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Empowerment in Home Care

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<p>Health care will have a more client-centred approach in which empowered clients will reduce costs in the long run. The purpose of this study was to explore the perceptions and experiences of empowerment in a public home care setting in Kouvola, South Eastern part of Finland, from the perception of clients and their care givers. This study aimed to evaluate how empowerment was implemented and how the experiences of the participants were related to each other.</p> <p>The methods of quantitative researches were used to investigate clients and care givers' perceptions of empowerment with validated and tested questionnaires. To look into the clients' perceptions of empowerment the 'Patient Perceptions of Patient-Empowering Nurse Behaviours Scale' was used. The 'Nurse Perceptions of Patient-Empowering Nurse Behaviours Scale' was provided to the care givers. The answers were scored on an 11-point Likert scale. Care givers had to be employed as a nurse at a home-care setting in Kouvola and be able to understand Finnish. The clients that were included were aged 75 or older, living at home and receiving home care services at least twice a week for a period of 4 weeks with the emphasis of service for activities of daily life. 76 care givers and 47 clients were included in this study.</p> <p>A web-based questionnaire on a Finnish electronic questionnaire platform was used as a data collection instrument for the care givers and the clients could fill in the questionnaires on paper. SPSS software was used to analyse all data.</p> <p>The results showed that for every question the care givers had valued their score higher than the clients. Among clients, the oldest age group (85+) scored lower than the group of 75-84 years old.</p> <p>The results lead to the conclusion that there is a need for more focus on participation, helping clients realize they have the right to make own health decisions. Clients have to feel more equal in the client-care giver relationship where, in a barrier free environment, opportunities should be created and where there is time to learn skills and communicate about the clients' needs and goals.</p>	
Keywords	empowerment, health care, home care, participation, decision-making

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1 Introduction

Patient empowerment has emerged as an interesting keyword in the last recent years. Many hope that empowering clients will improve medical outcomes and lower the costs of treatment. (Chatzimarkakis 2010: 1570.) Health policy analysts want to control health care costs by letting people take more responsibility in their own health, while health care professionals use empowerment to improve the health outcomes. Where health care professionals recognize the potential benefits of empowerment, the discussion touches a point that those benefits only can be realized if clients are motivated and involved in the decision-making process. (Nakamoto & Schulz 2011: 65.)

The client's experience will be essential. Because of the easy access to internet, medical records and easy communication with health care providers, the amount of information clients can find today is very powerful but can also be confusing. If clients can adapt and integrate their increased responsibilities into their daily lives, only then client empowerment will bring benefits. In addition, client empowerment can provide the chance to increase multidisciplinary communication where a client can be seen from a more holistic point of view. This will make the life of the health care professional more effective and this approach will also be more beneficial to clients. (Chatzimarkakis 2010: 1570-1572.)

It will become essential that clients understand their new role and improve their own responsibility in the management of their health. Shared decision making should allow clients to make own decisions, according to their own preferences. Another key component in the empowerment process is participation, which has multiple goals: to change health-related behaviours, empower people to take more responsibility for their own health, control health costs, advance the quality of health care provision and improve client experiences. (Williamson 2014: 4.)

The demographic situation nowadays in Europe puts a lot of tension on the health and social care services. The share of older adults rises, while there will be less young children. Elderly use more health and social services and therefore in the future increased pressure on budgets and capacity of health workforce is expected. Specific qualifications for health care workers and a more integrative approach will be needed to deal with the

special needs of older people. (Dijkman, Mikkonen & Roodbol 2019: 1.) There is a growing attention to change the care of elderly from institutional to home care since care at home has been seen less expensive. (Dijkman et al 2019: 111). Therefore, this research is focused on how empowerment is experienced in a home care setting by elderly clients and by their formal care givers. By comparing their results, it will be possible to find out what the positive points are at this moment and what the areas are where clients and care givers need extra support to get some benefits out of the empowerment concept.

2 Theoretical background empowerment

2.1 What is empowerment

As described by McWilliam et al already in 1994, health care providers should evaluate the client's goals and aims towards it in the wider life context as a way to adjust empowering to meet the individual needs. (Faulkne 2001: 40.) Nowadays empowerment includes also actively involving clients to become co-operators who take their health behaviour and management in own hands, in partnership with their (health) care provider(s). (Náfrádi, Nakamoto & Schulz 2017: 2; Williams, Bowler & Wright 2017: 737).

Empowerment is a rather abstract concept and therefore it has in the literature many definitions and terms that are almost similar synonyms. The World Health Organization, WHO, defines empowerment as “a process through which people gain greater control over decisions and actions affecting their health.” The process must allow people to gain knowledge and skills given by their formal care giver(s) and attitudes needed to participate in their care. (WHO 2009: 190).

Terms as patient empowerment, patient involvement and patient engagement are often used to explain the same concept, although there are small differences in understanding. The European Patients' Forum, EPF, (2015: 5) made a distinction between empowerment and involvement but later on combined the terms in a new definition. The underlined words in the definition are related to empowerment, the words in bold relate to involvement:

“An empowered patient has control over the **management** of their condition in daily life. They **take action** to improve the quality of their life and have the necessary knowledge,

skills, attitudes and self-awareness to **adjust their behaviour** and to **work in partnership** with others where necessary, to achieve optimal well-being.

Empowerment interventions aim to equip patients (and their informal caregivers whenever appropriate) with the capacity to **participate in decisions** related to their condition to the extent that they wish to do so; to **become “co-managers”** of their condition in partnership with health professionals; and to develop self-confidence, self-esteem and coping skills to **manage** the physical, emotional and social impacts of illness in everyday life.”

Despite the recognised benefits, nowadays there isn't yet any EU strategy on empowerment. The adaptation of a European framework that ensures the fundamental principles of client empowerment and centredness would contribute to improved health care in Europe's national systems. (European Health Parliament 2015: 9.)

2.2 Components of the empowerment process

According to the WHO (2009: 191) the opportunity for clients to participate more in their health has developed. It is fundamental that clients and health care professionals first understand their new role before they can empower or be empowered. The WHO made mention of four components that are essential to the process for clients: participation, the possibility to gain sufficient knowledge, skills and the presence of a facilitating environment. Shared- decision making and self- management can be added to these four components, according to the European Patients' Forum (2015: 5.)

2.2.1 Patient participation

Participation is seen as a central component in the promotion of sustainable health and health care in which 'autonomy' and 'choice' are important keywords and awareness among all partners should be established. (Williamson 2014.) “Patients have the right to be treated respectfully and honestly and to be involved in their own health care decisions.” Policies in the health care system should value the clients' rights and should put stress on the concept of participation and make it possible to create opportunities for all individuals to share their decisions. (Vahdat, Hamzehgardeshi, Hessem & Hamzehgardeshi: 2014: 3-6.)

Shared-decision making can be explained as a process between the clients and their care givers that intends to help clients be more active decision-makers when it comes back to their own health. The client, often supported by family members, has the important role in this process to communicate his/her social situation, his/her personal values and preferences that are formed by their knowledge of the options. The process to involve clients also includes establishing a partnership with the health care givers, communicating their health problem and priorities, searching and using information and implementing the decision. (Edwards & Elwyn 2009: 29.)

Nowadays the dominant conceptualization of clients' involvement in decision-making focuses on two main ideas: the exchange of information about the health care options and the client's understanding of those and as a second point, the influence the client has over the chosen option. To let clients participate in their own health care there is the need to raise awareness that there are several options to choose from and there is the need to respect the clients' personal autonomy. (Edwards & Elwyn 2009: 17-18.) According to Edwards & Elwyn (2009: 19) this concept is limited and doesn't cover the client's role in relation to possible activities who could influence the possible health options and is overlooking the relationship and attitudes from the clients and health care professionals towards each other. When clients consider their involvement in decision-making, they reflect on more than the given information and the influence they have over the treatment options. Communication about health problems and treatments, the relationship with the care giver and the feeling of the clients they are heard and respected as an individual influences the client's thinking and involvement in decision-making also.

It is proven that increased involvement of clients and shared-decision making have benefits such as better quality of care, grown satisfaction for clients and care givers and improved self-esteem for clients. Health care professionals not only value the personal rewards of clients' participation, but express the process as more effective. Client's voice that they mark more confidence and trust, experience reduced anxiety, have a better idea of personal needs, have better relationships with care givers and a positive health effect. (Edwards & Elwyn 2009: 4,40.) Vahdat et al (2014: 5) add some more benefits of participation: higher quality of life for the client, more positive and direct communication with the care giver, better decision making because of the accessibility to multiple insights, increased trust in services since there is more liberty, knowledge and transparency, encouragement of sense of independent responsibility.

It is of importance to point out and promote that clients are able to participate in treatment decision making. During this process clients benefit from having effectively presented and all-round information and there is access to tools that help clients in making decisions. (Vahdat et al 2014: 2.) Health professionals can enhance the level of involvement by presenting information about the options, checking the clients' understanding and knowing the clients' preferences and concerns. (Edwards & Elwyn 2009: 5,18.)

Age, culture, background, personality, level of intelligence and relationships have been recognized as key characteristics when wanting to engage clients. Experiences, depending from one situation to another, will be different when people are more exposed or familiar with participation and decision-making processes. (Edwards & Elwyn 2009: 4; WHO 2009: 191.)

It is essential to remember that clients only feel involved in their care when they are treated as equal partners, that privacy and time for discussion is needed and that clients have different expectations of the responsibility they want to accept. (Edwards & Elwyn 2009: 40). A better health care service can be provided when clients are considered as equal partners and are fostered to actively join in their own care. (Vahdat et al 2014: 2.)

2.2.2 Gain knowledge

An essential element when empowering clients is to provide them access to accurate and high quality information about their condition and the possible therapeutic options that are available for them. (European Health Parliament 2015: 4.) "Patients can be empowered only after having gathered enough information, understanding how to use the information and being convinced that this knowledge gives them shared responsibility with their health care workers." (WHO 2009: 191).

Health education will enlarge the individual's knowledge about his health and makes them more informed about their health choices. The WHO has emphasized the importance of education to support the care needs for elderly. To build knowledge, improved access to accurate, correct and culturally appropriate information is needed. The usage of clear language without medical/health terminology and the application of appropriate materials is crucial. (Bulduk & Kececi 2012: 153.)

Help building knowledge, provide time to practice new skills and support clients to discover skills to manage their care will provide access to opportunities to learn and grow. (Jerofke & Weiss 2016: 2930.) Clients will be more confident when understanding their own health situation or treatment options which will lead towards the opportunity to express their health concerns and preferences towards their care givers. (Chen, Mullins, Novak & Thomas 2016: 3.)

Clients need medical feedback in an adult-to-adult relationship which encourages them to be more inquisitive and gain knowledge about their condition. Empowerment should be build upon education and practical training where instruments and methods to develop mental and emotional skills to take responsibility for own needs and motivational factors for clients to integrate increased responsibilities into their daily lives are foreseen. The approach of mutual respect is person-centred. For this psychological change to take place, congruence, unconditional positive regard and empathy are the basic characteristics needed for the change in culture that is achieved. This demands everyone involved to put aside old ideas and habits. (Chatzimarkakis 2010: 1571; Náfrádi, Nakamoto & Schulz 2017: 738-740.)

2.2.3 Skills

2.2.3.1 Self- efficacy

“Self-efficacy can be defined as the individual’s belief in his/her own ability to implement a specific behaviour or a set of behaviours.” It can allude to perceptions of an individual’s own ability to mobilize resources and motivation to manage possible situations and challenges. Together with a common meaning of self-efficacy, what can be explained as a stable sense of personal competence across situations, research notified that a high sense of efficacy can be associated with better health outcomes, greater achievement and better social integration. (Náfrádi, Nakamoto & Schulz 2017: 2-3).

The theory of self-efficacy suggests that clients will be encouraged to take care of their health issues when they feel confident about reaching own goals. A good notion of self-efficacy leads to a feeling of control and to the will to deal with upcoming and severe tasks. (European Patients’ Forum 2015:10.)

According to the WHO (2009:191) there are four ways to improve self-efficacy. Self-efficacy will raise relate to the fact of previous successes, witnessing other people completing a task successfully, the impact of encouragement and individual perception and psychological responses.

By being confident and supply clients with knowledge and skills, self-care will be improved and personal goals and effective strategies for achieving the goals can be adjusted. (European Patients' Forum 2015: 10).

2.2.3.2 Health literacy

The European Patients' Forum clarifies health literacy as the cognitive and social skills which define the motivation and the competence of the person to acquire access to, understand and apply health information to make, in daily life, sustainable health decisions to maintain or improve quality of life. Good understandable information is a powerful instrument towards improved health literacy. To reach a functional level of health literacy it is essential that individuals can access relevant information so they are able to process, evaluate and use the information in their own condition. Interactive and critical health literacy are more advanced levels where interactive health literacy represents the growth of personal competences that leads towards more active participation and in critical health literacy individuals can critically analyse and apply information to join actions that overcome structural barriers to health. (Edwards & Elwyn 2009: 102; European Patients' Forum 2015: 8-9.)

There has been made mention of lower health literacy among elderly, less educated and poor individuals and members of minority groups. Health literacy is fundamental to client empowerment because of its association with lower health outcomes, increased rates of hospitalization and higher costs for care. (WHO 2009: 191).

The progress of health literacy and client empowerment gave a more active and leading role for clients where they could be more autonomous in making decisions relating to their health. (Nakamoto & Schulz 2011: 65.)

According to the European Health Parliament (2015: 4), people who have a higher level of health literacy have healthier behaviours that lead to a higher state of well-being, have an increased life expectancy and lower chances of developing a chronic disease.

2.2.4 Facilitating environment

In a facilitating environment clients are encouraged to generate an open communication about their care in a supportive environment, free of barriers and with mutual respect. There are three preconditions that health professionals need if they want to support clients and want to be seen as partners. These are: a workplace that has the structure to cultivate empowerment, a psychological belief in one's ability to be empowered and acknowledgement that the relationship and communication of health professionals with clients can be powerful. (WHO 2009: 191.)

When talking about empowerment, it can't be forgotten to refer to informal and unpaid caregivers. A care giver is enabling an individual to live longer in his/her own home, without informal care givers many elderly would be institutionalized. Those care givers are the primary factor affecting a successful return home after a hospital discharge. For many elderly, the presence of an informal caregiver is an essential factor facilitating the achievement of empowerment and well-being. (Heumann, McCall & Boldy 2001: 213.) Informal care consists of help and support to an individual and is often a long-term care that might also implicate help in everyday activities. Informal care givers generally aren't prepared or educated to meet the demanding care needs. Therefore it is wise to involve the informal care giver and to foresee support to keep their (emotional) stress levels as low as possible. Formal and informal care givers should provide different types of support for the client, where the formal care givers can use the knowledge and experience of the informal care giver. Access to information on the received service should be provided and attention should be paid that the client is satisfied and his/her needs are met. (Dijkman et al 2019: 23-26.) Engaging family members in the process of care integrates health and supportive services at home for the client and family. By determining the informal caregivers' goals and expectations and taking their values, preferences and needs into account, support and commitment can be strengthened and will improve also everyone's quality of life and quality of care. (Heumann et al 2001: 184.)

2.2.5 Self-management

"Self-management is a holistic approach providing the appropriate support and tools according to each person's individual needs and preferences." Self-management can be seen as a partnership where the health care team assists clients in "living with" their illness and in managing the conditions and their physical, psychological, emotional and

social impacts. (European Patients' Forum 2015: 9). A significant difference in the whole process of empowering will be made with a holistic view that considers a person's family, social and political context and by providing clients with information, technical skills and self-management education that will teach problem-solving skills. (Williamson 2014: 4-12.)

Clients are experts by experience. Their own experience on their health is unique and they have learned to manage their condition with or without the support of their care givers. To maximise the benefit of self-management clients do need effective support that is aiming to use the best available resources: knowledge, skills and motivation of the client. Supported by evidence, self-management improves health outcomes and reduces costs and should be seen therefore as an essential part in integrated care. (European Patients' Forum 2015: 8.)

2.3 Barriers

The EPF (2015: 11) explains that it is important to acknowledge that empowerment can be facilitated but can't be forced "top down". A client maybe doesn't want to participate in decision-making at some point and later on might wish to be involved more again. Also, a client may choose not to choose any treatment, after a discussion of all the options.

In conflicting situations, when a care giver wants to respect the individual's autonomy but also wants to promote his/her well-being, an individual's decision can seem harmful to the formal and informal care givers, still the goal of empowerment stays and aims to create the most empowering environment as possible. (Heumann, Boldy & McCall 2001: 23-24.)

In 2017 the World Health Organization made mention that the workforce, including formal health professionals and informal caregivers, is mostly unprepared to handle the demands of elderly. Because of the shortage of future health care givers there is the need to use more the social network and family of the elderly to provide care and support. This requires a different approach for the formal care giver nowadays. (Dijkman et al 2019: 2.) All health professionals must develop the needed competences and attitudes to adjust to the new cooperative role of the client. (European Patients' Forum 2015: 10.)

Empowering care optimises independence but research has shown that people are often exposed to circumstances that seem to contradict the principles of empowering. Increased dependence is created from care that is disempowering e.g. older clients develop an 'induced disability' when exposed to uncontrollability, specifically over-assistance with a psychomotor task. (Faulkne 2001: 40.)

Pittet's behaviour theory seems to have an influence on some of the barriers of client empowerment. Intrapersonal, interpersonal and cultural barriers can lessen client involvement. Intrapersonal factors like psychological vulnerability, illness and acute pain could be caused by poor knowledge and professional inequality. Using clear and easy language and the recognition of the importance of communication is a part of interpersonal factors that aims to have clear expectations. Cultural marginalization induced by social pressure has its impact on "speaking-up". Another meaningful element frequently marked by the client is the fear of negative impact/reply from their health care provider. These providers are frequently confronted with barriers that are mostly system-related instead of behavioural. When removing barriers of clients' empowerment and create involvement and participation, the context of an organization, culture or community is essential. (WHO 2009:193.)

Key barriers that were mentioned by the European Patients' Forum (2015: 10) included a lack of time/shortages of staff, clients' lack of information and attitudes of health professionals were seen as most important barriers by all stakeholders. The European Health Parliament (2015: 8) added that power imbalance, attitudes between qualified professionals and a general lack of recognition by healthcare professionals of clients' expertise and ability to contribute can be seen as barriers also.

Lots of circulation among employees and challenges in recruiting and retaining skilled care professionals can develop a barrier also. Health care workers have reported not having enough time to communicate, provide "little extras" and provide care in a psychosocial domain. (Bölenius, Lämås, Sandman & Edvardsson 2017: 2.)

As presented by Heumann et al (2001: 25) in figure 1, a classification scheme is presented showing four groups of potential limits and impediments that need to be considered and discussed when empowering frail elderly people. The four groups are: provider based, environment based, client based and societal based.

<u>Provider Based</u>	<u>Environment Based</u>	<u>Client Based</u>	<u>Societal Based</u>
a. poor/biased/insensitive training or education	location related	mental capacity	program choice alternatives
b. lack of knowledge of clients' views/wishes	built environment barriers	physical capacity	willingness to empower and be empowered
c. biases in service delivery	knowledge of and access to support features/technology	low self-esteem/expectations	awareness of choices and options
d. fragmentation of services and lack of coordination	complex maintenance	personal choice/perceptions regarding the aging/care processes	agism
e. inflexibility in program design and funding	living arrangements	cultural/language issues	
f. inappropriate views on informal care roles	housing choice and cost considerations	family dynamics	
g. inappropriate referral and admission to institutions	code/regulation restrictions	financial and other resource limits	
h. civil and criminal law regarding care/risk/professional practice			

Figure 1. Framework of limits and impediments to empower. (Heumann, Boldy & McCall 2001: 26).

2.4 From concept to practice

2.4.1 Clients empowerment

In 2015 the European Patients' Forum launched a campaign on client empowerment aiming to advance understanding of what empowerment contains from the clients perspective. The ultimate goal was to create awareness and to develop EU-wide implementations of policies and strategies on empowering clients to participate in the decision-making and management of their health. The slogan of the campaign was: "Patients prescribe E5 for sustainable health systems". The pamphlet in figure 2 explains more in-depth the content of the five 'E': education, expertise, equality, experience and engagement.

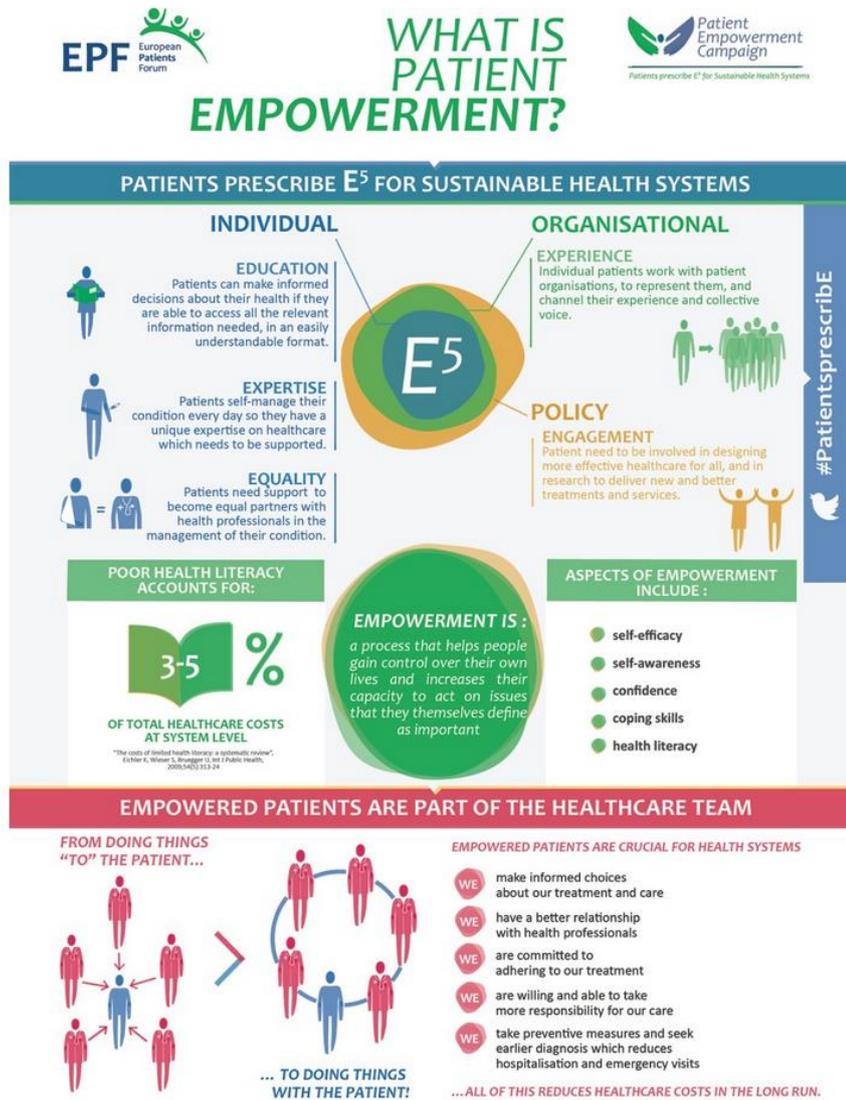


Figure 2. What is patient empowerment? European Patients Campaign. 2015.

As part of the campaign, a charter of patient empowerment was spread. The charter, as seen in figure 3, defines the fundamental principles of patient empowerment, from the patient's perspective.

The Patients' Charter on Patient Empowerment



Figure 3. The Patients' Charter on Patient Empowerment. European Patients' Forum. 2015.

2.4.2 Empowerment in nursing context

Already in 1991 empowerment in a nursing context was described by Gibson as “a complex and multi-dimensional concept in which empowerment can be conceptualized as the process of helping people to assert control over the factors which affect their lives.” This adaptation encloses the individual's responsibility but also the organizational or societal responsibilities in empowering individuals. (Gibson 1991). Gibson concluded that this concept has major profit for nursing application but to adopt an empowerment model in nursing, a drastic change is needed.

The adjustment in the role of the nurses from a traditional role towards a more health promotive role includes the wish that the nurse empowers and advocates for his/her clients. More recently client empowerment, from a nursing perspective, is defined as “a

process of giving hope, confidence and encouragement to people who feel disempowered by their health condition, ultimately promoting their well-being, decision making and self-management.” Later on it was added that the nurse-client relationship must exist for a client to be empowered and a balance of control, power and clear goals is necessary. Empowerment can only occur when nurses share control during the whole process of caring and don’t assert control over their clients. The higher amount and duration of the engagement will improve the level of empowerment. A more specific definition could be that empowerment is seen as the “relationship that a health practitioner tries to create with her client in order to help the client make better decision in achieving a healthier lifestyle and it is through the process of patient empowerment that relationships are built.” In the concept analysis on empowerment from the nursing perspective, defining attributes that were noted were “a practitioner-client relationship that is therapeutic, a consensus in decision making, sharing of social power or giving a sense of control and focusing on strength rather than weakness.” (Akpotor & Johnson 2018: 746-747.)

Client empowerment is a process and an outcome in which nurses have an active role. Promoting empowerment in others requires nurses to be attentive to both personal and professional empowerment in relation with principles of autonomy, respect, justice and involving clients in the decision-making process. Whereas some clients have the desire and skills to manage their health, others need to improve their skills or recognition of limitations in desire can be evaluated also. This requires skills and support from the nurses to recognize and accept that clients have the ability to tell what they need and to make own decisions. It also demands self-knowledge of personal values and needs for control, mutual respect and trust, effective communication, listening skills and a willingness to accept the clients’ decisions. (Burkhardt & Nathaniel 2014: 516-522.)

2.4.3 Organizational empowerment

“Empowerment is an important concept in nursing for both nurses and their patients” state Laschinger et al (2010:5). The key point of empowerment is the understanding of people to fulfil their job in a purposeful way. This power originates from working conditions that enable employees to work towards their work goals. In order for nurses to look after their clients in the best possible way, conditions that empower nurses in a surrounding that promote professional practice and effective working relationships should be created. Laschinger et al proposed an integrated model of nurse/client empowerment that

“suggests that empowering working conditions increase feelings of psychological empowerment in nurses, resulting in greater use of patient empowerment strategies by nurses, and, ultimately, greater patient empowerment and better health outcomes.” The proposed concept is guided by Rosabeth Kanter's' theory of structural power in organizations and could be used as a guide to develop high-quality nursing practice work surroundings that ensure positive outcomes for both nurses and their clients.

Kanter's theory of structural power of organizations concentrates on the structures within the organization rather than the individual's own qualities. The organization will benefit in total when a leader shares his power through empowering others and the organization will benefit from improved skill base of the people who will make informed decisions and accomplish more. (AUOBLC 2012).

Kanter, as one of the first proponents of empowerment, explains power as the skill needed to circulate information, resources and support to get things done in an organization. The managing board should provide their workers with the 'power tools' that empower them to maximize their ability to fulfil their work in a meaningful way. Information refers first to the knowledge needed to do the job but secondly also alludes to information concerning what is going on in the organization itself. Having the ability to gain materials, money, rewards and time needed to achieve the work demands explains the line of resources. Support relates to sources that want to maximize effectiveness. Next to the structure of power Kanter illustrates a second empowerment structure that relates to job conditions that provide individuals with the chance to advance within the organization and to develop their knowledge and skills: the structure of opportunity. Formal and informal power will give access to the empowerment structures. Formal power originates from job activities that show flexibility and discretion in decision-making processes. Informal power comes from relationships with people at different levels of the organizations. (Laschinger et al 2010: 5-6). Examples of empowering work structures that promote optimal nursing practice, organized according to components of Kanter's empowerment theory can be found in figure 4.

<i>Component of Kanter's theory</i>	<i>Examples of nurse empowering management behaviours</i>
Access to information	Practice open communication Share information Communicate goals of management Communicate current and proposed future state of the organization Provide timely information Communicate using various means (e.g. email, websites, on-line newsletters)
Access to support	Adopt an interactive, coaching and facilitating leadership style Provide specific timely feedback Provide recognition and applaud achievements Encourage autonomy Encourage collaboration and collegiality among staff Provide support Provide links to helpful people when needed
Access to resources	Assure adequate time and resources to accomplish work Assure supplies are accessible and responsibly used Involve nurses in evaluation of supplies to assure quality Develop a plan for equipment replacement and preventative maintenance strategies Develop proposals to obtain funding for new equipment and equipment sharing Promote staff involvement in resource decisions Encourage interpretation of workload data as a necessary part of decision-making
Access to opportunity to learn and grow	Encourage/facilitate advanced educational preparation Participate in training and development sessions Request secondment or job exchange to expand skills Negotiate expanded role/function in current job Add new challenges and developmental tasks Establish career ladders based on skill rather than status
Informal power	Participate in special task forces or important organizational committees Provide opportunities to network with colleagues through task forces, work groups Build networking skills initially at the unit level through team building exercises Broaden networking to include agency-wide and extra-organizational contacts Develop interdisciplinary networking opportunities Encourage collegiality
Formal power	Increase recognition of the staff nurse role as central and relevant Develop a comprehensive job analysis of professional nursing practice Define outcomes of nursing practice and align with organizational goals Encourage nurses to positively view their contribution to patient care and education Provide opportunities for nurses to showcase their skills Provide opportunities to develop skills Promote participative management and autonomous work units

Figure 4. Nurse empowering behaviours. Laschinger et al (2010: 6).

Employees will experience powerlessness when they don't have access to resources, information, support and opportunities. Empowered employees will have control over the work situations with the result of an overall improved organizational functioning. (Laschinger et al 2010: 6). Offering those six conditions to employees in a health care setting can have a clear impact on both employee empowerment and job satisfaction as well as organizational morale and success. (AUOBLC 2012; Larkin et al. 2008).

In the current situation of health care where leaders and organizations had/have to re-think strategies and structures, Kanter's theory still supports in giving a basic framework to guide towards an improved organizational efficacy. Kanter's theory has been used in nursing practices, showing how structures within the workplace that offer access to resources can empower employees to get their work done in a more meaningful way. (Larkin, Chelby, Stack, Morrison & Griffith 2008.)

Kanter's concept of empowerment can be extended to nurses' therapeutic interactions with their clients and the outcomes of nursing care. (Laschinger et al 2010: 7). In a process of care where clients are actively involved in their care, nurses and clients have a partnership in which they try to find together needed information, resources and support that they need to improve their health. In addition, opportunities to learn and grow can be explored when working with clients.

Clients also need access to information, resources, support and opportunities to gain or keep the best health conditions in their daily life. Nurses have an essential role in helping clients recognize those sources of empowerment within their own health conditions. Figure 5 gives clear examples of client empowering behaviours, organized according to the components of Kanter's empowerment theory. Each element of structural empowerment is translated to the client care process and explains what nurses can do to empower their clients. (Laschinger et al 2010: 8-9).

<i>Component of Kanter's theory</i>	<i>Examples of patient empowering nurse behaviours</i>
Access to information	Provide relevant information coupled with clear answers to patient questions Conduct nursing tasks only after explaining actions Dispense medications and treatments only after explaining what they entail Creative use of information technology Familiarize patients with their surroundings
Access to support	Ascertain how patient beliefs, thoughts and feelings might affect their efforts Ask what patients need to obtain from their interactions with health care providers Describe your caregiver role and support patients' right to be the decision-maker Respect patient choices Offer encouraging remarks for achieving specific health goals Address patient complaints and call bell triggers quickly Work quietly at night in order to allow patients to rest Provide a supportive environment by assuming a partnership approach
Access to resources	Facilitate access to clinical and community resources Facilitate patients' access to interdisciplinary team members Help patients identify their own resources, self-care abilities and internal strengths Create patient-centred practices that incorporate self-management support Provide patients with time necessary to accomplish personal activities (e.g. personal hygiene, eating etc.)
Access to opportunities to learn and grow	Provide learning opportunities at an appropriate level (jargon free) Provide scenarios to create opportunities to practice new skills Help patients to use knowledge and skills to manage their own health problems Supplement self-management support for patients with information technology
Informal power	Establish partnerships with families Promote strong alliances between patients and members of the health care team Develop strong relationships with family and friends in the community Work with patients to identify strategies for developing supportive alliances
Formal power	View patients as important allies in the health producing process Adopt a flexible approach to managing care that fosters self-determination Negotiate a mutually agreeable schedule Encourage patients to make decisions about care Acknowledge that there is more than one way to accomplish mutually defined goals Allow patients to decide when to eat and drink and what activities to engage in Refrain from using dominant postures or talking down to patients during visits Only attend to patients with permission Be visible and available to respect the patient needs

Figure 5. Patient empowering behaviours. Laschinger et al (2010: 9).

3 Theoretical background home care

3.1 Law and legislation in Finland

According to the Finnish law, municipalities should arrange good quality social and health services for elderly. These services should be adequate and given in right time according to the needs of the elderly. The service has to be arranged in a way that health care providers support the person's well-being, health, competences, independent performance and participation. Attention should be paid to rehabilitative services and services provided in home care. (Laki ikääntyneen väestön toimintakyvyn tukemisesta sekä iäkkäiden sosiaali- ja terveystalvveluista 980/2012).

3.2 Literature about home-care services

Many Europeans prefer to live independently which indicates that elderly need care and services at home. By using social and functional abilities, where functional means being able to participate in activities of daily life, autonomous living at home can be empowered. Individual resources help in maintaining elderly's well-being and capability to deal with daily activities since relationships with family and friends support elderly in a more psychological way when dealing with daily tasks. (Dijkman et al 2019: 107-110.)

"Home care professionals are expected to deliver goal-oriented, holistic and person-centred services focusing on supporting older adults to maintain, gain or restore their competences to engage in physical and daily activities so that they can manage their everyday life as independently as possible." Despite the best intentions of home care providers, traditionally, they seem to concentrate on doing things for elderly rather than with them which may result in depriving elderly of their chances to participate in a routine necessary for maintaining underlying capabilities. A change from curing diseases and creating dependency towards focusing on competences and opportunities and maximising independence is necessary. (Metzelthin et al 2017: 1419.) Bölenius et al (2017:1) confirms the findings that home care service nowadays is more task oriented with a small focus on involvement of the elderly. Research has shown that person-centred home care services can lead the way to create a more person-centred and health-promoting model for home care services for elderly.

According to Dijkman et al (2019: 26) health and social care will be more accessible, more individual and closer to home. The shift towards a more tailor-made, value-based

system will create new opportunities but will also expect new roles from the care professionals.

Services in home care consist of regular visits in the client's home, where guiding and supporting the client, in cooperation with the clients' relatives, in personal and physical self-care and everyday activities are organized. The requirement of home care services is based on assessment of individual needs and how the goals of care are to be achieved.

Planning of care is the first phase in the client-professional relationship. Clients are experts on their own lives and have their own expertise, together with the home care professional they can express and develop further their needs and goals and implement them in their care and services. The elderly's power to influence has direct consequences for their successful home care service. It has to be taken into account that there is a delicate relationship between the client and the care givers that is based on ethical perspectives where the clients have their own values and equal authority. In daily care it might be challenging for home care staff to identify and take client's resources into account and support them in daily activities. (Dijkman et al 2019: 111-113.)

Dijkman et al state (2019: 112) that the primary nurse has the main responsibility for planning and execution of care and together with the other formal care givers they should motivate clients to play an active role in their own care and services.

4 Summary of the theoretical background

“It's not about the things you do to or for people... it is the impediments you take away leaving space for folks to empower themselves” (Heumann, Boldy & McCall 2001: 24).

The European Patients' Forum has defined empowerment as “a multi-dimensional process that helps people gain control over their own lives and increases their capacity to act on issues that they themselves define as important.” Participation, knowledge, skills, self-management and a facilitating environment are the key features of empowerment. A client is empowered and involved when he/she acquires all the knowledge he/she needs to understand his/her condition, the benefits and risks of different therapeutic choices. The client should be able to reflect what therapeutic option is most suitable in his/her personal situation and is meaningful according to his/her life goals. The client

should be able to participate actively in the decision-making process with his/her care givers with the feeling of equality in an environment without barriers.

The ability to control one owns care planning, together with support of formal and informal care givers who understand the client's needs and wishes, will allow and encourage people to understand and realize their abilities and needs related to independence. (Heumann, Boldy & McCall 2001: 4.)

Empowerment is a shared process between the care giver and the client where the client-professional relationship is a partnership of equals. Formal care givers have the necessary skills and attitudes to help the clients realize they can participate in their own care planning, to define objectives and goals together, explore options and support the client during the whole process.

It is important during the whole process of empowering that there is access to information, access to support and resources, there should be time to create opportunities to explore and learn new skills and gain knowledge and to actively involve the client.

Because empowered people make informed choices, have a better relationship with health professionals, are more committed to treatment and might take more responsibility into their own care, this will lead to a more sustainable health system (European Patients' Forum 2015.) and will be in the long run more cost effective. (Heumann, Boldy & McCall 2001: xi.)

5 Aim and purpose

The concept of empowering is becoming more important in the changing health care system nowadays. Health care will have a more participative and client-centred approach in which empowered clients will reduce costs in the long run, which is beneficial for a sustainable health care system. Participation, communication and thinking needs to come from both sides to have as many positive effects on empowering and to improve quality of care. Therefore the purpose of this master's thesis is to explore the perceptions and experiences of empowerment among care givers (nurses) and clients in the home-

care setting in Kouvola. This research aims to evaluate how empowerment manifests and how those experiences relate to each other.

Specific objectives were:

1. To investigate the clients' experience of empowerment.
2. To investigate the care givers' perceptions of empowering the clients.

Research questions were:

-In perception of the care givers:

Do the care givers think they let clients participate in their own care?

Do the care givers think they let clients make their own decisions?

Do care givers think they create a learning environment where knowledge and skills are shared?

Do the care givers think they support and encourage the clients?

Do the care givers feel that clients are equal partners in their care?

-In perception of the clients:

Do clients think they can participate in their own care?

Do clients think they can make own decisions?

Do clients feel they gained knowledge and skills from the care giver?

Do clients feel supported and encouraged?

Do clients feel they are equal partners in their care?

The results of this study will lead to a better understanding about the current situation in the home care setting in Kouvola; how empowerment is experienced through the eyes of the clients and what the perception of the care givers is. It will show positive points and detect possible working areas.

6 Research work setting

The study environment was the home-care services provided by the city of Kouvola, located in the South Eastern part of Finland. Most of the clients are 65 years and older, 20% of the total amount of their clients are younger. Kouvola home-care service has 1600 clients of which 1000 of them are visited once a week, up to daily visits of 1 to 3

times a day. 600 clients are visited seldom, about 1-2 times a month, only for small problems. Three doctors are working in the home-care setting and all of them have about 300-400 clients that they see once a year. 50 registered nurses (sairaanhoitaja), 290 practical nurses (lähihoitaja) and 3 physiotherapists work with the clients. Every client has his own responsible nurse who speaks with the client and his family about their needs and help during a care meeting at the client's home. (Heikkilä 2017).

Before the clients' care plan is made up, a RAI performance measurement is done. This is a comprehensive clinical and functional assessment instrument also known as the Resident Assessment Instrument (RAI). All clients have an official care plan that is updated by the responsible nurse when it is necessary, or at least every six months. (Köninki 2019.)

7 Material and methods

7.1 Data collection

In this research a quantitative methodology was used. "Quantitative research generates statistics through the use of large-scale survey research, using methods such as questionnaires or structured interviews." (Dawson 2002 :15).

A good research design will support reliability and validity of the findings and will minimize biases and mistakes. When collecting original data, a detailed description should be written explaining how the data will be collected. (Plichta & Kelvin 2013: 11-12.)

To evaluate the experiences of the care givers and clients two existing, valid and tested questionnaires that investigate the aspects of empowerment were used. The questionnaire provided to the clients is named: 'Patient Perceptions of Patient-Empowering Nurse Behaviours Scale' (PPPNBS) and the questionnaire provided to the care givers was the 'Nurse Perceptions of Patient-Empowering Nurse Behaviours Scale' (NPPNBS).

Permission to use the questionnaires was asked from Dr. Jerofke, one of the authors and researchers of the questionnaires. The findings of the study on the PPPNBS, done by Jerofke & Weiss (2016) show strong evidence of the reliability and validity of both the long and short-form of the PPPNBS. The NPPNBS questionnaire was shared by Dr. Jerofke herself when contacting her about the usage of the PPPNBS. This questionnaire was tested also but not published yet at the time of data collection.

The questionnaires include the subscales derived from Kanter's theory: access to information, access to support, access to resources, access to opportunities, the development of informal power systems (collaborations inside and outside the healthcare system) and the development of formal power systems (flexibility and autonomy in decision-making). A seventh subscale 'initiation' was added to the questionnaires to measure the extent that clients felt they were encouraged to be active participants in their health and treatment planning. (Jerofke & Weiss 2016: 2926).

Both questionnaires consist of 45 questions, but, as proven in the original study, the short form of the questionnaire, consisting of 22 questions, can be used as well. Both questionnaires use Likert scales, where answers are scored on an 11-point Likert scale with 0 meaning 'never' and 10 meaning 'always'. A Likert scale is "a measurement scale that asks respondents to register the level to which they agree or disagree with a set of statements." (Pichta & Kelvin 2013: 459). Using an 11-point Likert scale allows clients to indicate their varying degrees of perception of each item that is stated as a declarative statement. Items were summed to calculate total and subscale scores; greater scores indicated higher perceptions of exposure to client-empowering nurse behaviours. (Jerofke & Weiss 2016: 2926). As requested by the author of the questionnaires the Finnish translation of both questionnaires and final results were shared with her.

To get as many answers as possible and because it would have been more time consuming for both the care givers and clients to fill in the long form of the questionnaire, the decision was made to use the short forms for both questionnaires. Also the questionnaires were provided in Finnish to attract as many persons as possible and to keep the language barrier as low as possible. To verify that the Finnish translation of the questions had the same content and meaning, the questionnaires, originally provided in English, were first translated from English into Finnish by one person and then translated back from Finnish into English by a second person. The translated Finnish version was used for both the clients and care givers' questionnaires. Very small changes were made so the questionnaires fitted the target group.

After the permission from Metropolia UAS, an application form guided with my research proposal was sent to the home-care service manager in Kouvola to ask permission to execute my master's thesis. After the official approval of the home-care service manager

that this research could take place, first a pilot study was conducted. According to Dawson (2002 :95) the questionnaire should be tested in a pilot study to check if the questionnaire brings the required results. The pilot study for the care givers went fluently, 5 questionnaires were filled in and no problems occurred, as well as no comments were made. During the exploratory study for the clients it seemed the biggest challenge would be to find the right clients who fit the inclusion criteria. Only one client out of the five who got the questionnaire during the pilot study fitted the correct profile. After the pilot study no changes were made and the questionnaires were spread through the online platform of E-lomake for the care givers and on paper for the clients. All answers of the care givers who participated in the pilot study could be used, only 1 answer of the clients participating the pilot study was used in the final version. Extra attention on the inclusion criteria was given during the data collection, to gain a better understanding by the care givers who had to spread the questionnaires to the clients.

In this study a web-based questionnaire on the E-lomake platform was used as a data collection instrument for the care givers because it is easy to use and it is a fast and inexpensive way to gather data from a big group. Also the gathered data could easily be transferred to SPSS which made it easier to start analysing afterwards.

For the clients the questionnaires were spread on paper because not all elderly have access to internet or know how to work with a computer. The questions were spread over five papers and the font style was a little bigger, aiming to have the lay out as clear as possible and not to have any confusion where to score and answer.

According to Plichta and Kelvin (2013: 13) "sampling is the process of selecting a portion of the population to represent the entire population. It is important to state exactly what the target population is, that is, the group to which the researchers want to generalize the study results." For this master's thesis the following inclusion criteria for the care givers were: employed as a nurse in the Kouvola home-care setting and able to understand Finnish. For the clients the inclusion criteria's were: aged 75 or older, living at home and receiving home care services at least twice a week for a period of 4 weeks with the emphasis of service for activities of daily life (ADL).

To collect the answers from the care givers, the link to the online questionnaire, accompanied with a guiding letter (appendix 1), was sent by the leader of home care service in Kouvola, to 340 care givers. Data collection was done during the holiday season and 12 weeks' time was given to answer the questionnaire. Three reminders have been sent

during those 12 weeks. In total 76 answers were gathered and could be used for analysing.

The questionnaires for the clients, accompanied with a guiding letter (appendix 2), were delivered by the leader of the home care service to the home care supervisors who checked which clients suited the criteria. Then the questionnaire was shared with the home care team who delivered it to the client. When filled in, clients gave the sealed envelope back to the home care nurse and the questionnaires were gathered by the leader of home care service. In total 150 letters have been spread in 12 weeks. Because of the inclusion criteria, in which a client had need to experience at least 4 weeks of home care, that much time was given to the clients also, so the target to find 150 clients could be reached. 58 questionnaires came back of which 47 clients fitted the target group. Some letters were shared with clients who did not had the correct inclusion criteria and one letter came back unfilled, those 11 were excluded when starting the analysis.

7.2 Data analysis

To analyse the collected data, descriptive statistics were used. "Descriptive statistics are simply numerical or graphical summaries of data, and may include charts, graphs, and simple summary statistics such as means and standard deviations to describe characteristics of a population sample." (Plichta & Kelvin 2013: 5).

The data that was gathered from the care givers was directly imported from the E-lomake platform into the SPSS 25.0 program. The clients' data was imported manually into the SPSS 25.0 program.

SPSS is a software for analysing data and running statistical tests. SPSS was used to calculate general means, to transform new variables out of the gathered data and non-parametric tests to analyse independent variables were used to check if the results could be generalised. The nonparametrically test that has been used to check if there were statistically significant differences is the Mann-Whitney U test. This nonparametric test doesn't require large normally distributed samples. It has been used to check if there were statistically significant differences between the age groups of the clients and the subscales of the questionnaire. For the care givers the Mann-Whitney U test has been used to compare professions (registered and practical nurses) towards the subscales. Differences inside two independent groups can be compared with the Mann-Whitney U test, where the dependent variables were the subscales of the questionnaire and the independent variable was the profession of the care givers or the clients' age groups.

To have a good overview of who answered the questionnaires, for the descriptive statistics the care givers were divided in two groups: registered nurses and practical nurses. To have a clear insight on the age of the care givers, four categories in this variable were created. The age groups of the care givers were made according to different generations that are present in a workplace: generation Z (23 years old and younger), generation Y (24-35 years old), generation X (36-51 years old) and the baby boom generation (52-70 years old). (De Meulenaere 2015.)

Work experiences of the care givers were divided in three categories, according to the pay rate in the Finnish public health care sector. (KVTES 2 luku 12 §).

The clients were subdivided into two groups according their age, using the classification described by Dijkman et al (2019:35). She divides older people in three groups: young old (between 65 and 74 years), middle old (between 75 and 84 years) and older old (over 85 years old). Only the two last categories were used for the descriptive statistics because the clients had to be 75 years old or older to participate this study.

8 Results

8.1 Descriptive statistics

8.1.1 Care givers

76 out of 340 care givers answered the online questionnaire through E-lomake which makes the response rate in total for the care givers 22,4 %: 7,9% are registered nurses, 92,1% are practical nurses. Table 1 gives more information about the care givers who are, for this background information, divided in two groups according their profession.

Table 1. Background information of the care givers (n= 76) who participated the study.

Variable	registered nurse n=6	practical nurse n=70
	7,90%	92,10%
<i>Age, years</i>		
mean <i>in years</i>	45,67	41,7
<24 years old, n (%)	0 (0)	6 (8,6)
24-35, n (%)	1 (16,7)	17 (24,3)
36-51, n (%)	4 (66,7)	30 (42,9)
52-70, n (%)	1 (16,7)	17 (24,3)
<i>Gender</i>		
female, n (%)	6 (100)	63 (95,1)
male, n (%)	0 (0)	7 (4,9)
<i>Work experience, years</i>		
mean <i>in years</i>	3,17	9,66
less than 5 years, n (%)	4 (66,7)	28 (40)
5-9 years, n (%)	2 (33,3)	17 (24,3)
10 years or more, n (%)	0	25 (35,7)

8.1.2 Clients

58 clients out of 150 responded to the questionnaire (response rate was 38,7%) but only 47 clients fulfilled the correct inclusion criteria. The final calculated response rate is 30,6 % for the clients.

Table 2 gives an overview about the background information of the clients who were included in the study for further analysis.

Table 2. Background information of the clients (n=47) who were included in the study.

Variable	age group n=18 75-84 years	age group n= 29 84+ years
<i>Gender</i>		
female, n (%)	14 (77,8)	21 (72,4)
male, n (%)	4 (22,2)	8 (27,6)
<i>Live alone</i>		
yes, n (%)	15 (83,3)	25 (86,2)
no, n (%)	3 (16,7)	4 (13,8)
<i>Had home care service before</i>		
yes, n (%)	12 (66,7)	25 (86,2)
no, n (%)	6 (33,3)	4 (13,8)
<i>Visits/week</i>		
2 times, n (%)	1 (5,6)	2 (6,9)
3 times or more, n (%)	17 (94,4)	27 (93,1)

8.2 Results of the questionnaires

Before studying the answers to the different research questions, the mean scores of every question were analysed. To have a better overview of the 7 subscales, table 3 points out the mean numbers for every subscale, where care givers' and clients' numbers can be compared. The results show that the clients' scores are at least one full point less in all themes compared to the care givers scores.

Table 3. Mean numbers, calculated on a 0 to 10 Likert-scale, for the 7 subscales of the questionnaires.

Subscale	Care givers	Clients
Initiation	7,75	6,45
Access to information	8,63	7,13
Access to support	8,86	7,51
Opportunities	8,03	6,04
Informal power	8,36	7,29
Formal power	8,64	7,29
Access to resources	8,18	6,65

Inside the group of care givers there was not enough evidence for normal distribution because the group of registered nurses was very small (n= 6) compared to the group of practical nurses (n=70). For the two age groups of the clients the Mann-Whitney U test showed there was a statistically significant difference for 3 subscales: access to support, access to resources and opportunities.

8.2.1 Participation

The first research question in perspective of the clients: “Do clients think they can participate in their own care?” was compared to the similar research question of the care givers: “Do the care givers think they let clients participate in their care?”

This question is connected to the subscale initiation in both questionnaires, which is linked with the principles of participation of clients in their own health and treatment planning. First for every group of participants a new variable ‘initiation’ was created in SPSS in which the answers of 3 questions, which were related to the subject of participation, were combined and interpreted together as the result of the answer to the first research question. Next, a mean score was calculated for this research question. Table 4 shows the means, medians, lowest and highest scores that were calculated for this subscale for both the groups of participants.

Table 4. Results on the subscale ‘initiation’, scored on a Likert- scale from 0 to 10.

Initiation	Care givers	Clients
Mean	7,75	6,45
Median	8,00	6,83
Minimum	2,00	2,00
Maximum	10,00	9,33

8.2.2 Decision-making

The answer to the second research question for the clients ‘Do clients think they can make own decisions?’ was analysed based on one question of the questionnaire. The clients were asked to give a score between 0 and 10 on the question: “The nursing staff helped me recognize that I am capable to make decisions about my health.”

This question was asked from the care givers from the same perspective: “I help patients recognize that they are capable of making decisions about their health.”

Table 5 shows the means, medians, lowest and highest scores that were calculated for this question for both the groups of participants.

Table 5. Results on the research question about decision-making, scored on a Likert- scale from 0 to 10.

Decision-making	Care givers	Clients
Mean	7,45	6,49
Median	8	7
Minimum	0	0
Maximum	10	10

An overview of how the scores are spread among the participants can be seen in table 6. It shows how many care givers and clients valued every possible score between 0 and 10.

Table 6. The amount of care givers and clients' scores given related to the question of decision-making.

Score	Care givers	Clients
0	1	1
1	0	0
2	0	3
3	2	1
4	1	3
5	7	7
6	6	3
7	20	12
8	17	11
9	11	1
10	11	5

8.2.3 Knowledge and skills

“Do clients feel they gained knowledge and skills from their care giver?” “Do care givers think they create a learning environment where knowledge and skills are shared?”

To answer this question the subscales 'opportunities' and 'access to information' are important. The previous table 3 shows the mean numbers for the participants on those two subscales. To answer the research question, the response to the questions of both subscales were combined for both groups. In total, when those 2 subscales were combined, a mean number of 6,63 on a scale from 0-10 was obtained for the group of clients. For the group of care givers a mean number of 8,10 was found.

While digging a little deeper into the results, it became clear that the oldest group of clients scored lower than the first age group (75-84 years) in the subscale 'opportunities'. A mean score of 5,48 and a median of 6 was noted for the group of 84+, in comparison with a mean score of 6,93 and a median of 7,50 for the age group below 85 years. As can be seen in figure 6, the oldest group had many variations in low scores whereas the group of 75-84 years old had very little low scores.

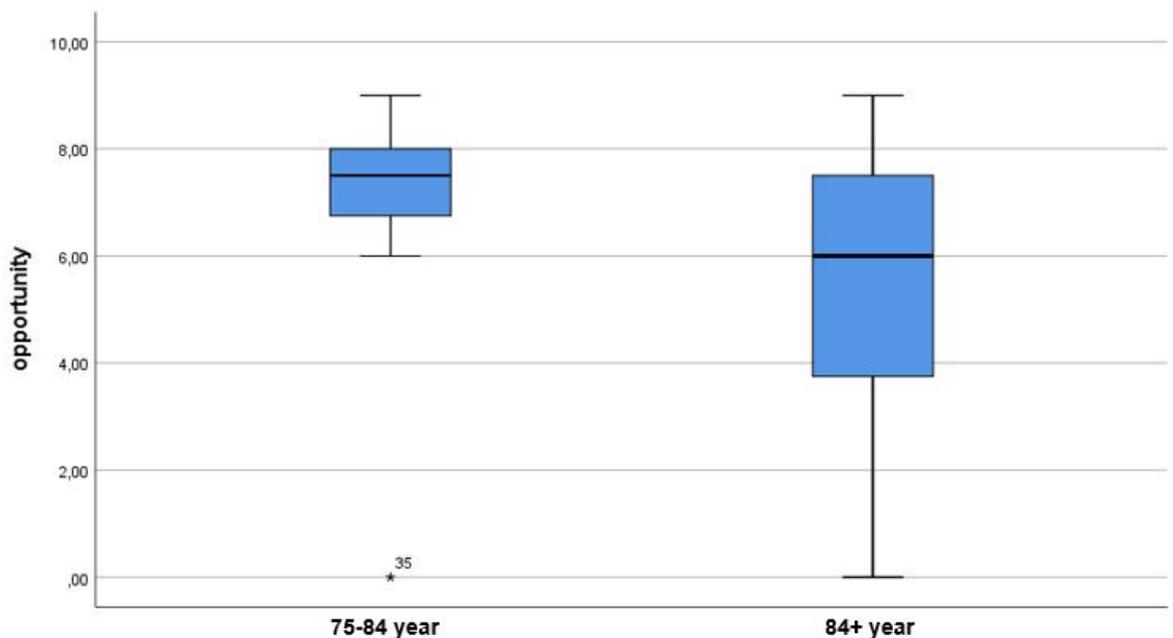


Figure 6. Boxplot on the subscale 'access to opportunity' for both age groups of the clients.

The variations in scores was also observed in the subscale 'access to information', as can be seen in figure 7, in which the youngest group of clients had very little low extreme numbers and most of the clients started valuing on the scale starting from the number of 6. Here the 84+ group presented also more variation in low scores but in the end the mean scores for this subscale, when comparing the two age groups, do not differ that

much (with a mean score of respectively 7,10 and 7,14 for the youngest and older age group).

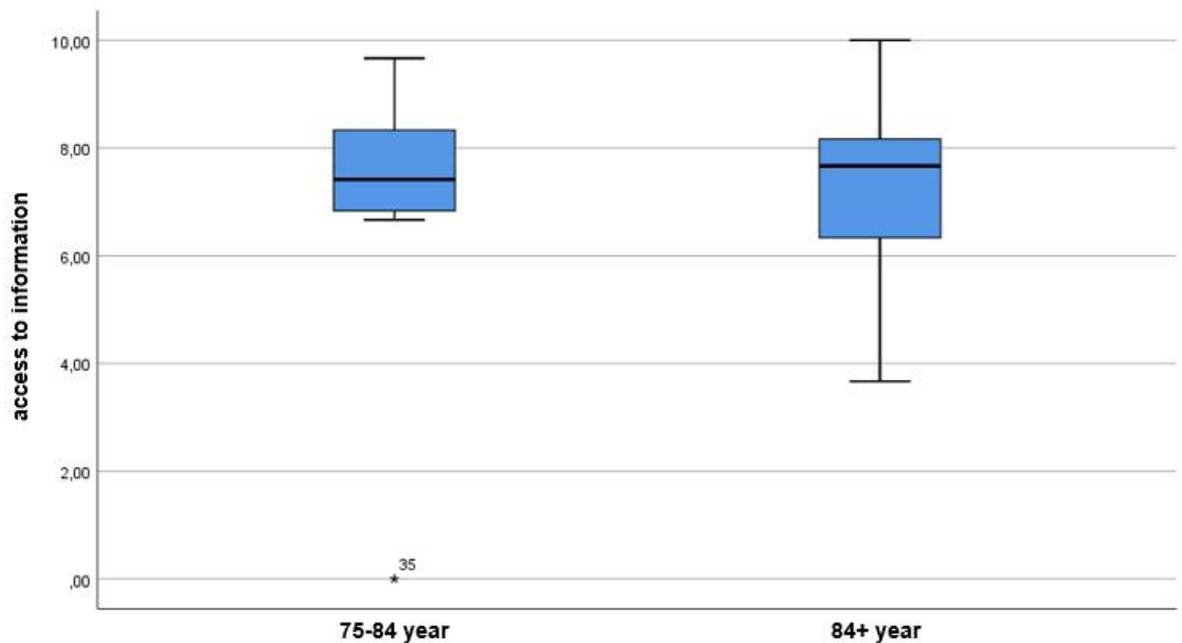


Figure 7. Boxplot showing the results of "access to information" for both age groups of the clients.

8.2.4 Support and encouragement

"Do clients feel supported and encouraged?" "Do the care givers think they support and encourage the clients?" The subscales 'access to support' and 'access to resources' were combined to answer this question. Table 3 shows the mean numbers that were calculated first for those two subscales separately. Later, a new variable was created that consisted of these two subscales that are linked to support and encouragement and that giving an answer to this research question. In total this results in a score of 7,17 on a scale from 0-10 for the group of clients and a score of 8,61 for the care givers.

Table 7 shows the difference between the two age groups of the clients for the subscales separately and when combined. It shows that for the older age group scores were lower than for the other group.

Table 7. Background information on how the clients scored per age group. Numbers are means calculated on a Likert -scale from 0 to 10.

Subscale	age group n=18 75-84	age group n= 29 84+	Total
Access to resources	7,69	6,18	6,65
Access to support	8,06	7,19	7,51
Combined subscales	8,02	6,80	7,17
Minimum	6,88	3,63	
Maximum	9,25	9,25	

8.2.5 Partnership

“Do clients feel they are equal partners in their care?” This question was asked as a last question in the questionnaire: “I feel as though the nursing staff and I were partners”. In total a mean score on a scale from 0-10 shows a number of 7,80 for the clients. The care givers valued the question “I feel as though patients and I are partners” with a score of 8,74 as a mean number on the same scale.

The two age groups of clients were compared and for the youngest group (75-84 years old) a score of 8,65 was calculated whereas the other group (84+ years old) had a mean score of 7,31 on a scale from 0 to 10.

9 Discussion

Rethinking the design and service delivery of health care is a big topic nowadays. The challenge to require new strategies that include high levels of client empowerment will need a shift in mindset in the health care area so high quality and sustainable healthcare systems can be build.

During the literature search it was clear that empowerment is recognised as an important concept. Many studies have reported on the effectiveness of empowerment strategies where empowerment improves health outcomes and quality of care. Job satisfaction has

been associated with empowerment also multiple times. Participation and individual responsibility for one's own health has become a key point in many findings. Most of the studies have been done in institutionalized care and haven't had a specific aim towards empowerment in a home-care setting. The studies have been focussing on either one component of empowerment or only towards clients. There aren't many studies in which literature supports the need for empowering care givers. This study gives an insight on both the care givers and their clients in the home-care setting. It is possible to compare results and see opportunities and issues from both sides. The research questions have been based on the components of empowerment and should give a general idea how empowerment is experienced at this moment in the research setting.

As it has been written many times in the literature, there is a clear need for health professionals to create a learning environment that enables clients to actively participate in the decision-making process. Health care providers can help build skills and knowledge and can provide learning opportunities by supporting and encouraging the client and possibly his/her network.

In this study the components of participations gave a similar outcome as is often suggested in the literature. The clients' feelings on the recognition of the right to make health decisions, the realization of the ability to participate in the treatment planning and the awareness of the treatment planning itself are features in which clients need to be supported more. The results showed that care givers try to let clients participate but clients feel less ability to participate in their own care. This could suggest that clients aren't aware enough about their own role or don't get enough information to take part in the decision-making process. On the other hand this result can also indicate that the clients might not communicate enough their values, preferences, problems and priorities to the care givers. To do this a partnership needs to be established with efforts from both sides.

To improve knowledge and skills good health education is needed to gain knowledge first so better informed decisions can be made. As the WHO (2009: 191) already wrote it is known that elderly have a lower ability to understand health information, process the information and then use it to make good decisions. Health literacy and self-efficacy have been expressed in researches as important features when trying to motivate and empower clients.

In total there is a lower score from the clients which indicates there is room for improvement when it comes to creating opportunities and providing information. It is important to

see that the oldest group of clients (84+) had an even lower score in the subscales when compared to the 75-84 age year olds.

Looking back at Kanter's theory, access to information means that care givers need to provide applicable information with clear answers to the clients and nursing tasks should only be conducted after explaining them. Also Kanter's theory explains that care givers can help clients realize they can use existing or new knowledge and skills to manage their personal health and well-being. An important feature here for the care givers is to pay attention to the clients' level of comprehension and to use jargon free language. In the new role of the care giver, it is beneficial to involve the family and establish a partnership to develop collaborative goals.

Another point of discussion is the provided time care givers have to create a learning environment in which time is given to practice skills and time is provided to investigate what the client's abilities are. Clients don't always realize the skills they have, or can learn when enough time to practice is provided. If there is no time to create opportunities and clients don't believe in their own ability to learn they won't feel confident about achieving their goal.

Helping the client find extra support at home and enlarge social networks seems to be part of the new role the home care workers have nowadays. (Dijkman et al 2019:26.) Ensuring clients have access to the needed resources so optimal health is achieved is consistent with Kanter's theory and is an essential element in the empowerment process. Looking at this from the care givers perspective, the results suggest the care givers do feel they support and encourage the clients. As written by Bölenius et al (2017:2), high turnover rates and challenges in recruiting and retaining skilled care professionals can develop a barrier also. Health care workers have reported not having sufficient time to communicate, provide "little extras" and provide care in a psychosocial domain.

The results of this study pointed out that clients feel less supported and encouraged as the care givers think, especially the eldest group of clients gave a lower number than the younger age group. When looking at the answers of the questions that are linked with 'access to support' and 'access to resources' it is clear that the biggest differences in the scores have to do with the clients' feeling that their concerns aren't taking in consideration, they don't feel the encouragement as the care givers try to offer them and the help in who could support them at home isn't valued high.

9.1 Ethical concerns

During a research it is important to follow the guidelines that are described in the “European Code of Conduct for Research Integrity” (2017) and to observe and promote these practices and principles.

To start this study first a research proposal was made. This proposal was the first official document made and used to ask for permission of Metropolia UAS to do this study as a master’s thesis. When the permission was given, official permission of the author of the questionnaires was asked. When I received the permission to use and adapt the questionnaires, an application form and my research proposal was sent to the home-care setting in Kouvola to ask for a final permission to conduct this study as my master thesis.

As described by the National Advisory Board on Research Ethics (2009: 5) ”ethical principles of research in the humanities and social and behavioural sciences are divided into three areas: Respecting the autonomy of research subjects, avoiding harm and privacy and data protection.” Participation in research should be voluntary and based on informed consent. Research subjects can give consent orally or in writing, or their behaviour can otherwise be interpreted to mean that they have given consent to participate. (National Advisory Board on Research Ethics 2009:5). The information that must be provided to the participants depends on the nature of data collection methods. In studies based on questionnaires, the participants must be informed what the study is about and what participating in the study means in concrete terms and how long it will take. (National Advisory Board on Research Ethics 2009: 7). In this study the participants gave their consent by responding to the questionnaires. Information regarding this study was provided with a guiding letter the participants got. This letter included the research topic, a brief explanation how data will be gathered and why, the estimated time for the participant that is possibly required to fill in the questionnaire, the voluntary nature of participation and my contact information.

“The protection of privacy is a right protected by the Constitution of Finland. It is also an established and important principle in research ethics. Data protection forms the most important area of privacy protection regarding the collection and processing of research data and the publication of results.” (National Advisory Board on Research Ethics 2009: 10). The gathered information was treated with respect and ensured anonymity. No names or personal information that could identify a participant was asked and the data

was processed only by me. The paper questionnaires were kept in a safe place and to have access to the online questionnaires a double password was needed. The questionnaires of the clients will be destroyed when this master's thesis is finished.

9.2 Validity and reliability

Issues of validity and reliability are important in research. Quantitative researchers aim to show that their chosen methods succeeded in measuring what they should measure and that their measurements are stable and consistent. (Dawson 2002 :110.)

According to Easterby-Smith, Thorpe and Lowe (2004: 134) validity is a question of how far we can be sure that a test or instrument measures the attribute that it is supposed to measure.

The use of the recent questionnaires contributes to the trustworthiness of this study because both questionnaires were validated and tested before in a study where the research methodology of the development and analysis of those tests was described and published by Jerofke & Weiss (2016). In their conclusion was stated that "the results provide evidence supporting reliability and validity of both forms".

Where validity means that a test or instrument should measure what it's supposed to measure, reliability can be seen as the ability for a test to be repeatable. "Reliability is a matter of stability, if an instrument is administered to the same individual on two different occasions the question is, will it yield the same result?" (Easterby-Smith et al 2004: 135). "Research in the humanities and social and behavioural sciences is not always repeatable, but the scientific community should have the possibility, if necessary, to verify research findings from the data analysed in a study. Openness is a key characteristic of science and also a precondition for testing the validity of scientific information, critically evaluating information and advancing science". (National Advisory Board on Research Ethics 2009: 12).

In this study it might be possible that participants have been influenced by taking part in this study. It is not possible to ensure that individuals, or other factors, haven't changed if the participants would take the questionnaire again. Also because of anonymity it will not be possible to track down the same group of participants, so it isn't possible to administer the same questionnaire to the same participant.

The reliability of research can be reduced if the respondents don't understand the questions correctly. In this study first a pilot study was done to get a better insight in possible problems that could occur with the online questionnaire and to get a better understanding what could be possible problems with the paper questionnaires (logistic, readability and understanding) so adjustments could be made if needed. During the pilot study of the clients it became clear that it could be a problem that the inclusion criteria weren't followed. The questions about the clients age and how many times they got home care service a week were the 2 criteria that could be checked straight from the questionnaire. I based myself on those answers to include or exclude the client. It can't be proven that all included clients were receiving home care services for a period of 4 weeks with the emphasis of services for activities of daily life. During the study extra notes were added when the questionnaires were distributed to remind the home care team what the criteria were so the responsible nurses could take them into account. It was clear that during the 12 weeks' time less and less answers came back which were filled in by clients with the wrong inclusion criteria. This gave a good impression of the understanding of the inclusion criteria and the follow up of those by the nurses who had to decide who got a questionnaire.

The questionnaires for the clients were distributed in such a way that they had to pass 4 people (from the leader of home care service to the home care supervisors, to the home care team to the nurse who delivered the questionnaire) before reaching the client and had to be returned the same way, therefore it is possible that letters went missing or not reached the client or came back to me.

Besides the research questions, in the results and discussion part there has been added also more in-depth information about how the two age groups inside the clients group relate to each other. Because the proportions of the registered nurses (n=6) and practical nurses (n= 70) were not in balance, there haven't been made assumptions based on profession.

Good research practices are based on the fundamental principles of research integrity: reliability, honesty, respect and accountability. Chapter 7, in which the methodology, research design and data collection and analysis was explained, contributes to the reliability of this study.

10 Conclusion

The aim of this study was to explore how empowerment manifested in the home care setting in Kouvola and how care givers and clients' perceptions related to each other. The results showed that the clients had little lower scores than the care givers on all themes of the research questions. Especially the most elderly clients who live at home are a group to whom extra attention should be paid.

To execute an effective empowerment strategy focus should be on all components of empowerment to have the most effective quality in care of which clients and care givers will benefit. This study gives an overview on the components of empowerment and how clients experienced those features. From the care givers' perception this study gives a better insight on how they try to act according the concept of empowerment. The value of this study lies in the possibility that the results can be compared and the opportunity to improve based on concrete information that is provided for the home-care setting.

It would be beneficial that the strategy and components of empowerment are discussed between the care givers and their management so better insight can be established and suggestions can be created to offer an even better care to their clients. Also from this dialogue the management will get a better understanding how they can create more value and empower their employees.

To meet the needs of the clients and to execute the strategy of empowerment, care givers should also be supported. The workplace needs to facilitate access to information, resources and support and can offer opportunities to learn and grow for their own care givers too. It can be a thinking exercise at management level to identify possible angles of approach where to support their employees in their new role.

In the new role the clients have, they should understand they are able to make own decisions and they are equal in the relationship with their care givers. Based on the information the responsible nurse gets from the client and his/her family/ informal care givers, the care plan can be updated according to the created goals and needs but also valuable information about the expectations of the care givers towards their clients can be shared.

From the theory it is clear that health care is going through some changes and the role of the health professionals and clients will change in the future. Clients are supposed to

take responsibility for their own conditions and manage their own health, whereas care givers need to offer a more goal-oriented, holistic and person-centred care. It could be an interesting addition to this study to investigate more in-depth if health professionals and clients understand their new role and how they can be supported in this new role. Furthermore it would be interesting to go a little more in-depth on the care givers view and to understand better their motives, actions and barriers towards empowerment in the home-care setting.

“The quality of life, the quality of human interaction, the satisfaction with and dignity of the roles of both care recipient and care giver will improve as a result of maximizing empowerment over care delivery for frail elderly people.” (Heumann et al 2001: 247). Empowerment of elderly people will ask for a refocus of the delivered care system. With the new change in power and responsibility extra challenges will occur but also opportunities will find its way.

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Guiding letter for the care givers in Finnish and English

Hyvät Kouvolan kotihoidon työntekijät,

Kouvola, 13 kesäkuuta 2018

Opiskelen Terveysalan liiketoiminnan johtamista (Health Business Management) Metropolia ammattikorkeakoulussa. Teen opinnäytetyötä voimaantumisen kokemuksista Kouvolan kotihoidossa. Ohjaajanani toimii lehtori Marianne Pitkäjärvi. Kouvolan kotihoidon palvelupäällikkö Tiina Köninki on antanut luvan toteuttaa tämän tutkimuksen 06.06.2018.

Tutkimuksessani vertailen voimaantumisen kokemuksia asiakkaan ja hoitohenkilökunnan näkökulmista. Voimaantumisella tarkoitetaan sitä, että asiakkaalla on mahdollisuus osallistua aktiivisesti hoitoaan koskevaan päätöksentekoon sekä vaikuttamaan omaa terveyttään koskeviin asioihin, yhdessä hoitohenkilökunnan kanssa.

Tutkimuksen tavoitteena on vertailla asiakkaan ja hoitohenkilökunnan näkemyksiä voimaantumisesta. Tulosten perusteella teen ehdotuksia, miten voimaantumista voitaisiin edistää Kouvolan kotihoidossa. Kyselyt tehdään suomeksi, mutta opinnäytetyön kirjoitan englanniksi.

Olisin kiitollinen osallistumisestanne. Toivon, että vastaatte kysymyksiin omasta näkökulmastanne, mikään vastaus ei ole oikein tai väärin. Osallistuminen tutkimukseen on vapaaehtoista. Tutkimus tehdään anonyymisti, nimiä tai henkilötietoja ei kysytä missään vaiheessa. Kyselyn vastauksia ei käsittele kukaan muu kuin minä. Yksilöllisiä vastauksia ei eritellä vaan analyysi tehdään kokonaisuuksien perusteella. Kyselyssä on 22 monivalintakysymystä ja niihin vastaaminen kestää noin 15 minuuttia. Vastausaikaa on 31.8.2018 saakka.

Vastaan mielelläni, jos teille ilmenee kysymyksiä kyselylomakkeeseen tai tutkimukseen liittyen.

Tässä on linkki kyselyyn: <https://elomake.metropolia.fi/lomakkeet/22539/lomake.html>

Vastauksistanne kiittäen,

Eline Blindeman

eline.blindeman2@metropolia.fi

En puhu äidinkielenäni suomea, joten toivon, että jos kysymyksiä ilmenee, lähestytte Anne Heikkilää (Kouvolan kotihoidon hoitotyön vastaava) numerosta: 020 615 7863. Hän pystyy vastaamaan kysymyksiin suomeksi tai kääntämään vastaukseni suomeksi teille. Kysymyksiä voi myös lähettää minulle sähköpostitse englanniksi tai suomeksi osoitteeseen eline.blindeman2@metropolia.fi

Dear care giver,

Kouvola, 13 June 2018

I am a student in the Health Business Management program at Metropolia University of Applied Science, faculty of Health care and Social Services. I am writing my thesis about experiences of empowerment in Kouvola home care setting. My supervisor is teacher Marianne Pitkälä. I have been given the permission to conduct this study by Tiina Köninki, home-care service manager in Kouvola, on 06.06.2018.

In my study I compare the experiences of empowerment from the clients and caregivers perspective. Empowerment can be explained as “a process through which people gain greater control over decisions and actions affecting their health.”

The purpose of the study is to compare the clients and caregivers perceptions of empowerment. According to the results I will make suggestions how empowerment could be enhanced in the home care setting in Kouvola. The questionnaires are in Finnish but I am writing the thesis in English.

I would be grateful for your participation. I hope that you answer the questions from your own perspective, no answer is right or wrong. Participation is voluntary. The research is made anonymously, no names or personal data will be asked in any phase of the study. Only I will be handling the answers to the questionnaires. No analysis is made according to individual answers, the data is analysed as a whole. There are 22 multiple-choice questions and it takes approximately 15 minutes to answer them. You have time to answer until 31.8.2018.

I gladly answer if there are any questions regarding the questionnaires or the research.

Here is the link to the questionnaire:

<https://elomake.metropolia.fi/lomakkeet/22539/lomake.html>

Thank you for your response,

Sincerely,

Eline Blindeman

eline.blindeman2@metropolia.fi

I am not a native Finnish speaker so for questions regarding the questionnaires or this research you can also contact Anne Heikkilä (Kouvola- kotihoidon hoitotyön vastaava) at this number: 020 615 7863. She will be able to help you in Finnish. She can pass on the questions to me if needed and I will answer you as quick as possible through her. Written Finnish or English questions are welcome at eline.blindeman2@metropolia.fi

Guiding letter for the clients in Finnish and English

Hyvät Kouvolan kotihoidon asiakkaat,

Kouvola, 21 Huhtikuuta 2018

Opiskelen Terveysalan liiketoiminnan johtamista (Health Business Management) Metropolia ammattikorkeakoulussa. Teen opinnäytetyötä voimaantumisen kokemuksista Kouvolan kotihoidossa. Ohjaajanani toimii lehtori Marianne Pitkäjärvi. Kouvolan kotihoidon palvelupäällikkö Tiina Köninki on antanut luvan toteuttaa tämän tutkimuksen 06.06.2018.

Tutkimuksessani vertailen voimaantumisen kokemuksia asiakkaan ja hoitohenkilökunnan näkökulmista. Voimaantumisella tarkoitetaan sitä, että asiakkaalla on mahdollisuus osallistua aktiivisesti hoitoaan koskevaan päätöksentekoon sekä vaikuttamaan omaa terveyttään koskeviin asioihin, yhdessä hoitohenkilökunnan kanssa.

Tutkimuksen tavoitteena on vertailla asiakkaan ja hoitohenkilökunnan näkemyksiä voimaantumisesta. Tulosten perusteella teen ehdotuksia, miten voimaantumista voitaisiin edistää Kouvolan kotihoidossa. Kyselyt tehdään suomeksi, mutta opinnäytetyön kirjoitan englanniksi.

Olisin kiitollinen osallistumisestanne. Toivon, että vastaatte kysymyksiin omasta näkökulmastanne, mikään vastaus ei ole oikein tai väärin. Osallistuminen tutkimukseen on vapaaehtoista. Tutkimus tehdään anonyymisti, nimiä tai henkilötietoja ei kysytä missään vaiheessa. Kyselyn vastauksia ei käsittele kukaan muu kuin minä. Yksilöllisiä vastauksia ei eritellä vaan analyysi tehdään kokonaisuuksien perusteella. Kyselyssä on 22 monivalintakysymystä ja niihin vastaaminen kestää noin 15 minuuttia. Vastausaikaa on 31.8.2018 saakka.

Toivon, että ette pyydä hoitohenkilökuntaa auttamaan kyselyyn vastaamisessa. Perheenjäsenten ja ystävien apu kyselyn täyttämässä on sallittua. Pyydän, että täytettyänne kyselylomakkeen laitatte sen suljettuun kirjekuoreen. Kotihoidon hoitaja toimittaa kirjekuoren suljettuna minulle.

Vastaan mielelläni, jos teille ilmenee kysymyksiä kyselylomakkeeseen tai tutkimukseen liittyen.

Vastauksistanne kiittäen,
Eline Blindeman
eline.blindeman2@metropolia.fi

En puhu äidinkielenäni suomea, joten toivon, että jos kysymyksiä ilmenee, lähestytte Anne Heikkilää (Kouvolan kotihoidon hoitotyön vastaava) numerosta: 020 615 7863. Hän pystyy vastaamaan kysymyksiin suomeksi tai kääntämään vastaukseni suomeksi teille. Kysymyksiä voi myös lähettää minulle sähköpostitse englanniksi tai suomeksi osoitteeseen eline.blindeman2@metropolia.fi

Dear customers of Kouvola home care,

Kouvola, 21 May 2018

I am studying Health business management in Metropolia UAS. I am writing my thesis about experiences of empowerment in Kouvola home care setting. My supervisor is teacher Marianne Pitkälä. I have been given the permission to conduct this research by Tiina Köninki, home-care service manager in Kouvola, on 06.06.2018.

In my study I compare the experiences of empowerment from clients and caregivers perspective. By empowerment it is meant that the client has a possibility to actively participate in the decision-making of their care and affect the things concerning their own health, together with the care-givers.

The purpose of the study is to compare the clients and caregivers perceptions of empowerment. According to the results I will make suggestions how empowerment could be enhanced in the home care setting in Kouvola. The questionnaires are in Finnish but I am writing the thesis in English.

I would be grateful for your participation. I hope, that you answer the questions from your own perspective, no answer is right or wrong. Participation is voluntary. The research is made anonymously, no names or personal data will be asked in any phase of the study. Only I will be handling the answers to the questionnaires. No analysis is made according to individual answers, the data is analysed as a whole. There are 22 multiple-choice

questions and it takes approximately 15 minutes to answer them. You have time to answer until 31.8.2018.

I hope that you do not ask help from the caregivers in filling the questionnaires. The help from family members and friends in filling the questionnaires is allowed. I request after filling the questionnaire you could place the questionnaire in a sealed envelope. The home care nurse will then deliver the envelope sealed to me.

I gladly answer if there are any questions regarding the questionnaires or the research.

Thank you for your response,

Eline Blindeman

eline.blindeman2@metropolia.fi

I am not a native Finnish speaker so for questions regarding the questionnaires or this research you can also contact Anne Heikkilä (Kouvola- kotihoidon hoitotyön vastaava) at this number: 020 615 7863. She will be able to help you in Finnish. She can pass on the questions to me if needed and I will answer you as quick as possible through her. Written Finnish or English questions are welcome at eline.blindeman2@metropolia.fi