, A., & Goldberg, L. R. (2007). A meta-analysis on the power of personality: The comparative validity of personality traits, socioeconomic status, and cognitive ability for predicting important life outcomes. *Perspectives on Psychological Science*, *2*(4), 313-345.

Rogers, C. R. (1961). *On Becoming a Person - A Psychotherapists View of Psychotherapy*. London: Constable.

Rorer, L. G. (1965). The great response-style myth. *Psychological Bulletin*, *63*(3), 129-156.

Rosenthal, R. (1991). Effect sizes: Pearson's correlation, its display via the BESD, and alternative indices. *American Psychologist*, *46*(10), 1086-1087.

Routasalo, P., & Pitkala, K. H. (2003). Loneliness among older people. *Reviews in Clinical Gerontology, 13*(4), 303-311.

Sachau, D. A. (2007). Resurrecting the motivation-hygiene theory: Herzberg and the positive psychology movement. *Human Resource Development Review, 6*(4), 377-393.

Sackmann, S. A. (2011). *Culture and Performance. The Handbook of Organizational Culture and Climate.* (2nd ed.). London: Sage.

Savla, J., Davey, A., Sundström, G., Zarit, S. H., & Malmberg, B. (2008). Home help services in Sweden: Responsiveness to changing demographics and needs. *European Journal of Ageing, 5*(1), 47-55.

Schneider, B., Ehrhart, M. G., & Macey, W. H. (2011). Perspectives on organizational climate and culture. In W. H. Z. Sheldon (Ed), *APA handbook of industrial and organizational psychology, Vol 1: Building and developing the organization,* (pp. 373-414). Washington D.C.: APA.

Schneider, E., & Lieberman, T. (2001). Publicly disclosed information about the quality of health care: response of the US public. *Quality in Health Care, 10*(2), 96-103.

Schneider, B., & Snyder, R. A. (1975). Some relationships between job satisfaction and organization climate. *Journal of Applied Psychology, 60*(3), 318-328.

Schneider, B., & White, S. S. (2004). *Service Quality: Research Perspectives*. Thousand Oaks, CA: Sage.

Senić, V., & Marinković, V. (2012). Patient care, satisfaction and service quality in health care. *International Journal of Consumer Studies, 9*(2), 155-168.

Spector, P. E. (2006). Method variance in organizational research truth or urban legend?. *Organizational Research Methods, 9*(2), 221-232.

Stewart, M. (2001). Towards a global definition of patient centred care: The patient should be the judge of patient centred care. *BMJ: British Medical Journal, 322*(7284), 444-450.

Stolt, R., Blomqvist, P., & Winblad, U. (2011). Privatization of social services: Quality differences in Swedish elderly care. *Social Science & Medicine, 72*(4), 560-567.

Szebehely, M., & Trydegård, G. B. (2012). Home care for older people in Sweden: A universal model in transition. *Health & Social Care in the Community, 20*(3), 300-309.

Szymanski, D. M., & Henard, D. H. (2001). Customer satisfaction: A meta-analysis of the empirical evidence. *Journal of the Academy of Marketing Science, 29*(1), 16-35.

Sundström, G., Fransson, E., Malmberg, B., & Davey, A. (2009). Loneliness among older Europeans. *European Journal of Ageing, 6*(4), 267-275.

Sundström, G., Malmberg, B., & Johansson, L. (2006). Balancing family and state care: Neither, either or both? The case of Sweden. *Ageing & Society, 26*(05), 767-782.

Thalmayer, A. G., Saucier, G., & Eigenhuis, A. (2011). Comparative validity of brief to medium-length Big Five and Big Six Personality Questionnaires. *Psychological Assessment, 23*(4), 995-1009.

Theobald, H. (2003). Care for the elderly: Welfare system, professionalisation and the question of inequality. *International Journal of Sociology and Social Policy, 23*(4/5), 159-185.

Thorslund, M., Bergmark, Å., & Parker, M. G. (1997). Difficult decisions on care and services for elderly people: The dilemma of setting priorities in the welfare state. *International Journal of Social Welfare, 6*(3), 197-206.

Thorslund, M. (2010). Äldreomsorgens utmaningar – i dag och i framtiden. *Underlagsrapport till Timbro/Arena Idé-kommissionen rörande välfärdens framtida finansiering.* Aging Research Center: Karolinska Institutet/Stockholms Universitet.

Titchen, A. (2004). Helping relationships for practice development: Critical companionship. *Practice Development in Nursing, 2004,* 148-174.

Trafimow, D. (2015). The intelligibility of r or r2 as an effect size statistic: dichotomous variables. *Frontiers in Psychology, 6,* 294.

Trydegård, G. B., & Thorslund, M. (2010). One uniform welfare state or a multitude of welfare municipalities? The evolution of local variation in Swedish elder care. *Social Policy & Administration, 44*(4), 495-511.

United Nations (2001). *Replacement migration: Is it a solution to declining and ageing populations?* New York: United Nations, Population Division.

Wagner, J. I., Cummings, G., Smith, D. L., Olson, J., Anderson, L., & Warren, S. (2010). The relationship between structural empowerment and psychological empowerment for nurses: A systematic review. *Journal of Nursing Management, 18*(4), 448-462.

Welford, C., Murphy, K., Wallace, M., & Casey, D. (2010). A concept analysis of autonomy for older people in residential care. *Journal of Clinical Nursing, 19*(9-10), 1226-1235.

White, D. L., Newton-Curtis, L., & Lyons, K. S. (2008). Development and initial testing of a measure of person-directed care. *The Gerontologist, 48*(1), 114-123.

Wilderom, C. P., & Berg, P. T. (2000). *Firm culture and leadership as firm performance predictors: a resource-based perspective*. Tilburg: Tilburg University.

Williams, A., Straker, J. K., & Applebaum, R. (2014). The nursing home five star rating: How does it compare to resident and family views of care? *The Gerontologist, 10.1093/geront/gnu043*. In press.

Yarkoni, T. (2010). The abbreviation of personality, or how to measure 200 personality scales with 200 items. *Journal of Research in Personality, 44*(2), 180-198.

Zohar, D. (2000). A group level model of safety climate: testing the effect of group climate on micro-accidents in manufacturing jobs. *Journal of Applied Psychology 85,* 587–96

Öhlén, A., Forsberg, C., & Broberger, E. (2013). Documentation of Nursing Care in Advanced Home Care. *Home Health Care Management & Practice, 25*(4), 169-175.

APPENDIX

The appendix includes the elderly questionnaire which provided the data for this thesis. The original look with its enlarged letters has been kept. The original letter is translated and supplied in the appendix.

Statistiska centralbyrån
Statistics Sweden

Socialstyrelsen

Uenr Hösten 2012

Vad tycker du om din hemtjänst?

Alla äldre har rätt till en hemtjänst med god kvalitet. För att kunna förbättra och utveckla hemtjänsten genomför Statistiska central- byrån (SCB) denna undersökning på uppdrag av Socialstyrelsen.

Alla svar är viktiga

Du är en av cirka 90 000 personer i åldern 65 år och äldre som blivit utvald att delta i denna undersökning. Vi skulle vilja veta hur hemtjänsten fungerar i din kommun och ber dig därför besvara frågeformuläret. Du väljer själv om du vill delta i undersökningen, men för oss är dina synpunkter mycket viktiga. Möjligheten att få ett rättvisande och användbart resultat är större ju fler som svarar.

Undersökningen pågår till och med vecka 39 men vi vill gärna få dina svar så snart som möjligt. Om du inte själv kan fylla i dina svar på frågorna ber vi att en närstående, god man eller bekant fyller i dina svar åt dig. Den som hjälper dig bör inte tillhöra hemtjänst- personalen.

När du har svarat

När du har svarat på frågorna lägger du enkäten i det bifogade svars- kuvert. Frimärke behövs inte.

TACK FÖR DIN MEDVERKAN!

Med vänliga hälsningar

Mona Heurgren
Enhetschef
Socialstyrelsen

Jessica Forsman
Undersökningsledare
Statistiska centralbyrån

Hjälp oss gärna att underlätta bearbetningen av dina svar

Enkäten kommer att läsas maskinellt. Det är därför bra att tänka på följande när du besvarar frågorna.

Bästa sätt att markera

- Använd helst kulspetspenna, svart eller blå.
- Markera helst innanför rutorna **- så här** ☒
- Om du ångrar dig och behöver ta bort ditt kryss, kan du täcka hela rutan **- så här** ■

Statistiska centralbyrån
Statistics Sweden

Socialstyrelsen

UEnr Autumn 2012

What do you think of your elderly care?

All older persons are entitled to retirement with good quality. In order to improve and develop senior housing, the Statistics Bureau (SCB) implements this survey on behalf of the the National Board of Health and Welfare.

All responses are important
You are one of approximately 90 000 persons aged 65 years and older who has been selected to participate in this survey. We would like to know what you think about your retirement home and ask that you answer the questionnaire. You choose if you want to participate in the survey, but your views are very important. The ability to get a fair and useful result is greater the more responses we get.
The study will continue through week 39 but we would like to get your response as soon as possible. If you are not able to fill in your answers to the questions we ask a related party, trustee, or acquaintance to fill in your answers for you. Anyone who helps you should not belong to the staff.

Once you have answered the questions put to it in the return envelope. Stamp is not necessary.
THANK YOU FOR YOUR COOPERATION!
Sincerely

Mona Heurgren

Head of department

National Board

of Health and Welfare

Jessica Forsman

Head of research

Statistics Sweden

Please help us to facilitate the processing of your answers

The questionnaire will be read by machine. It is therefore useful to consider the following when answering the questions.

Best way to mark

- Preferably use ballpoint pen, black or blue.
- Check anywhere inside the boxes **- like this** ☒
- If you decide you need to remove your choice, you can cover the entire box **- like this** ■

Hälsa

1 Hur bedömer du ditt allmänna hälsotillstånd?

- ☐ Mycket gott
- ☐ Ganska gott
- ☐ Någorlunda
- ☐ Ganska dåligt
- ☐ Mycket dåligt

2 Har du besvär av ängslan, oro eller ångest?

- ☐ Nej
- ☐ Ja, lätta besvär
- ☐ Ja, svåra besvär

3 Hur är din rörlighet inomhus?

- ☐ Jag går själv utan svårigheter
- ☐ Jag har vissa svårigheter att gå själv
- ☐ Jag har stora svårigheter att gå själv
- ☐ Jag kan inte alls gå själv

Boendemiljö

4 Fick du plats på det äldreboende du ville bo på?

- ☐ Ja
- ☐ Nej
- ☐ Vet inte

5 Trivs du med ditt rum eller lägenhet?

- ☐ Ja
- ☐ Delvis
- ☐ Nej
- ☐ Ingen åsikt

6 Är det trivsamt i de gemensamma utrymmena?
T.ex. matsalen, sällskapsrum, korridorer.

- ☐ Ja
- ☐ Delvis
- ☐ Nej
- ☐ Ingen åsikt

7 Är det trivsamt utomhus runt ditt boende?

- ☐ Ja
- ☐ Delvis
- ☐ Nej
- ☐ Ingen åsikt

Mat och måltidsmiljö

8 Hur brukar maten smaka?

- ☐ Mycket bra
- ☐ Ganska bra
- ☐ Varken bra eller dåligt
- ☐ Ganska dåligt
- ☐ Mycket dåligt
- ☐ Ingen åsikt

9 Upplever du att måltiderna på ditt äldreboende är en trevlig stund på dagen?

- ☐ Ja, alltid
- ☐ Oftast
- ☐ Ibland
- ☐ Sällan
- ☐ Nej, aldrig
- ☐ Ingen åsikt

Hjälpens utförande

10 Brukar personalen ha tillräckligt med tid för att kunna utföra sitt arbete hos dig?

- ☐ Ja, alltid
- ☐ Oftast
- ☐ Ibland
- ☐ Sällan
- ☐ Nej, aldrig
- ☐ Vet inte/Ingen åsikt

11 Brukar personalen meddela dig i förväg om tillfälliga förändringar?
T.ex. byte av personal, ändringar av olika aktiviteter etc.

- ☐ Ja, alltid
- ☐ Oftast
- ☐ Ibland
- ☐ Sällan
- ☐ Nej, aldrig
- ☐ Vet inte/Ingen åsikt

12 Brukar du kunna påverka vid vilka tider du får hjälp?
T.ex. tid för att duscha/bada, gå och lägga dig etc.

- ☐ Ja, alltid
- ☐ Oftast
- ☐ Ibland
- ☐ Sällan
- ☐ Nej, aldrig
- ☐ Vet inte/Ingen åsikt

Personlig omvårdnad

13 Får du hjälp med att borsta tänderna och/eller sköta tandprotesen i den mån du behöver?

- ☐ Ja
- ☐ Delvis
- ☐ Nej
- ☐ Inte aktuellt

14 Får du hjälp med fotvård i den mån du behöver?

- ☐ Ja
- ☐ Delvis
- ☐ Nej
- ☐ Inte aktuellt

15 Får du hjälp med att gå på toaletten i den mån du behöver?

- ☐ Ja
- ☐ Delvis
- ☐ Nej
- ☐ Inte aktuellt

16 Får du hjälp med gymnastik och träning i den mån du behöver?

- ☐ Ja
- ☐ Delvis
- ☐ Nej
- ☐ Inte aktuellt

Bemötandet

17 Brukar personalen bemöta dig på ett bra sätt?

- ☐ Ja, alltid
- ☐ Oftast
- ☐ Ibland
- ☐ Sällan
- ☐ Nej, aldrig
- ☐ Vet inte/Ingen åsikt

18 Har du känt dig kränkt av någon personal under det senaste året?

- ☐ Nej
- ☐ Ja, någon gång
- ☐ Ja, flera gånger
- ☐ Vet inte/Ingen åsikt

19 Brukar personalen ta hänsyn till dina åsikter och önskemål om hur hjälpen ska utföras?

- ☐ Ja, alltid
- ☐ Oftast
- ☐ Ibland
- ☐ Sällan
- ☐ Nej, aldrig
- ☐ Vet inte/Ingen åsikt

Trygghet

20 Hur tryggt eller otryggt känns det att bo på ditt äldreboende?

- ☐ Mycket tryggt
- ☐ Ganska tryggt
- ☐ Varken tryggt eller otryggt
- ☐ Ganska otryggt
- ☐ Mycket otryggt
- ☐ Vet inte/Ingen åsikt

21 Känner du förtroende för personalen på ditt äldreboende?

- ☐ Ja, för alla i personalen
- ☐ Ja, för flertalet i personalen
- ☐ Ja, för några i personalen
- ☐ Nej, inte för någon i personalen
- ☐ Ingen åsikt

Sociala aktiviteter

22 Hur nöjd eller missnöjd är du med de aktiviteter som erbjuds på ditt äldreboende?

- ☐ Mycket nöjd
- ☐ Ganska nöjd
- ☐ Varken nöjd eller missnöjd
- ☐ Ganska missnöjd
- ☐ Mycket missnöjd
- ☐ Ingen åsikt

23 Är möjligheterna att komma utomhus bra eller dåliga?

- ☐ Mycket bra
- ☐ Ganska bra
- ☐ Varken bra eller dåliga
- ☐ Ganska dåliga
- ☐ Mycket dåliga
- ☐ Vet inte/Ingen åsikt

24 Händer det att du besväras av ensamhet?

- ☐ Ja, ofta
- ☐ Ja, då och då
- ☐ Nej
- ☐ Vet inte/Ingen åsikt

Tillgänglighet

Nu kommer några frågor om hur du tycker det är att få kontakt med personal från olika personalgrupper.

25 Hur lätt eller svårt är det att få träffa sjuksköterska vid behov?

- ☐ Mycket lätt
- ☐ Ganska lätt
- ☐ Varken lätt eller svårt
- ☐ Ganska svårt
- ☐ Mycket svårt
- ☐ Vet inte/Ingen åsikt

26 Hur lätt eller svårt är det att få träffa läkare vid behov?

- ☐ Mycket lätt
- ☐ Ganska lätt
- ☐ Varken lätt eller svårt
- ☐ Ganska svårt
- ☐ Mycket svårt
- ☐ Vet inte/Ingen åsikt

27 Hur lätt eller svårt är det att få kontakt med personalen på ditt äldreboende, vid behov?

- ☐ Mycket lätt
- ☐ Ganska lätt
- ☐ Varken lätt eller svårt
- ☐ Ganska svårt
- ☐ Mycket svårt
- ☐ Vet inte/Ingen åsikt

Hjälpen i sin helhet

28 Hur nöjd eller missnöjd är du sammantaget med ditt äldreboende?

- ☐ Mycket nöjd
- ☐ Ganska nöjd
- ☐ Varken nöjd eller missnöjd
- ☐ Ganska missnöjd
- ☐ Mycket missnöjd
- ☐ Ingen åsikt

Avslutande frågor

29 Har du själv svarat på frågorna?
Med SVARAT menas att du antingen själv kryssat i svaren eller att du uppgett svaren till någon som kryssat i för dig.

- ☐ Ja → **Tack för din medverkan! Var god skicka in enkäten**
- ☐ Nej, frågorna besvarades av annan person → **Gå till fråga 30**

30 Vem har svarat?

- ☐ Närstående/anhörig
- ☐ Bekant
- ☐ God man/förvaltare
- ☐ Personal
- ☐ Annan person

31 Varför har personen själv inte svarat på frågorna?
Flera alternativ kan anges

- ☐ Nedsatt syn/synskada
- ☐ Nedsatt fysisk hälsa
- ☐ Nedsatt psykisk hälsa
- ☐ Demenssjukdom
- ☐ Annat skäl