Bachelor's thesis

Degree programme in Nursing

NNURSS13

2017

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CLIENT-ORIENTED NURSING AND ITS SIGNIFICANCE TO COPING WITH WORKLOAD

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BACHELOR'S THESIS | ABSTRACT

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Introduction: In the 1980's the discussion about patient's position and rights in health care started, which eventually led to a concept called client-oriented nursing. Its position is becoming the centred principle in health care.

The purpose of this Thesis was to find out what client-oriented nursing and coping with the workload are and study whether there is a connection between the two separate themes as well as what the possible connection's significance to nursing is. Aim was to provide information about client oriented nursing and coping with the workload for nursing students, nurses, supervisors and policymakers. Three research questions were set to guide the process. 1. What is good client-oriented nursing? 2. What affects a nurse's capability of coping with the workload? 3. What kind of connection do client-oriented nursing and a nurse's capability of coping with the workload have or do they have a connection?

Methods and data: This thesis was a literature review with characteristics of a systematic literature review. Searches were made in Medic (12 articles were included out of 393 hits) and Cinahl (2 articles out of 181 hits). In total, 14 articles were included.

Results: Client-oriented care takes time and resources, but ensures better individual care. Coping with the workload is affected by numerous factors (e.g. staff resources, patient, workplace and nurse related factors, supervisors and work overload). Nursing work was considered demanding and sometimes not being able to answer the patients' needs caused feelings of frustration and failure.

Conclusions: Client-oriented care is individual and educational cooperation that requires staff and time to be able to perform individual care. Nurses could get frustrated and stressed, if care provided does not match the quality they were hoping to offer. More research is needed to determine how client-oriented nursing affects the workload and regarding young nurses' intentions to leave the nursing field.

KEYWORDS:

Client-oriented nursing, workload, coping with the workload

OPINNÄYTETYÖ (AMK) | TIIVISTELMÄ

TURUN AMMATTIKORKEAKOULU

Sairaanhoitaja AMK

2017 | 39

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ASIAKASLÄHTÖINEN HOITOTYÖ JA SEN MERKITYS HOITOTYÖSSÄ JAKSAMISELLE

Johdanto: 1980-luvulla alkoi keskustelu potilaan asemasta ja oikeuksista terveydenhuollossa, mikä loppujen lopuksi johti käsitteeseen asiakaslähtöinen hoitotyö. Siitä on tulossa keskeinen käsite terveydenhuollossa.

Tämän opinnäytetyön tarkoitus oli etsiä tietoa asiakaslähtöisestä hoitotyöstä, hoitotyössäjaksamisesta ja onko näiden eri teemojen välillä yhteyttä ja mikä sen merkitys on hoitotyölle. Pyrkimyksenä oli tarjota tietoa asiakaslähtöisestä hoitotyöstä ja työssäjaksamisesta hoitotyön opiskelijoille, hoitajille, esimiehille ja päättäjille. Kolme tutkimuskysymystä asetettiin ohjaamaan työtä. 1. Mikä on hyvää asiakaslähtöistä hoitotyötä? 2. Mikä vaikuttaa hoitajan työssäjaksamiseen? 3. Mikä yhteys on asiakaslähtöisellä hoitotyöllä ja hoitotyössäjaksamisella vai onko niillä yhteyttä?

Menetelmä ja aineisto: Tämä opinnäytetyö oli kirjallisuuskatsaus systemaattisin piirtein. Hakuja tehtiin Mediciin (12 artikkelia otettiin mukaan 393:sta osumasta) ja Cinahliin (2 artikkelia 181:stä osumasta). Yhteensä mukaan otettiin 14 artikkelia.

Tulokset: Asiakaslähtöinen hoitotyö vie aikaa ja resursseja, mutta takaa parempaa yksilöllistä hoitoa. Hoitotyössä jaksamiseen vaikuttaa lukuisia tekijöitä (esim. Henkilöstöresurssit, potilas, työpaikkaan ja hoitajaan liittyvät tekijät, esimiehet ja työn ylikuormitus). Hoitotyötä pidetään vaativana ja joskus se, että ei pysty vastaamaan potilaan tarpeisiin aiheutti turhautumisen ja epäonnistumisen tunteita.

Johtopäätökset: Asiakaslähtöinen hoitotyö on yksilöllistä ja opettavaa yhteistyötä, joka vaatii henkilökuntaa ja aikaa yksilölliseen hoitoon. Hoitajat saattavat turhautua ja stressaantua, jos hoidon laatu ei vastaa sitä laatua, jota he olisivat halunneet tarjota. Tarvitaan lisätutkimuksia asiakaslähtöisen hoitotyön vaikutuksesta työmäärään ja nuorten hoitajien aikomuksista vaihtaa alaa.

ASIASANAT:

Asiakaslähtöinen hoitotyö, työn määrä, hoitotyössä jaksaminen

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1 INTRODUCTION

In the 1980's the discussion about patient's position and rights in health care started, which eventually led to a concept called client-oriented nursing. It has taken a long time, many efforts and governments but its position is becoming the centred principle in health care. (Kiikkala 2000, 112 – 115.) This direction is to be seen in the current Finnish government's plan for health, social services and regional government reform, which includes for example the possibility to choose from which sector to get the services needed. Its goal is to equalise services between regions, make them more efficient, available and equal for service users and manage costs (Ministry of Social Affairs and Health & Ministry of Finance 2017b). Another goal is to ensure local services and local decision making (Ministry of Social Affairs and Health & Ministry of Finance 2017b). Services should be organised so that they take place at the right time, are effective and high-performance. (Ministry of Social Affairs and Health & Ministry of Finance 2017a.)

According to Kiikkala's (2000, 116 – 120) description, client-oriented care has many perspectives and demands certain approach to work. It consists of four dimensions that together create the ethical obligation. Kiikkala mentions for instance the following qualities that are required to be able to work client-oriently. This means the nurse is required to see the client as a holistic human, who is an individual with the best knowledge and expertise of one's life and who has power, is empowered and makes their own choices.

Coincidentally, also since the 1980's, the intense workload in the nursing field has been recognised. Still, workload as a concept is challenging to determine. There are various measurement tools but many of them lack in recognising the amount of work that is not directly taking care of patients. Nursing care includes a lot of indirect care such as interruptions for some reason, locating utensils, documenting and management tasks, which increases the workload significantly. It becomes a problem if this is not taken into consideration when planning staff resources for inpatient units. (Swiger et al. 2016.)

Nuikka's (2002) doctoral thesis studied nurses' physical and mental workload during real care situation with physical measurements. Also, mental workload was analysed with surveys and thematic interviews. Nurses were experiencing stress because they felt they did not have enough time for a holistic care of the patient, for example due to hurry and a lack of staff resources. One case mentioned was a scared and anxious patient that

was medicated rather than having a calming conversation about the situation. These situations caused burdening and sometimes haunted the nurses still at home.

This thesis has three different themes: client-oriented nursing, nursing workload and their connection. The meaning of client-oriented care in nursing, how it is executed, and whether completely client-oriented care is possible is discussed. The most interesting question is whether it increases or decreases the nursing workload or is it possible that it does not have an effect at all. Also, what affects nurses' capability of coping with the workload? Is client-oriented nursing one of those effects and if so, how? The two main objectives are studying about good client-oriented nursing and a nurse's capability to cope with the workload and what affects the latter. Another interest is finding a possible connection between those two, making it the third objective.

The purpose was to find out what client-oriented nursing and coping with the workload are and study whether there is a connection between the two separate themes as well as what the possible connection's significance to nursing is. The interest for this theme has risen both from the current economic situation in the world and its consequences in politics and from witnessed working situations at practical training places during the nursing education. Also, the new ongoing health, social services and regional government reform is considered an important reason for the chosen subject.

Chapters 2-4 present the themes, present literature and determine the important concepts: client-oriented nursing, workload in nursing and coping with the workload. The following chapters describe stages of the literature review and present the results, finishing with chapters for discussion and conclusions.

2 CLIENT-ORIENTED NURSING

According to Kiikkala (2000, 116 – 120), client-oriented care has many perspectives and demands a certain approach to work. It consists of the following four dimensions. **1) Client-oriented care is a fundamental value**, which refers to respecting the client and working together with the client in an agreement instead of just ordering the solutions. **2) Recognising the client client-oriently** means understanding the different levels and roles of the client in their own life and in the community. The client is an individual but at the same time part of one's family (or similar) and together they belong to a local community and eventually they are part of the society.

3) Care or services from a client-oriented view are arranged and proceed based on the client's questions and needs. The nurse listens to those questions and needs carefully and makes sure the client knows they are heard and understood. Finally, **4) a client-oriented caregiver is equal**, steps down to the client's level and shows trustworthiness and genuine interest towards the client. The caregiver should possess the following qualities: sincerity, genuineness, bravery, a forward-thinking mindset, equality, activity and professionality. All of these four dimensions are taken into consideration when a service is client-oriented. (Kiikkala 2000, 116 – 120.)

Kiikkala (2000, 116 – 120) mentions for instance the following qualities that are required to be able to work with a client-oriented point of view: seeing the client as a holistic human, who is an individual with the best knowledge and expertise of one's life and who has power, is empowered and makes their own choices. The idea is that together the nurse and the client create the best individual care, using the nurse's professionalism and the client's expertise on their life.

The latter is also mentioned in the Finnish law regarding patient's position and rights. By the law, the patient's maternal tongue, independent needs and culture must be taken into consideration in nursing care and in interacting. The care plan must be written out in mutual understanding. (Laki potilaan asemasta ja oikeuksista 1992.) Supporting the patient's own resources and providing individual care while respecting the patient's right to self-determination is part of a nurse's ethical guidance. (Sairaanhoitajaliitto 1996).

When working client-oriently, the nurse considers the patient as an equal and supports the patient towards independency and self-sufficiency. This point of view allows the

nurse to see the patient as a human, as a holistic person, rather than just a problem, which needs solving or a disease that needs to be cured. To be able to work in a client-oriented way, the nurse should have certain capabilities to be able to sense the differences of situations and different human beings and adjust to these differences. The goal is to empower the patient, not to do everything for them. (Kiikkala 2000, 116 – 120.)

Empowering is an interesting concept in the present and future nursing. It stands for individual ongoing process that consists of freedom, responsibility, self-confidence and positive attitudes. It is an important concept in client oriented care and the two concepts have similarities, such as human dignity, designing services individually for user's point of view and the fact that the user is an active operator, not just a target. However, a nurse cannot ensure the empowering the client, because it is only possible to give the target tools for empowering. (Lassander et al. 2013.)

Determining and analysing the patient's personal health and resources is not a simple process and the more unique the care is the more it could get complicated. There are many models to do that, for example Tierney and Logan's model that includes 12 functions for living: maintaining safe environment, communication, breathing, eating and drinking, secretions, taking care of personal hygiene and dressing, monitoring body temperature, motion, working, having hobbies and playing, expressing sexuality, sleeping and resting, and dying. (Nuikka 2002.)

However, Nuikka (2002) presented in her literature review that the Tierney and Logan model has been criticised for not being able to model the effect of a disease in life. Another option for it is to approach the matter from human basic needs and how to fill them and that way promote wellbeing. Every patient's unique features are affected by age, gender, education, work, economic situation, lifestyle, culture and patient's own view of their health and coping. The possible problems with the previous needs are determined together with the patient. Solving them sometimes requires multi-professional team expertise and effort.

Other references consider client-oriented care hard to define and execute. Hyvärinen (2011) concluded how different types of services (public, private and third sector) and organisational leadership have a great effect on how a client-oriented approach is interpreted. Organisations might prevent client-oriented nursing because of the many policies and the fact that the patient (client of the service) is offered the services that others considered the patient needs (especially at public health care services). On the

other hand, some of the experts Hyvärinen interviewed stated that in some cases the patient is not necessary capable of doing the evaluation of what services and care they need and therefore it should always be a health care professional who leads the assessment and offers information and options. (Hyvärinen 2011.)

In this thesis patient-centered, patient-oriented and client-centered care are all referred to as client-oriented care.

3 WORKLOAD AND NURSING

Workload in nursing as a concept is challenging to determine and therefore to measure. Workload often consists of different amounts of time spent with the patient and in other tasks depending on the type of the workplace. For example, in acute care nurses usually spend more time with the patient than in outpatient care. There are various ways used to measure the workload (e.g. nurse-patient ratio, amount of care needed based on the diagnosis), which are often utilised for determining the amount of staff needed. However, these are often not accurate enough. All of the workload does not include direct patient care, but many other tasks such as interruptions for some reason, locating utensils, documenting and management tasks, which increase the workload significantly. (Swiger et al. 2016.)

Swiger et al. (2016) did a literature-based concept analysis on the workload in nursing and proposed a definition for it: “Nursing workload is the amount of time and physical and/or cognitive effort required to accomplish direct patient care, indirect patient care, and non-patient care activities.” The amount of time and effort used is affected by four parameters (nurse, patient, unit, and organisational characteristics), which could increase or decrease the workload needed for the best outcome of care. Some of these parameters are easily calculated and therefore added to a program that measures workload, but some need more testing. (Swiger et al. 2016.)

Nuikka’s (2002) doctoral thesis studied nurses’ physical and mental workload during a real care situation with physical measurements (heart rate monitor and muscle tester to analyse shoulder neck tension). Mental workload was analysed with surveys and thematic interviews. She found out that mood (negative or positive) and whether the nurse is in a relationship affect the strenuousness of the workload. Nurses in relationships experienced more tension, tiredness, anxiety and uncertainty. Health, lifestyle or tricky symptoms did not have an effect.

Nuikka (2002) concluded that the nurse’s workload is burdening when hurry, changes in the patient’s state of health and emotion caused by grief increased the workload in situations where physical effort, body control, manual and technical skills were needed. In a three-shift working system, morning shift was the hardest, but the reasons behind the work overload were different (according to the two physical measurement results) in each shift. In the morning shift the most burdening was giving injections (neck shoulder

tension) and helping with toileting (heart rate). Evening shifts were burdened by helping a tearful patient (neck shoulder tension) and helping with toileting (heart rate). Night shift nurses experienced washing (heart rate) and tearful patient (neck shoulder tension) the most burdening tasks.

Many mentally most burdening working situations were described by the nurses. Those were categorised under several themes: dealing with dying or suffering patients or relatives, cooperative care together with patient or relatives seems impossible (denial, excessive demands, aggression, relative's trust issues), nurse's inadequate knowledge (resuscitation, new equipment) and a lack of control of the situation (constant hurry, no time to listen to patients, learning new tasks in a hurry). (Nuikka 2002.)

Nurses were experiencing stress because they felt they did not have enough time for a holistic care of the patient, for example due to hurry and a lack of staff resources. One case mentioned was a scared and anxious patient that was medicated rather than having a calming conversation about the situation. These situations caused burdening and sometimes haunted the nurses still at home. (Nuikka 2002.)

The shortage of registered nurses is recognised as a worldwide problem, although there are regional differences. Reasons for the shortage include aging population (both patients and nurses) and the profession is not considered appealing in many countries. The demand is high, but still, for example, quite many young registered nurses all around the world consider leaving the profession. (Flinkman 2014: 26 – 35). This is brought up as a problem also by World Health Organisation, as it was mentioned in Flinkman's doctoral thesis (2014: 13 – 16).

Many of the young registered nurses included in the study reported they ended up studying nursing by accident which led them to consider the change of field. However, a considerable number of participants brought up ethical issues and not being able to provide good enough care as well as the hurry and too demanding a workload. (Flinkman 2014.)

4 COPING WITH THE WORKLOAD

One definition for coping describes it as a cognitive and behavioural process that allows the management of external and internal demands. Those demands consume the personal resources without the capability of coping with them and the process of coping is constantly changing. (Lazarus & Folkman 1984, according to Lambert & Lambert 2008, 40.) Coping is mainly a conscious action but it can become an automatic one with repetition (although it being only a conscious or also an unconscious method is debated). Partly coping response is controlled by personality features and it is estimated that age, sex, culture, and ethnicity play an important role in coping but these subjects still require more research. Age gives experience, for example the younger the person is, the more temperament has an effect on coping responses. (Carver & Connor-Smith 2010, 687 – 695.)

Usually coping is considered as an adaptive and a constructive method, although some are considered sometimes maladaptive (non-coping). However, assessing coping methods requires the assessment of a situation; a maladaptive method in some situation might work in another. There are hundreds of different ways to cope in stressful situations and those have been grouped into six different types of coping strategies presented below (Weiten et al. 2015.):

Problem-focused versus emotion-focused coping: In problem-focused coping the person tries to fix the problem, for example preparing to a stressful situation with saving money. Emotion-focused solution includes for example self-soothing to help control the stress. (Weiten et al. 2015.)

Engagement versus disengagement coping: Engagement coping refers to actions done to confront the reality of the situation, for example looking for new places to live after a break-up. Disengagement strategy means denying the situation. (Weiten et al. 2015.)

Meaning-focused coping means finding a meaning to what has happened that helps the person to accept the reality. **Proactive coping** means anticipating and preparing for the future situation, for example with organizing thoughts before going to negotiation situation. (Weiten et al. 2015.)

Coping process or strategy can be used directly to solve a problem (e.g. confronting a situation) or to alleviate emotional stress (e.g. avoiding confrontive behaviour, wishful thinking). Usually in a stressful situation both are used. Eight different coping strategies have been identified: confrontive coping, distancing, self-control, seeking social support, accepting responsibility, escape-avoidance, planful problem-solving and positive reappraisal. (Lambert & Lambert 2008, 40.)

Occupational or workplace stress occurs when demands of the workplace exceed personal resources. When personal resources are exceeded, it causes stress and proper responding to that stress requires coping methods presented above. (Lambert & Lambert 2008, 38.) Stressor is defined as "a stimulus that causes stress" in Merriam-Webster Medical Dictionary (2017). Nursing job tends to have many different stressors that Lambert & Lambert (2008, 40) identified from the existing literature. Those are presented in the table below (Table 1.).

Table 1. Stressors at nursing job (Lambert & Lambert 2008, 40.)

Work-place related stressors	Nurse related stressors
• Low job control • High job demands • Lack of supportive relationships or resources at work • Dealing with death and dying • Workload • Being moved around wards or care units or staying at one place for extended time • Dealing with uncooperative family members and patients	• Escape-avoidance, problem-focused or distancing as a coping mechanism • Conflict with physicians and other nurses or lack of support • Inadequate educational preparation or uncertainty about patients' treatment • Workload and dealing with death and dying • Psychological hardiness and poor communication • Confidence in one's ability and use of self-control

5 THE PURPOSE AND GUIDING RESEARCH QUESTIONS OF THE BACHELOR'S THESIS

This thesis focused on three separate matters: client-oriented nursing and the nurse's capability to cope with the workload and what affects them. The purpose was to find out what client oriented nursing and coping with the workload are and study whether there is a connection between the two separate themes as well as what the possible connection's significance to nursing is. The interest for this theme has risen both from the current economic situation in the world and its consequences in politics and from witnessed working situations at practical training places during the nursing education.

The aim was to provide information about client-oriented nursing and coping with the workload for nursing students, nurses, supervisors and policymakers. This thesis could indicate a need for further research on the connection of the two themes.

Three research questions were set to guide the process:

1. What is good client-oriented nursing?
2. What affects a nurse's capability of coping with the workload?
3. What kind of connection do client-oriented nursing and a nurse's capability of coping with the workload have or do they have a connection?

These research questions were answered in the thesis.

6 DATA AND METHODS

6.1 Research methods

6.1.1 Literature review with characteristics of a systematic literature review

This Thesis was a literature review with characteristics of a systematic literature review. In a systematic literature review, information is systematically gathered together from different databases from all the studies made before by other researchers. A researcher searches for the data with the help of certain beforehand defined inclusion and exclusion criteria, in other words, what kind of studies or articles are included in the literature review. This helps scientist to review the amount of information as a whole and find out what kind of information already exists and has been studied. It also shows the gaps in the knowledge and that way suggests a theme for a new study. All the phases should be documented properly to ensure liability and other researchers' possibilities to evaluate and repeat the same study methods with same results. (Johansson et al. 2007, 3 – 9.)

The guidelines of Stolt et al. (2016, 23 – 34) guidebook on how to perform a literature review were followed. The purpose was defined together with the guiding expert and discussed as well as peer reviewed in a Thesis Plan seminar. After the test searches the search, inclusion and exclusion criteria were formed.

6.1.2 Search, inclusion and exclusion criteria

In this Thesis the search was limited with the following regulations. For example, in order to get relevant information for present day nursing, the search was limited between 2007 to recent. The study languages accepted were Finnish and English (according to author's language skills and time limit) to avoid misunderstanding. Additionally, concepts were determined before searching. In this Thesis a nurse was either a registered nurse or a practical nurse or a person performing a nursing job with an education similar to a Finnish practical nurse education.

At first many testing searches were carried out in databases (e.g. Medic, Cinahl, Ovid, Pubmed) as guidelined (Johansson et al. 2007, 3 – 9). This led to defining inclusion and

exclusion criteria based on the three research questions and their goals. Inclusion criteria is used to limit the taken studies' starting points, research methods, research target, results or the quality criteria. Studies were selected based on the chosen criteria. (Johansson et al. 2007, 58 – 70, Stolt et al. 2016, 23 – 34).

The inclusion and exclusion criteria chosen by the author for this thesis is presented below (Table 2).

Table 2. The Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
Study/article is about an encounter between the nurse and the patient and what affects the encountering	Subject is not relevant to research questions
Study/article describes a nurse's workload and burdening	**Study/article only approaches the theme with physical measurements, that are not relevant to the research questions**
Study/article presents how the nurse's work overload affects the nurse's work and patient's care	
Study/article describes from different points of view (e.g. the nurse's and the patient's) how they see nursing (e.g. goals, motivation, communication)	
Results of the study were possible to use as answers to research questions	Results did not answer research questions
Study/article is evaluated to be valid by the Johansson et al. criteria (2007, 101 – 108) (Appendix 1 and 2).	Study/article is not considered valid or qualified
All kinds of studies, articles and patient cases are accepted if they meet one of the criteria mentioned above	The author did not have the access to the article/study

6.2 Data collection

Before searching for articles and studies, the criteria of material selection and search filters were carefully defined and documented. The search for literature was done mainly

in the following databases, Medic and Cinahl. Articles were read and the ones that met the criteria were included to the Thesis.

Medic gave most of the results, 12 articles were included out of 393 hits. Many searches were made in Cinahl but only the last one provided 2 articles with 181 hits. In total, 14 articles were included (Table 3.). Search words used were the following: “asiakaslähtöinen hoitotyö AND "Client oriented" nursing” (only Medic because of the Finnish language), client-centered nursing, “workload of nurses AND coping” and workload of nurses OR nursing workload AND client centered nursing.

Table 3. Literature search table

Database	Filters	Search words	Number of results	Chosen on the ground of topic	Chosen on the ground of abstract	Chosen on the ground of full text
Medic	2007-2018 Full text English and Finnish	Asiakaslähtöinen hoitotyö AND "Client oriented" nursing	393	47	24	12
CINAHL complete	2007-2018 Full text English	Client centered nursing	13	6	3	-
CINAHL complete	2007-2018 Full text English	Workload of nurses AND coping	9	6	3	-
CINAHL complete	2007-2018 Full text English	Workload of nurses OR nursing workload AND client centered nursing	181	25	11	2

6.3 Data-analysis

The collected data was read and classified into categories according to the research questions in order to ease the interpreting of the results. After that the studies were analysed and evaluated carefully by their methods, validity, content, results and ability to provide the information needed, in other words, answers to research questions. Guidance was asked for whenever the author was not sure what to do. Finally, the results

were gathered and synthesized into a consistent narrative, which represented all the results objectively. The results are divided to the three mentioned categories according to research questions. (Stolt et al. 2016, 23 – 34.)

7 RESULTS

7.1 What is good client-oriented nursing?

Nursing documentation habits and their significance to client-oriented care was studied with a grounded theory approach in Laitinen's (2014) doctoral thesis. Client-oriented care requires getting to know to the patients. Laitinen explains her observations of documenting and information exchange and how that affected the care in four acute somatic wards and compares them with the electronic patient documents. She followed from the patient's point of view the care of 43 patients, who also were key informants.

Client-oriented care requires continuance of the information obtained during the care at the time of shift change, discharge to home or transfer to a different ward. Also in a multi-professional care team, all parties should have all the information regarding the patient. The most efficient ways to ensure the continuance of the information were documenting while interviewing the patient with a mobile computer at the bedside. This reduced the time used for double documenting; firstly, the nurse would take notes on a small paper and later document to the patient files based on the notes and memory. Also, the important information was delayed and possibly forgotten. (Laitinen 2014.)

Knowing their own situation and what is going on at the ward was important for the patients during their care because it made them feel they were in control in a potentially life changing and scary situation. They also appreciated the presence of relatives and loved ones. The most effective way to work with patients was "working in collaboration", meaning the care process was cooperation, teaching and learning between the patient and the nurse, rather than the nurse just ordering what to do. This also included collaborative decision making, where patients' life situation and wishes were taken into consideration when planning the care. Being in charge of their own care made the patient a part of and involved in their care and gave confidence and abilities to self-care. Including family members is important when they are part of the care. All parties attending the care were up to date of what needed to be taught and learnt more. (Laitinen 2014.)

Biggest obstacles in the way of patient centred care were organisational policies, interruptions, intentional or unintentional ignoring of the patient as the centre of care and incomplete documentation. Sometimes decisions relating to the care were made without

discussing them with the patient and patients were discharged without proper instructions. Laitinen (2014) also describes a moment of interruption where in the middle of intimate care one or more professionals approached the patient regarding another matter. Incomplete documenting irritated both patients and staff and caused plentiful extra work when the missing information needed to be tracked down. Patients felt unsafe when the same things were asked many times and staff did not know the information the patients had already provided earlier even though they were supposed to know.

All the same, also reading the electronic patient records and learning about the patients was as important as the documenting. Depending on the organisational policies, some wards had verbal reports during the shift change and some did not. A verbal report was meant for the most important information but also reading oneself the records gave bigger and better picture of the patients and that way made the client-oriented care possible. (Laitinen 2014.)

Tiainen (2016) studied adult psychiatric patients' involvement in their own care from their, their relatives' and personnel's points of view and how that affected the care (reinforcing and preventing factors). Data was collected with a themed group interview. Better involvement of the patient in the care increased the patients' wellbeing and satisfaction. They also had a stronger motivation when they were able to be part of the care and felt that they were heard.

All parties strongly agreed that the involvement benefitted the care in many ways, but the ways on how to involve were different. Patients considered that being involved meant nurses' and doctors' genuine interest towards the care and the patient, remembering and knowing the patients' case and appropriate encountering of the patient. They valued continuing and relaxed care relationship where jokes were allowed and where they really were heard and, in addition, were given options and were able to influence their own care. (Tiainen 2016.)

Relatives considered that the involvement was fulfilled when the patient was brought to the negotiation about the care plan and listening to and noting the patient's wishes, although with the latter one they sometimes feared patient was given too much power, especially if their condition was poor. Personnel considered the involvement was best when the patient was brought to care meetings and involved in making the care plan, when their knowledge about their disease was utilised. Best care relationship was formed with open and equal interaction. (Tiainen 2016.)

Preventing factors according to patients included the feeling of shame that was connected to the psychiatric disease, lack of personal resources, relatives who do not understand the psychiatric disease and the problems of interaction between personnel and patients. Relatives listed the difficulties of getting information on the patient's condition, being left out of the care, unclear responsibilities and unprofessional personnel. Personnel considered earlier negative experiences of psychiatric care, negative feelings caused by the patient within personnel and the lack of commitment of the personnel to the values that guide the care were factors that prevented the patients' involvement in care. (Tiainen 2016.)

Anttonen (2016) studied in her Doctoral Thesis the palliative care by interviewing patients, relatives and staff (nurses). In total the sample consisted of 45 participants. The study and analysing method used was grounded theory. The goal was to find the way to improve and enhance palliative care to become more client-oriented. She found that a good death requires patient and, also family oriented care by getting to know patients as humans with their own life stories, beliefs, choices etc.

A good death required the whole staff to allow the patient and relatives to have time to deal with the future death. Sometimes the staff refused (consciously or not) due to different reasons to offer chances to deal with death properly. This lead to "an unfinished death" – an experience that burdened all parties. Patients were stressed and anxious before dying and after death relatives' life came to a halt because grief or overcoming the loss took a much longer time. Nurses sometimes changed work places, because of the influence of the unprocessed event. (Anttonen 2016.)

For the nurse, the undealt death of the patient in the family was emotionally burdening; they felt disappointment and failure at the job. Patients need information on their condition early enough to avoid too sudden decisions for palliative care and to be supported in their decisions, e.g. if they want a second opinion. However, the responsibility of the care is the staff's, not the patient's. Bureaucracy of centring the care (for example with an aid equipment unit, that was moved far away to a bigger unit) led to rising costs for palliative care patients according to the nursing staff. (Anttonen 2016.)

There are a few examples in Finland of successful but relatively small changes in the health care system that improved the care system to become more client-oriented. These are explained shortly below.

Central Finland Central Hospital developed a special care plan for patients with fatal cardiac insufficiency. The care plan was made with time together with the patients and they had a permission to come to the health care centre ward immediately when they felt like it. The key was to allow patients time to accept the forthcoming death and accept it. The result was a smaller care unit compared to a big special care hospital. (Vierula 2016.)

Before this change, palliative patients were bounced around special health care and emergency room, because the patients' trust for health care centres' care quality was weak. When the patient gets too sick and the care in special health was not needed anymore, the basic health care should continue as responsible for the care. However, the cooperation between the care levels was not working properly and needed improvement. Both care parties were in the dark of what the other party did and that caused unneeded visits to emergency rooms and visits in special health care. The palliative polyclinic was invented as a bridge and transfer from special health care to basic health care for palliative patients. (Vierula 2016.)

Another example of the benefits of centralising care to a smaller unit comes from another city Tampere, where the care of diabetes patients was located in one place to avoid bouncing the patients between different places. According to Larsson's article (2015), many studies have proven the centralised care for diabetes slows and decreases the appearing of comorbidities. Normally, people suffering from diabetes get the care from health care centres and special health care, from different locations. Tampere's model for diabetes practice includes the care and all the skilled specialists needed together: nurses, doctors, an endocrinologist, a podiatrist, a head nurse and a nutrition therapist (nearby). (Larsson 2015.)

The patient gets all the care for the diabetes from the same place, which saves their time, working hours and money directly since many of them use the taxi service and assistants paid by the society. It gives better possibilities for good care because the number of visiting patients and staff is smaller and they already know each other and are able to provide the care client-oriently. A small place allowed for example the doctor to take a quick look at the wound in the middle of the care, instead of having to book an entire appointment for it. (Larsson 2015.)

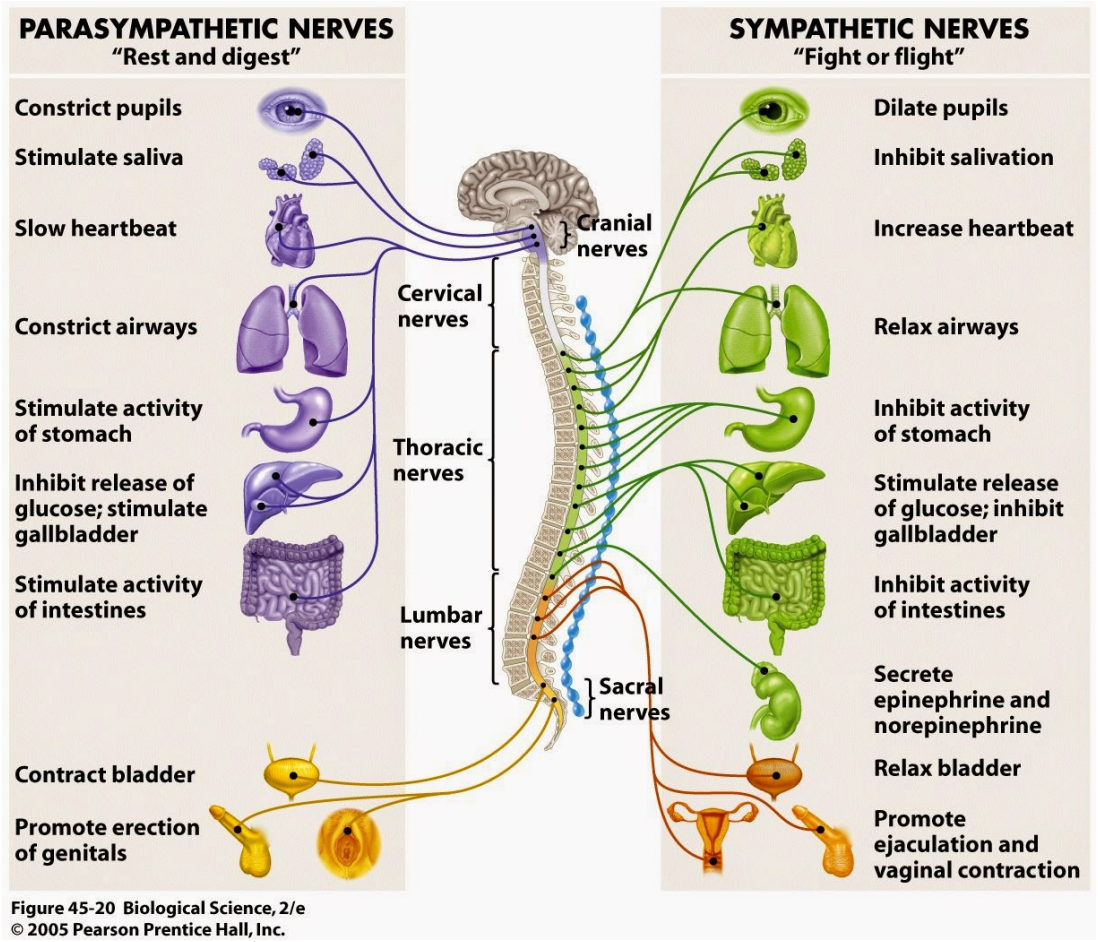
The third example comes from Southern Finland. Since the Spring of 2014 some health care centres have been testing a new model in organising the services for patients with comorbidities and usually many visits to health care centres in a short time. The solution

was to train nurses, public health nurses or midwives to become client responsibles ("asiakasvastaava" in Finnish), who plan together or without the doctor all the services that the client needs, from the client's point of view, ensuring holistic care. (Kantonen 2014.)

7.2 What affects a nurse's capability of coping with the workload?

Järvelin-Pasanen (2014) studied how the working time affected burdening and recovering of the autonomic nervous system by observing the activity of the sympathetic and parasympathetic systems, which were measured by the changes in heart rate (HRV, heart rate variability) (Picture 1.). The author studied two groups: female teachers with daytime jobs as the comparing group and female nurses who worked in two or three shifts. The results were compared to the individual's results (meaning changes in the nervous activity), not amongst all participants' results. The HRV was the indicator for nervous systems' activity at work, free time and during sleep.

It was found out that occasional long working days were not as burdening as the regular morning shift. During the long shift tasks were more evenly balanced with time whereas during the normal morning shift there was less time to complete them. Also, short recovery time between the shifts should be avoided, because it increased the activity of the sympathetic nervous system and decreased the parasympathetic one. Ensuring a longer recovery time gave the opposite results but increased the sympathetic activity at the end of the shift. However, increased sympathetic activity at the end of the shift did not have a negative effect if the employee was given enough time to recover. The HRV measurements supported the use of the forward rotating working shift system (from morning shifts to evenings and then to night shifts which were followed by days off), because it gives the best recovery times. (Järvelin-Pasanen, 2014.)



Picture 1. The tasks of parasympathetic and sympathetic nervous systems. (Nelson 2015.)

North Karelia Central Hospital and Honkalampi centre in Finland ran a project for testing a calculator that determined the number of nurses needed for a specific ward according to the workload that patients required (not just by the number of patients). A calculator model based on Pitkäaho's (2011) (according to Kaila et al. 2016) doctoral thesis was used. The goal was to learn to plan staff sizing and to be able to treat client-oriently, in other words the number of nurses in a shift should meet the demand of the patients to avoid work overload and unnecessary nurses in a shift. It resulted that some parts of the nurses' work were hard to analyse and include in the calculations due to lack of information. The need for nurses in different services varied and to fill the gaps caused by the variations, staff should be easily moved according to the need. (Kaila et al. 2016.)

Spooner-Lane and Patton (2007) studied determinants of burnout among public hospital nurses. The sample (273 nurses) was collected with a questionnaire survey, that later was assessed with SPSS-program. One of the main findings indicated that younger

nurses and full-time workers were more exposed to burnout than others and the burnout was more likely be the cause of broad demands rather than more specific reasons. However, support from supervisors seemed to be a contributor for coping with Depersonalisation and reduced Personal Accomplishment (subscales of a burnout self-report instrument MBI-HSS). It was suggested that supervisors could define the expectations of work outcome in order to ease the workload.

Van Bogaert et al. (2017) studied staff nurses' and nurse managers' assessments and experiences of workload, job outcome and quality of care. It was performed as a mixed-method study in two hospitals in Belgium with two independent phases: quantitative analysis with self-report questionnaires (751 participants, two hospitals) and qualitative semi-structured interviews (9 staff nurses and 10 nurse managers, from one of the hospitals). In the third phase, both studies' results were used to ease the interpretation of one another. The results were divided into the following categories: organisation of daily practice and work conditions, interdisciplinary collaboration, communication and teamwork, staff nurse personal characteristics and competencies, patient centeredness, quality and patient safety.

Under the category organisation of daily practice and work conditions, many issues were mentioned. Nurses had noticed patient types had changed. They had more chronic conditions, the cases were more acute and required more demanding, complex care. On the other hand, hospital stays were shorter, but it caused more admissions in a shorter time, which took a lot of time. At the same time staff resources were reduced, there were many changes and they had communication problems between professionals (e.g. nurses and doctors), which caused more workload. Also, the amount of paperwork (patient records, mandatory additional registrations) and interruptions such as phone calls or a lack of necessary equipment took a lot of time. The hospital was also involved in different patient safety and quality improving programs which demanded changes that were considered happening too fast. Still, it was felt they were useful and provided good ideas and solutions to ease the workload and make the care more efficient, such as bed side reporting. (Van Bogaert et al. 2017.)

To improve collaborative and team work, they had interdisciplinary meetings, where workload issues were addressed together. It was considered useful and important to be able to express one's feelings but also the way and style how it was done, was fundamental. The feeling that the management and administration department does not listen to their concerns was stressful. (Van Bogaert et al. 2017.)

Stress-resistance and strong capacity of self-management were the personal characteristics and competencies needed from a staff nurse to begin with. These were the qualities that would help to control the acceptable or manageable workload, which was challenging and needed to avoid feeling bored. An acceptable workload did not interfere with patients' needs and the quality of care. An unacceptable workload led to neglecting patient centeredness and affected the nurses negatively, for example with letting go and being less accessible and approachable coping methods. Other symptoms were also reported and included physical (decreased adequacy and efficacy, fatigue, headache and vulnerability for diseases) and mental (failure and impotence, restlessness, frustration, negativity and feelings of querulous and sadness). (Van Bogaert et al. 2017.)

Professional guidance and its effects on nurses' well-being at work was studied in a quantitative study. Professional guidance does not have an exact definition but general goals that fit in different professional fields are enhancing mental resources, professional knowledge and skills and strengthening sensing emotional life and professional identity in one's working role. Basically, it is a method to support the growth, learning and creativity and to improve working performance. The exact goal depends on the main function of the professional guidance (e.g. educational professional guidance could focus on improving problem solving and administrative guidance the understanding how one's work is part of the organisation or changes in the organisation). The guidance counsellor could be somebody from the organisation or an outsider. For example, the familiarization period of the new worker is one sort of professional guidance. (Haapala 2012: 12-13, 23.)

Haapala (2012) studied professional guidance's effect on nurses' well-being at work with a quantitative study and three different questionnaires whose results' were evaluated with the SPSS-program. Professional guidance had a positive effect on good social interaction (e.g. supervisors, leadership, organisational culture and atmosphere), satisfaction on possibilities to influence matters at workplace, lesser work burnout and cynicism. Successful professional guidance was noted to be connected to nurses who considered family important. It also made the nurses feel they were taken into consideration, which gave them more confidence and energy to deal with demanding work situations. Successful professional guidance is greatly connected to the supervisor's attitude towards it. Successful leadership is empowering and increases the

worker's work control and the feeling of being capable to influence matters, which increases well-being at work. (Haapala 2012.)

7.3 The connection between client-oriented nursing and a nurse's capability of coping with the workload

There were no studies found that would directly indicate how client-oriented nursing affected the workload. However, studies mentioned for example individual care and high quality care and how those required resources, meaning increasing workload. The failure to provide individual care or good enough care according to the nursing standards was sometimes experienced as burdening or frustrating. This question was approached from a different angle.

Flinkman's doctoral thesis (2014) studied why young registered nurses intend to leave the nursing field. She uses various methods including descriptive, sequential mixed-methods study, qualitative questionnaires and key informants. The first study was made with the questionnaire and the second one with interviews.

Around 24-50% of the young registered nurses thought about leaving the nursing profession. However, they considered more leaving the organisation rather than giving up nursing completely. Those who considered leaving the organisation, also thought more about leaving the nursing profession. Flinkman (2014) listed the following variables that related to stronger intention to leave: personal burnout, poor opportunities for development, weak affective professional commitment, low job satisfaction, work–family conflicts and high quantitative work demands.

Personal burnout, feeling tired often and dissatisfaction of how work schedule affected the wellbeing made the young registered nurses consider more about leaving nursing. On the other hand, generally most of the nurses, 65%, were satisfied with their job and a majority of 74% agreed they belonged to the nursing field. In open ended questions, the main factors for the intention of leaving the profession were dissatisfaction with the salary, work demands and shift work and working hours. (Flinkman 2014.)

The first part of the second study included three nurses with intentions to leave nursing who told their career story in the first and follow up interviews. The purpose of this was to receive in-depth information. It resulted to be "a long-lasting and complex individual consideration process" with three main themes: nursing as a 'second-best' or

serendipitous career choice, demanding work content and the poor practice environment, and inability to identify with the stereotypical images of nurses ("'angels with pretty faces and empty heads', 'physicians' handmaids' or 'naughty nurses'"). Flinkman (2014) continued with thematic interviews that introduced the following results presented below in Flinkman's table (Table 4.).

Table 4. Results of Flinkman's (2014) thematic interviews.

Main themes	Sub-themes	Categories
Poor nursing-practice environments	Ethical problems in nursing	Not able to care as well as would like to Working in organizations where poor quality care was provided
	Unsatisfactory working conditions	No opportunities for development No opportunities for career advancement Poor distribution of tasks Low salary Shift work
	Mistreatment	Verbal abuse from physicians and patients. Physical violence from patients in the workplace
Lack of support, orientation and mentoring	Did not receive social support	Unsupportive management Unsupportive colleagues Feeling of being left alone
	Insufficient support for the transition from a student to a practicing registered nurse	Inadequate orientation Inadequate mentoring
Nursing as a 'second best' or serendipitous career choice	Nursing as a second best career choice	Applied to university to study for another profession but didn't pass the entrance exams Deterred by university studies because of demanding entrance exams
	Nursing as a serendipitous career choice	Chose nursing education mainly for financial reasons Did not come up with any other occupation during high school Could not report why they applied for nurse education

Many ethical problems, fear of being left alone and not being listened to were mentioned in the interviews. If orientation in the organisation was inadequate, it caused insecurity and fear of making a fatal mistake. The future attractiveness of a nursing career for young people was not seen bright according to more than half of the respondents. 49% of survey responses considered the future becoming worse and 18% much worse. (Flinkman 2014.)

In summary, the decision to leave nursing for young nurses takes a long time and it might not be coherent. One's living experiences and social support were a factor when making the decision. Some nurses considered already before studies the nursing career would not be the final one, some did not adapt to poor practice environments (e.g. ethical problems in nursing, inadequate nurse-patient ratios) and associated poor nursing outcomes (e.g. personal burnout, work-family conflicts). (Flinkman 2014.)

Van Bogaert et al. (2017) studied staff nurses' and nurse managers' assessments and experiences of workload, job outcome and the quality of care. The category of patient centeredness, quality and patient safety brought up that workload also affected the patients. It endangered patient safety (e.g. risk for hospital-acquired-infection, falls, not detecting clinical signs etc.) but the main impact was the decrease in social interaction with the patients: "Patient communication and information about diagnostics and treatment were briefer and patients' questions and worries were more neglected." Some nurses then felt frustrated and that they had failed because they were unable to meet the patients' needs. (Van Bogaert et al. 2017.)

In her Master's Thesis, Heiskanen (2012) also studied eight nurses who had left the nursing field and started some other career. The method for sample collecting was snow-ball sampling and announcing in the social media. Participants wrote and sent to the researcher their stories of their personal experiences of how they ended up in nursing, how they stayed in the field and what made them leave, which were then analysed, categorised and interpreted. In this Thesis, the focus will be on the last two themes, staying and leaving the nursing field.

The factors that encouraged the nurses to stay at nursing profession were advancing at nursing profession, functioning work community, immediate supervision and work engagement. Especially at the start of the career, nursing care was very challenging but rewarding when working with skillful colleagues. The functioning of social relations at workplace was very important, along with good leadership. Positive features of a good leader were supportiveness and trustworthiness while lack of empathy and frightfulness were considered negative sides. Work engagement was strong due to innovative developing of the nursing care and creativity from a client-oriented point of view. The joy of working came from pleasure of the work and devoted staff. (Heiskanen 2012.)

The decision to leave was ready when after a long time of considering something changed radically in the nurse's life. Nurses were tired of non-functioning working

community, the demanding work and burnout or non-functioning leadership. They also felt that after some point it was not possible to advance one's skills. Until some point the love for the profession and patients were enough to cope. Nurses felt their investment was not appreciated. The demanding work caused burdening and the lack of resources made them feel they were not able to provide the best care possible to their patients; they did not have the time to be there for the patients. This with unequal relationships with doctors led to a spiritual suffering because they were not able to take care of the patient individually and give the best treatment. (Heiskanen 2012.)

8 ETHICS AND VALIDITY OF BACHELOR'S THESIS

8.1 Ethics

Studies and results are not ethically approved and trusted as valid unless the researcher is committed to responsible conduct of research including research ethics and integrity. These regulations are also controlled by different laws. (TENK 2012.)

To improve the ethics of this thesis, the guidelines given by Finnish Advisory Board on Research Integrity (TENK, Tutkimuseettinen neuvottelukunta in Finnish) were followed. Studies' ethics were evaluated and the author followed ethical principles throughout the whole process, from the start to presenting results. Original work and achievements from other authors was appreciated and respected; nothing was presented without correct quotation and referencing nor presented as own work. This Thesis was planned beforehand, executed and reported with the help of a guiding expert. (TENK 2012.)

Results were evaluated and presented thoroughly and precisely as they were found objectively and without falsifying or personal agenda to ensure trustworthiness. Data acquisition, research and evaluation methods were ethically sustainable. (TENK 2012.)

Ethical permissions for studies were not applied, because they were not needed. This thesis was a literature review and no participants were needed. No conflicts of interest were encountered. This Thesis did not receive any funding.

8.2 Validity

While writing a systematic literature review, it is important to evaluate the validity, or trustworthiness, of the studies included in order to improve the validity of the research in progress. It also guides the interpreting process of the results and that the significance of the results. It is necessary to construct a minimum quality level for the studies included to the research and investigate the differences in validity and their possible cause to differences in results. (Johansson et al. 2007, 101 – 108.)

This thesis is a literature review but the fact that the literature was not searched completely systematically was a great risk to reliability. This could have caused that some important material or different points of view could have been missed or wrongly

emphasised. Also, access to articles was not as unlimited as compared to bigger studies and researchers, since only the free articles and databases offered by TUAS were used. Only one person (author) read and included or excluded articles obtained with searching. This was also a reliability risk, but to improve it, the author had a guiding expert throughout the writing process. (Johansson et al. 2007, 101 – 108.)

The studies used were both qualitative and quantitative. In order to improve the validity of this thesis, the validity of all the studies used was evaluated with the criteria on how to determine quantitative and qualitative studies presented by Johansson et al. (2007, 101 – 108). The studies that mostly met the items of those in the criteria list mentioned (Appendix 1 and 2), were chosen. Also the beforehand defined inclusion and exclusion criteria and search filters improved validity of the study.

It resulted challenging to find articles that met the inclusion criteria and goals of the research questions. The inexperience of the author surely had an effect during searches and analysing the results and it is believed a more experienced researched would have found more international results. The articles chosen were considered medium and high in validity, but the sample is relatively small. Obtained results definitely indicate a need for further research but other usage of the information displayed should be used very cautiously.

9 DISCUSSION

This thesis had three different themes: client-oriented nursing, nursing workload and their connection. The goal and purpose of this thesis was to seek information on all the subjects and deduce if there is a connection between client-oriented nursing and nursing workload and what the possible connection's significance to nursing is. Principal results are explained in the following chapters with comments.

Client-oriented care takes time and resources (Nuikka 2002; Kaila et al. 2016), but ensures better individual care (Van Bogaert et al. 2017). An effective way to perform it is for the nurse to familiarise oneself to one's patient by reading the patients' electronic records and interviewing and communicating verbally with the patients (Laitinen 2014). Nursing care should be collaborative working and teaching rather than just giving orders (Laitinen 2014). Collaborative working and involving the patient to their care motivated the patient more to commit to their own care (Tiainen 2016). Good results were also obtained from bedside reporting and documenting (Laitinen 2014; Van Bogaert et al. 2017).

Coping with the workload was affected by numerous factors. In this Thesis, the following were identified from different sources: working in shifts, staff resources, patient types and diagnoses and the level of care they needed, age of the nurse, contract type, supervisors, paperwork (e.g. electronic records, registrations), team work, constant changes at workplace, work overload and professional guidance. These were mentioned by Järvelin-Pasanen (2014), Spooner-Lane and Patton (2007), Van Bogaert et al. (2017) and Haapala (2012).

There were no studies found that would directly indicate how client-oriented nursing affected the workload. The last question was approached from a different angle providing results from studies that investigated why nurses left their profession. Studies mentioned for example individual and high quality care and how those required resources, meaning increased workload. The failure to provide individual care or good enough care according to the nursing standards was sometimes experienced as burdening or frustrating (Flinkman 2014; Van Bogaert et al. 2017). Some nurses stated they wanted to offer their patients better care than they felt was possible at the workplace's conditions (e.g, hurry, inadequate nurse-patient ratios, ethical problems) (Heiskanen 2012; Flinkman 2014).

Nursing work was considered demanding and taken seriously. Not being able to answer the patients' needs sometimes caused feelings of frustration and failure and in some cases led to feelings of burnout (Van Bogaert et al. 2017). Anttonen (2016) also mentioned how unsuccessful care of a palliative patient's death in a palliative care unit was burdening for nurses because the care had not been ideal. If the feeling of failure was left undealt with, it was sometimes too much to handle and caused the nurse to change workplaces.

Some other examples of unsuccessful client-oriented care and consequences were pointed out in several studies. Both Van Bogaert et al. (2017) and Nuikka (2002) mentioned the medicating of the anxious patient instead of verbal reassurance due to lack of resources. Laitinen (2014) described the moment where in the middle of intimate care one or more professionals approached the patient regarding another matter concerning the care. This latter kind of action violates the patient's privacy and should not be allowed unless there is an emergency. Unfortunately, the author has also witnessed this kind of behaviour many times. For example, after starting the care for personal hygiene, doors and curtains remain open or they are closed too carelessly. In other words, other patients or relatives are still able to see inside.

An interesting point of view of the possibility to provide client-oriented care was offered by Hyvärinen (2011). Hyvärinen brought up that totally client-oriented care might always not be possible, due to organisational limiters but also because the client is not always capable to decide on their own about their care. Like Laitinen (2014), Hyvärinen also concluded that in those cases the client is offered information about the situation and options making the care collaborative.

10 CONCLUSIONS

According to the results and findings of this thesis, the following conclusions and suggestions for follow-up studies are presented.

1. Client-oriented care is individual and educational cooperation rather than just one-sided nursing care executed by the nurse. Individual care requires time for getting familiarised with one's patient.

2. Client-oriented care requires a certain amount of staff to be able to perform individual care and it is not possible to take care of the patients client-oriently if the health care staff does not have enough resources.

3. Registered nurses could get frustrated and stressed when the care they are forced to give by the many different circumstances does not match the quality they were hoping to offer. Stress and frustration can sometimes lead to not caring and depersonalising.

4. Young registered nurses are more vulnerable to stress and burnout.

5. More research is needed to determine how client-oriented nursing affects the workload and nurses and regarding young nurses' exposure to burnout and intention to leave the nursing field.

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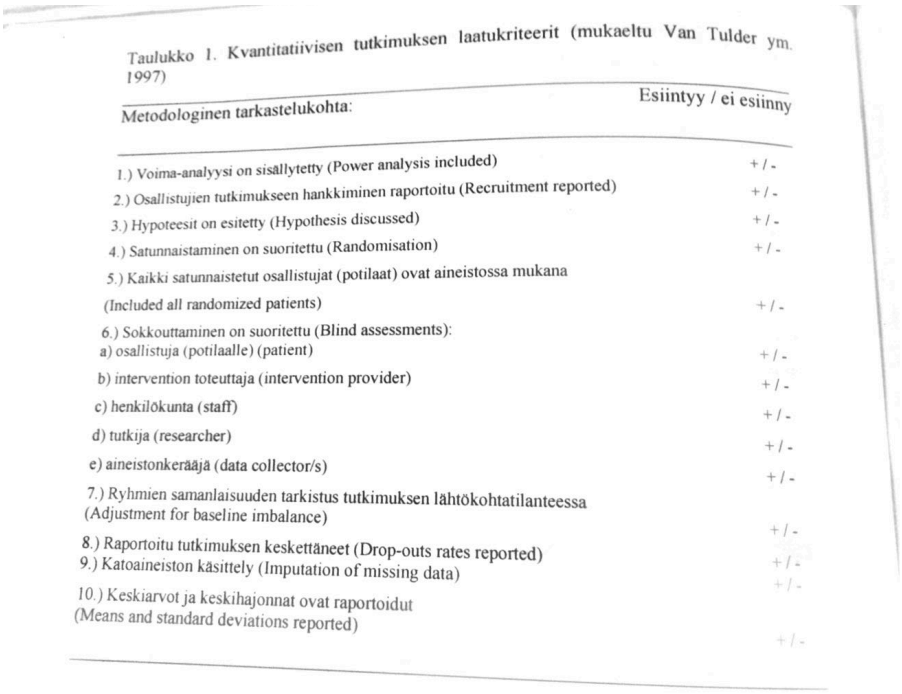
Appendix 1: Quality criteria of qualitative research

Taulukko 2. Kvalitatiivisen tutkimuksen laatukriteerit (mukaeltu Suomen sairaanhoitajaliitto 2004)

Tutkimus:			
	Kyllä	Ei	Ei tietoa / Ei sovellu
Tutkimuksen tausta ja tarkoitus			
Onko tutkittava ilmiö määritelty selkeästi?			
Onko tutkimuksen aihe perusteltu kirjallisuuskatsauksen avulla sisällöllisesti, menetelmällisesti ja eettisesti ja onko se riittävän innovatiivinen?			
Onko tutkimuksen tarkoitus, tavoitteet ja tutkimustehtävät määritelty selkeästi?			
Aineisto ja menetelmät			
Ovatko aineistonkeruumenetelmät ja –konteksti perusteltu ja kuvattu riittävän yksityiskohtaisesti?			
Soveltuuko aineiston keruumenetelmä tutkittavaan ilmiöön ja tutkimukseen osallistujille?			
Onko aineiston keruu kuvattu?			
Onko aineisto kerätty henkilöiltä, joilla on tietoa tutkittavasta ilmiöstä?			
Onko aineiston sisällön riittävyyttä arvioitu (saturaatio)?			
Onko aineiston käsittely ja analyysin päävaiheet kuvattu?			
Soveltuuko valittu analyysimenetelmä tutkittavaan ilmiöön?			
Tutkimuksen luotettavuus ja eettisyys			
tutkija on nimennyt kriteerit, joiden perusteella hän on arvioinut tutkimuksen luotettavuutta			
tutkimuksessa on käytetty aineiston tai menetelmien triangulaatiota lisäämään luotettavuutta			
tutkija on pohtinut huolellisesti eettisiä kysymyksiä (mm. tietoinen suostumus)			
tutkimukseen osallistuneet ovat arvioineet tutkimustuloksia ja vahvistaneet tulosten vastaavuuden kokemuksiinsa; tai lukija voi tunnistaa ja ymmärtää tulokset			
tutkija on pitänyt päiväkirjaa tai kirjoittanut muistiinpanoja tutkimuksen kulusta			
Tulokset ja johtopäätökset			
tuloksilla on uutuusarvoa ja merkitystä hoitotyön kehittämisessä			
tulokset on esitetty selkeästi, loogisesti ja rikkaasti ja niiden antia on verrattu aikaisempiin tutkimuksiin			
tutkimuksen johtopäätökset perustuvat tuloksiin ja ovat hyödynnettävissä			
Muut huomiot/kokonaisarvio			
tutkimus muodostaa eheän, selkeän ja johdonmukaisen kokonaisuuden			

Appendix 2: Quality criteria of quantitative research



Taulukko 1. Kvantitatiivisen tutkimuksen laatukriteerit (mukaeltu Van Tulder ym. 1997)

Metodologinen tarkastelukohta:	Esiintyy / ei esiinny
1.) Voima-analyysi on sisällytetty (Power analysis included)	+ / -
2.) Osallistujien tutkimukseen hankkiminen raportoitu (Recruitment reported)	+ / -
3.) Hypoteesit on esitetty (Hypothesis discussed)	+ / -
4.) Satunnaistaminen on suoritettu (Randomisation)	+ / -
5.) Kaikki satunnaistetut osallistujat (potilaat) ovat aineistossa mukana (Included all randomized patients)	+ / -
6.) Sokkouttaminen on suoritettu (Blind assessments):	
a) osallistuja (potilaalle) (patient)	+ / -
b) intervention toteuttaja (intervention provider)	+ / -
c) henkilökunta (staff)	+ / -
d) tutkija (researcher)	+ / -
e) aineistonkerääjä (data collector/s)	+ / -
7.) Ryhmien samanlaisuuden tarkistus tutkimuksen lähtökohtatilanteessa (Adjustment for baseline imbalance)	+ / -
8.) Raportoitu tutkimuksen keskeyttäneet (Drop-outs rates reported)	+ / -
9.) Katoaineiston käsittely (Imputation of missing data)	+ / -
10.) Keskiarvot ja keskihajonnat ovat raportoidut (Means and standard deviations reported)	+ / -