Competence development of registered nurses in municipal elderly care in Sweden: A questionnaire survey

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Abstract

\textbf{Background:} Skilled and specialist registered nurses (RNs) are central to evolving elderly care. The past decades’ organisational and structural changes have altered RNs’ roles and work situations in municipal elderly care in Sweden. This calls for appropriate educational preparation. However, a substantial proportion of RNs in municipal elderly care lack adequate specialist competence.

\textbf{Aim:} The focus of this study was to describe RNs’ perceptions of needs and possibilities for competence development in municipal elderly care and compare the perceptions of RNs’ who work solely in dementia care (DC) with those who work in general elder care (GC) where older persons have diverse diagnoses.

\textbf{Design:} A non-experimental, descriptive and comparative design was used.

\textbf{Settings:} Sixty special housing with subunits in a large city in the middle of Sweden.

\textbf{Participants:} Participating RNs were a total of 213, with a response rate of 62.3%. Of the 213 RNs, 95 (44.6%) worked in DC and 118 (55.4%) in GC.

\textbf{Method:} A structured questionnaire that was specifically designed for this study and focused on needs and possibilities for competence development in nursing.

\textbf{Results:} The RNs were on average not lacking or were hardly lacking knowledge in examined domains. However, RNs in GC lacked knowledge of dementia, falls, and fall injuries to a greater extent than RNs in DC. RNs in DC perceived greater possibilities for competence development at work. Most RNs requested a better organisation for competence development, especially in GC. The majority of RNs had no supervision. The use of RNs’ competence was high, although they used their highest competence about half of the working hours. The employers’ financial contribution to RNs’ continuing education was poor.

\textbf{Conclusion:} A better organisation and greater possibilities for RNs’ competence development is needed. The employers need to make a greater contribution financially to RNs’ continuing education. It is essential to provide RNs with supervision.

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\textbf{Keywords:} Competence development; Municipal elderly care; Questionnaire; Registered nurse
What is already known about the topic?

- There is a paucity of extensive description of RNs’ needs and possibilities for competence development in municipal elderly care in Sweden.

What this paper adds

- A better organisation and greater possibilities for competence development at work were requested by RNs, especially in GC.
- The findings revealed that the employers’ financial contribution to RNs’ continuing education was poor in both DC and GC.
- Organised supervision for RNs was rare.

1. Introduction

Skilled and specialist registered nurses (RNs) are central to any evolving elderly care (Johnson, 1998). RNs can shape and deliver quality healthcare services (Malone, 2002) in collaboration with other occupational staff (Swedish Association of Health Professionals, 2004). However, a substantial proportion of RNs in municipal elderly care in Sweden lack adequate specialist competence (Svensson and Thörnblom, 2002; Swedish Association of Health Professionals, 2004; Josefsson et al., 2006a, in press). In addition, four of ten assistance nurses lack formal vocational competence in municipal elderly care (National Board of Health and Welfare, 2004). Hence, opportunities for offering good nursing and care depend to a great extent on how well municipalities are able to manage the supply of skilled nursing staff.

Persons 80 years and older comprise the majority of care receivers in municipal elderly care in Sweden (Thorslund and Larsson, 2002). The majority of those reaching old age continue to experience good health (Thorslund and Larsson, 2002). However, there is a relationship between increasing age and health problems that become more prevalent at around the age of 80. Several health problems are common in this group, such as post-stroke conditions, malnutrition, fractures, and dementia (SBU, 2003). Therefore, it is reasonable to expect an increasing need for nursing care and medical services (Thorslund and Larsson, 2002; National Board of Health and Welfare, 2004).

Cheah and Moon (1993) suggested that specialist status revolves around the assumption that older people have unique and special needs. The authors argue that these needs are what make care of older people a speciality. According to the Swedish Society of Nursing (2004), RNs working in elderly care have nursing responsibility for persons who often have age-related symptoms such as multiple somatic and psychogeriatric illnesses, while RNs in dementia care (DC) are working with those who have dementia as the main diagnosis. Since early 1980s in Sweden, special group residencies with small, homelike units and a well thought-out care philosophy for people with dementia have become an alternative to traditional institutions, as described by Annerstedt (1995) and Melin Emilsson (2004a, b). This has divided elderly care into two groups: (1) specialisation in DC and (2) general elder care (GC) where RNs have to deal with a greater scope of various diagnoses.

In 1992, an Elderly Reform Act (in Swedish: Ädel Reform) was realised in Sweden (Government bill, 1990/91:14; National Board of Health and Welfare, 1996). Earlier, the municipalities handled the social services, and the county councils handled the medical care for persons 65 years and older in Sweden. As a consequence of the reform, the municipalities assumed the main responsibility for older peoples’ care and housing (Ministry of Health and Social Affairs, 2005a). Medically trained nursing staff was employed in municipalities to provide elderly care.

The organisational changes following the reform altered the role and work situation of RNs in municipal elderly care in Sweden (Kapborg and Svensson, 1999; Tunedal and Fagerberg, 2001; Beck-Friis, 2003). It led to a shift from mainly service tasks during office hours to more qualified health care twenty-four hours a day (National Board of Health and Welfare, 1996). Previously, RNs worked closely with physicians, often in teams. Nowadays, RNs are often solely in charge with no colleagues or superiors for discussion or consultation (Kapborg and Svensson, 1999; Fagerberg et al., 2000; Tunedal and Fagerberg, 2001). Fewer staff (Fagerberg et al., 2000), often under time pressure (Tunedal and Fagerberg, 2001; Weman et al., 2004; Josefsson et al., 2006b, in press) provide care for older persons, most of whom suffer from bad health (Board for Occupational Safety and Health, 2000; Fagerberg et al., 2000). This altered professional role places new demands on RNs’ competence. This transfer of RNs, to work in municipalities, calls for appropriate professional educational preparation to enable RNs to be effective in their new roles (Kapborg, 1998; Joy et al., 2000).

The number of available places in special housing, i.e. nursing homes, group residences, retirement homes, and service buildings in Swedish municipal elderly care has decreased in the past few years. However, in the community, the number of persons 80 years and older has increased (Statistics Sweden, 2005). Hence, older people who have multiple illnesses and therefore the greatest need for care, have priority for a place in special housing (Gurner and Thorslund, 2003; National Board of Health and Welfare, 2005a). This in turn means that persons living in special housing have become more
dependent on healthcare efforts. Therefore, there is a great need for well-educated and competent staff (Thorslund et al., 2001). A majority of municipalities in Sweden report ongoing problems with recruitment of competent nursing staff. In response to these problems, the Swedish central authorities (National Board of Health and Welfare, 2004) propose increased opportunities for RNs’ continuing education in order to increase staff competence in the municipalities. RNs in Sweden complete a 3-year university education, according to the rules laid down by the European Union. The education may be developed with additional courses towards a specialist education, such as Elderly Care Nursing (see Josefsson et al., 2006a, in press).

In this study, the definition of competence is the same one that is used by the National Board of Health and Welfare (2005b). The national overarching description of RNs’ competence in Sweden states an ability and a will to perform a task by applying knowledge and skill (Swedish Standards Institute, 2002). The aim of this description is to help clarify the RNs’ profession and thus contribute to a high-quality and safe health care system. This description is also used to create curriculums for nursing education in Sweden. Furthermore, competence development is as an activity that broadens and increases individuals’ and groups’ competence (Swedish Standards Institute, 2002).

In summary, after the development of dementia units, elderly care has split into two groups, DC and GC. An altered health care structure occurred after introduction of the Elderly Reform Act. In addition, older persons, especially those over 80 years, are an increasing population (Statistics Sweden, 2005). This increases the demands on RNs and employers to maintain high competence in elderly care. Little is known about the RNs’ educational needs that arose when they transferred from the hospitals to the municipalities (Joy et al., 2000). Therefore, it is of interest to compare RNs working in DC with those in GC, regarding their needs and possibilities for competence development in municipal elderly care.

2. Aim

The objective of this study is to describe RNs’ perceptions of needs and possibilities for competence development in municipal elderly care; with focus on the needs for knowledge, possibilities for competence development, managers’ competence, supervision, organisation of RNs’ competence development, financial support, and competence utilisation. Taking into account the specific structure of elderly care, the perceptions of RNs who work solely in DC are compared with those who work in GC where older persons have diverse diagnoses.

3. Method

3.1. Design

A non-experimental, descriptive and comparative design was used (Politi and Beck, 2004). The study was approved by the Ethics Committee of Karolinska Institutet, Stockholm.

3.2. Sample selection

Information about the total number of employed RNs and their names, and whether they worked in DC or GC was obtained from the residence managers. All RNs worked directly contact with care receivers. The target population was RNs (n = 342) from 60 special housing subunits in municipal elderly care in a geographic area in the middle of Sweden. Of these special housing units 33 were in DC, 20 were in GC, and seven had both DC and GC. They were divided into two groups, 143 in DC and 199 in GC. The number of participating RNs was 213, comprising 62.3% of the target population. Of the 213 nurses, 95 (44.6%) worked in DC and 118 (55.4%) in GC.

3.3. Instrument selection and development

The questions in this study were derived from two questionnaires, developed by Aronsson’s et al. (1992) and Hagström’s et al. (1996). These questionnaires have previously been used to gain information about staffs’ perceptions on their work conditions and their competence development. Questions for this study were modified to better suit RNs as an occupational group in elderly care, as the two earlier instruments were designed for physicians and for RNs compared to engineers.

The questions for this study were carefully selected to suit a larger project in municipal elderly care which is reported elsewhere. The larger project sought to describe the RNs’ work situation (Josefsson et al., 2006b, in press), their education and desire to invest in competence development (Josefsson et al., 2006a, in press), as well as violence, access to prevention, and routines for violent behaviour (Josefsson et al., 2006c, in press).

Two main sections of the questionnaire were developed to meet the aims and objectives of this study. The first section asked for demographic and background information such as age, gender, and number of active years as a RN. The second section explored RNs’ views on their competence development and consisted of seven subsections: (1) RNs’ need for knowledge; (2) possibilities for competence development required in current position; (3) managers’ competence; (4) organised supervision; (5) the organisation of RNs’ competence development; (6) the employers’ financial support for RNs’
In order to map domains of requirements for RNs working in municipal elderly care (see Tables 2, 3 and 4) following literature was used: (1) The examination requirements in Swedish nursing education (SFS, 1993); (2) the national overarching description of RNs’ competence in Sweden (National Board of Health and Welfare, 1995, 2005b); and (3) The Institution for Good Elderly Care (BraVå, 2003) which highlights domains required for good elderly care. Furthermore, Tunedal and Fagerberg’s (2001) findings of competence requirements for RNs working in municipal elderly care were also taken into consideration. These requirements were medical, nursing, and pedagogical competence.

The participants had to specify in the questionnaire whether they worked in DC or GC. The questions were mainly presented with a selection of response categories, the majority of which were rated in ordinal scales; for example, a Likert-type scale of 1–4 ranged from “absolutely not” to “yes, absolutely” and sometimes with the alternative “not relevant” and “do not know”. The “not relevant” and “do not know” responses were handled as answers, but were excluded from the analysis of data. The participants were given an opportunity to add their own alternatives to answers in some questions and to add their comments at the end of the questionnaire. The questionnaire contained a limited number of nominal and ratio scales.

3.4 Procedure

Data was collected during a 1-year period (2003–2004). Local municipal managers with overarching responsibility for elderly care and the managers for each of the special elderly care residences approved the study. The residence managers provided the information on the total number of employed RNs and their names, and whether they worked in DC or GC. The questionnaires were distributed in sealed envelopes to the RNs at their work addresses, either by their managers or by the principal investigator. Participation was voluntary.

The sealed envelope to the RNs included: an introductory letter (a) explaining the purpose of the study, (b) that data would be kept confidential, and (c) that the RNs’ identification would be protected. A postage-paid return envelope was also included. A second reminder was sent directly to the RNs if necessary. A third reminder was sent after 3 months to those RNs who had still not answered.

To record the reasons of non-respondents (n = 129), a form with the following statement was distributed: “I have not answered the questionnaire because...”. Non-respondents’ motives were analysed by their manifest content and were discussed with an outsider researcher.

The motives are reported elsewhere (Josefsson et al., 2006b, in press) and are available from the authors upon request.

3.5 Data analysis

The statistical analysis was performed using the Statistical Package for the Social Sciences (SPSS) for Windows version 12.0. p-Values less than .05 were considered to be statistically significant. Statistical tests used were the chi-square test ($\chi^2$) to examine the distribution of one variable in two independent groups and the Mann–Whitney U-test ($z$) to examine differences between two independent samples (Altman, 1997). The internal loss of data was minimal and data was neither replaced nor imputed.

4 Results

4.1 Sample description

The RNs’ characteristics, such as gender, age, employment, and working years as a RN are described in Table 1.

4.2 Need for knowledge

Table 2 shows RNs’ needs for acquired knowledge at their present positions across groups, DC, and GC. The majority of RNs were on average not lacking or were hardly lacking knowledge in their current positions with regard to examined domains (Table 2). RNs in GC perceived to a greater extent that they lacked knowledge of dementia, falls and fall injuries, compared to those in DC. Research methods, economy, and computer management were not relevant for some RNs in both groups (Table 2).

Few RNs (DC n = 8, GC n = 6) added their own domains to describe lacking knowledge. Six RNs in DC lacked knowledge of computer documentation, supervision of nursing students, information to relatives, handling of conflicts, religions, and difficult conversations. Furthermore, two RNs in DC felt a constant need for ‘filling-up’ with knowledge. Six RNs in GC lacked knowledge of, multiple diagnoses, handling of conflicts, supervision, signs and symptoms of diseases, wound treatment, diabetics, news in nursing, and handling other staff’s shortage of knowledge.

4.3 Possibilities for competence development

The RNs’ possibilities for developing competence required for their current positions are specified across groups, DC and GC, in Table 3. There were significant differences between groups regarding possibilities for
sufficient competence development required for their current positions (see Table 3). RNs in DC had significantly greater possibilities for competence development in theoretical and clinical knowledge, clinical methods and common praxis, ethical reasoning, teaching, research methods, leadership, teamwork, administration, economy, legislation and constitutions, local regulations and directions, dementia and palliative care. Several domains in Table 3 were not relevant for some RNs in both groups.

Few RNs (DC n = 7, GC n = 2) added their own domains for competence development at work. Seven RNs in DC requested competence development in the areas of work environment issues, hygiene, medicine administration in elderly care, conflict handling, different religions and cultures, psychiatry, teaching nursing aids, and fire training. Two RNs in GC requested cultures and teaching untrained staff.

RNs in GC stated more often than RNs in DC that the employer had not offered any competence development (GC 20.7%, DC 12.7%). Approximately half of those RNs (DC n = 82, GC n = 92) who perceived that the employer offered competence development stated that their needs were represented sometimes (DC not at all 13.4%, hardly 15.9%, sometimes 50%, mostly 20.7%; GC not at all 9.8%, hardly 22.8%, sometimes 45.7%, mostly 21.7%). There was no significant difference between groups.

Compared to GC (n = 117), RNs in DC (n = 93) stated to a greater extent, on a scale of 1 (totally disagree) to 5 (totally agree), that the local management provided good possibilities for development at work (DC median 4, inter-quartile range 3–5; GC median 3, inter-quartile range 3–4). No significant difference between groups was found.

The majority of RNs in both groups (DC n = 94, GC n = 112) perceived opportunities for developing occupational competence in the past 2 years as unaltered (DC unaltered 59.6%, impaired 14.9%, improved 25.5%; GC unaltered 62.5%, impaired 17.9%, improved 19.6%). As before no significant differences between groups were found.

4.4. Managers’ competence

Some RNs in both groups did not know if the local management had competence in RNs’ specific subject fields (DC 5.4%, GC 4.2%). A good half of the other RNs (DC n = 88, GC n = 113) stated that the local management had full competence in RNs’ subject field (DC scarcely 9.1%, in certain parts 37.5%, to the full 53.4%; GC scarcely 15%, in certain parts 31%, to the full 54%). Once again, no significant differences were found.

The majority of RNs in both groups (DC n = 93, GC n = 117) perceived, on a scale of 1 (totally disagree) to 5
4.5. Supervision

Most of the RNs in both groups (DC \( n = 94 \), GC \( n = 116 \)) stated that there was no organised supervision for RNs, such as an adviser, a supervisor, or a mentor (DC no 85.1%, yes 14.9%; GC no 89.7%, yes 10.3%). There was no significant difference between groups.

4.6. Organisation

Table 4 provides a summary of the statistics for the organisation of RNs' competence development across groups, DC and GC. The majority of RNs in both groups perceived that their competence development required better organisation at work, with regard to the examined domains (Table 4). However, compared to GC, the organisation of RNs' in DC had better competence development in the areas of nursing, caring of older people, gerontology, geriatric, dementia, and leadership (Table 4).

RNs in DC (\( n = 94 \)), compared to GC (\( n = 116 \)) stated, on a scale of 1 (totally disagree) to 5 (totally agree), greater possibilities to clearly see how they develop further at work (DC median 3, inter-quartile range 2–4; GC median 3, inter-quartile range 2–3). The difference between the groups was significant (\( z = 2.145, p < .05 \)).

4.7. Financial support

Data on the employers' financial support for RNs' continuing education in the past 0–5 years across groups, DC and GC, are shown in Table 5. Half of all RNs had not been given a paid leave of absence during continuing education in the past (0–5) years (see Table 5). Most of the RNs' expenses for travel,
allowance, accommodation, study literature or other costs associated with continuing education were not paid by the employer (Table 5).

4.8. Competence utilisation

Table 6 shows RNs’ perceptions about the use of their competence across groups, DC and GC. There was no difference between groups how RNs’ competence was used at work (Table 6).

5. Discussion

5.1. Need for knowledge

The need for knowledge in examined domains was perceived as low in both groups. This was unexpected, since relatively few RNs in this sample had adequate specialist education (Josefsson et al., 2006a, In press), which is in accordance with earlier studies by Svensson and Thörnblom (2002) and Swedish Association of Health Professionals (2004). These findings may reflect the fact that some RNs had reached retirement age. Others had only a few years left to retirement and therefore may have experienced a de-escalation of their careers. However, it is important not to overlook the fact that a long active professional life might provide requirements such as self-assurance and skills, which, according to Tunedal and Fagerberg (2001), are needed to manage professional nursing duties. At the same time, there is a risk that RNs’ thoughts and actions might stabilise in the form of routines and habits (Ellström, 1996). Our results showed that the use of RNs’ competence was high, although they used their highest competence about half their working hours. This might decrease RNs’ desire to increase their knowledge.
Another aspect to consider is that these are findings from a self-reported questionnaire, and RNs’ perceived needs for knowledge may be different from that of their managers’. Differences, if any, of RNs’ needs might due to a gap between RNs working with older persons and managers working in leading positions (Melin Emilsön., 2004a). Further differences might depend on RNs’ and managers’ different educational backgrounds, as well as work experiences (Åberg et al., 2004). A preferred solution could be that managers have education in nursing (Lindholm, 2000). Measures, such as reviewed personal development plans can also be taken to ensure greater synergy between views. Additionally, it is of importance to be aware of the many meanings of occupational competence (Ellström, 1997). Namely, (1) an attribute of the individual, (2) the qualifications required by the job, and (3) an interactive view of competence-in-use. The problem merits further investigation.

RNs in GC had a greater need to increase their knowledge of falls and fall injuries than those in DC. This was unexpected, since Fonad et al. (2004) reported that the frequency of falls per care receiver and year was three times higher in DC nursing homes compared to GC nursing homes. Likewise, Jensen (2003) showed that the incidence rate of falls in DC was twice that of at the old peoples’ homes and senior citizen apartments. Jensen (2003) found that a prevention program in

Table 4
The organisation of nurses’ competence development across groups, dementia care (DC) and general elder care (GC)

<table>
<thead>
<tr>
<th>Variables</th>
<th>DC (n = 95)</th>
<th>GC (n = 118)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (quartiles)</td>
<td>Mean rank</td>
</tr>
<tr>
<td>Nursing and caring of older people</td>
<td>2 (2–3)</td>
<td>89.19</td>
</tr>
<tr>
<td>Gerontology</td>
<td>2 (2–2.5)</td>
<td>88.34</td>
</tr>
<tr>
<td>Geriatric</td>
<td>2 (2–3)</td>
<td>80.87</td>
</tr>
<tr>
<td>Dementia</td>
<td>2 (2–3)</td>
<td>98.09</td>
</tr>
<tr>
<td>Computer managing</td>
<td>2 (1–2)</td>
<td>88.43</td>
</tr>
<tr>
<td>Training in collaboration</td>
<td>2 (1–2)</td>
<td>82.35</td>
</tr>
<tr>
<td>Leadership</td>
<td>2 (1–2)</td>
<td>88.70</td>
</tr>
<tr>
<td>Handling of changes and development work</td>
<td>2 (1–2)</td>
<td>83.71</td>
</tr>
</tbody>
</table>

aThe 25th and 75th percentile.
bScale range 0 = do not know, 1 = lacking, 2 = need of better organisation, 3 = well organised.
cOne internal loss.
dTwo internal losses.

Table 5
The employers’ financial support for nurses’ continuing education the past 0–5 years across groups, dementia care (DC) and general elder care (GC)

<table>
<thead>
<tr>
<th>Variables</th>
<th>DC (n = 95)</th>
<th>GC (n = 118)</th>
<th>Mann–Whitney U (z)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course fees</td>
<td>35 (37.6)</td>
<td>43 (46.2)</td>
<td>35 (30.2)</td>
</tr>
<tr>
<td>Travels</td>
<td>67 (72)</td>
<td>15 (16.1)</td>
<td>77 (67.0)</td>
</tr>
<tr>
<td>Allowance</td>
<td>67 (72)</td>
<td>12 (12.9)</td>
<td>93 (80.9)</td>
</tr>
<tr>
<td>Accommodation</td>
<td>65 (69.9)</td>
<td>9 (9.7)</td>
<td>80 (69.6)</td>
</tr>
<tr>
<td>Leave of absence with salary</td>
<td>46 (49.5)</td>
<td>6 (6.5)</td>
<td>60 (51.7)</td>
</tr>
<tr>
<td>Study literature</td>
<td>54 (58.1)</td>
<td>26 (28.0)</td>
<td>62 (53.4)</td>
</tr>
<tr>
<td>Other costs</td>
<td>64 (68.8)</td>
<td>12 (12.9)</td>
<td>72 (62.6)</td>
</tr>
</tbody>
</table>

aTwo internal losses.
bScale range 0 = not relevant, 1 = 0%, 2 = 1-50%, 3 = 51-100% of the costs.
cThree internal losses.
special housing reduced falls and femoral fractures in older people with both higher and lower levels of cognition. Hence, it would be important to offer a prevention program for RNs.

It is not surprising that a substantial proportion of RNs in both groups reported that research methods were not relevant for their present employment (see Tables 2 and 3). Nursing is traditionally considered to be practical work, a view that influence both the education and the profession (Pilhammar-Andersson, 1999). Most RNs in this sample had not studied research methods in their basic nursing education. Nilsson-Kajermo et al. (1998) and McCleary and Brown (2003) reported that RNs who did not study research methods in the basic nursing education seemed to perceive more barriers to research utilisation than those who had. Thus, it is unsatisfactory that research methods were not relevant for RNs, since they have a personal obligation to pursue their profession (SOSFS, 1995) in accordance with not only proven experience, but also accepted standards of science (SFS, 1998). Further, RNs in GC and DC reported that computer managing was not relevant. This might be an obstacle for the RNs’ obligations to maintain nursing documentation (SOSFS, 1993), keep up to date, and to search for new knowledge (SOSFS, 1995; International Councils of Nurses, 2002).

5.2. Possibilities for competence development

RNs in GC, compared to DC, perceived fewer possibilities for sufficient competence development at work in 13 of 23 examined domains. Most of RNs in both groups felt that the possibilities for developing occupational competence were unaltered in the last 2 years. In addition, more RNs in GC than DC stated that their employers had not offered any competence development. This group difference might depend on research of the past decade, development projects, and education in DC. These findings underline the relevance for comparing RNs working in DC and GC. The findings regarding GC are noteworthy, especially since Karasek and Theorell (1990) and Theorell (1993) state that workers with good opportunities for competence development have a relatively large possibility to control most situations that occur at work and to influence their own work (Swedish Work Environment Authority, 2004).

Approximately half of those RNs who reported that the employer had offered competence development stated that their own need for competence development was represented only sometimes. These findings were inconsistent, since most RNs were not lacking or were hardly lacking knowledge in examined domains. The problem is worth examining for its own sake.

5.3. Managers’ competence

RNs reported that they were in agreement with their local management regarding the subjects that comprise RNs’ competence. This should be interpreted with the knowledge that half of the RNs stated that local management had full competence in the RNs’ subject fields. This is relevant taken into to account that managers in municipal elderly care often have long experience and education in social care, rather than in nursing (Aberg et al., 2004). Lindholm (2000) showed that nurse managers (n = 13) who had a master’s degree in the nursing increased their management focus to include research and nursing development.

5.4. Supervision

Most of the RNs had no organised supervision. This was a distressing result since RNs need a supportive context in elderly care, especially if they feel that they (or

**Table 6**

Use of nurses’ competence across groups, dementia care (DC) and general elder care (GC)

<table>
<thead>
<tr>
<th>Variables</th>
<th>DC n = 95</th>
<th>GC n = 118</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possibilities for nurses to use one’s competence</td>
<td>3 (3–4)</td>
<td>3 (3–3)</td>
</tr>
<tr>
<td>Use of nurses’ competence</td>
<td>4 (3–5)</td>
<td>4 (3–4)</td>
</tr>
<tr>
<td>Use of nurses’ highest competence during the working hours</td>
<td>3 (2–4)</td>
<td>3 (2–4)</td>
</tr>
<tr>
<td>Possibilities for nurses to use one’s competenceb</td>
<td>112.98</td>
<td>98.60</td>
</tr>
<tr>
<td>Use of nurses’ competencec</td>
<td>111.31</td>
<td>100.88</td>
</tr>
<tr>
<td>Use of nurses’ highest competence during the working hoursf</td>
<td>112.63</td>
<td>100.57</td>
</tr>
<tr>
<td>aThe 25th and 75th percentile.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bScale range 1 = absolutely not, 2 = hardly, 3 = mostly, 4 = yes, absolutely.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cTwo internal losses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dScale 1 = totally disagree, 5 = totally agree.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eOne internal loss.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fScale range 1 = never/seldom, 2 = lesser than half, 3 = about half, 4 = a greater part, 5 = the whole working hours.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
the staff) cannot provide the optimal quality of care (Fagerberg and Kihlgren, 2001). Findings are in agreement with previous studies reporting that RNs are often left to their own resources (Kapborg and Svensson, 1999; Fagerberg et al., 2000; Tunedal and Fagerberg, 2001). Access to supervision is an urgent requirement for several reasons. First, RNs often have to deal with everyday ethical issues that arise when caring for patients and their relatives (Berggren, 2005). Berggren (2005) showed that RNs participating in clinical nursing supervision with opportunities for structured discussion and reflection could make better decisions, taking care receivers, colleagues, and themselves into account. Secondly, clinical supervision also leads to development and improvement of the relationship between staff and care receivers and thus provides more opportunities for RNs to reflect upon their way of working (Severinsson and Hallberg, 1996; Olsson and Hallberg, 1998). Furthermore, Bégat (2006) pointed out that clinical nursing supervision influenced the RNs’ well-being and work satisfaction. Furthermore, supervision can also promote personal and professional development and thus improve care quality (Hansebo and Kihlgren, 2004). Likewise, Gustafsson and Fagerberg (2004) reported that RNs' reflection and consideration of their work is regarded as a means for professional development. Supervision offers opportunities for RNs who have undertaken continuing education to reflect on how they have developed both personally and professionally as a result of their studies (Wood, 1998). Finally, a supervisors’ social support is essential for buffering the effect of work-related stress (Karasek and Theorell, 1990; Theorell, 1993).

5.5. Organisation

A substantial proportion of all RNs reported that they were unaware of how competence development for RNs was organised at their current work. The majority of RNs required a better organisation for competence development and this requirement was even greater in GC. This is consistent with Tunedal and Fagerberg (2001) who argued that well thought-out strategies for the development of RNs in municipal elderly care are presumably lacking. RNs also reported a lack of organisation of RNs’ competence development in GC when it came to leadership and training in collaborative efforts. These findings are disturbing, since RNs in municipal elderly care have to function within a great network of contacts (Weman, 2005, p. 14), for example with assistant nurses (40%) without formal vocational competence (National Board of Health and Welfare, 2004). Furthermore, leadership is also a key area in the RNs’ profession (National Board of Health and Welfare, 2005B) and the conditions for leadership change when the organisation and structure of working life change (House, 1995).

RNs in DC had greater possibilities than those in GC to clearly see their further development at work. According to the National Board of Health and Welfare (SOSFS, 1995), there should be plans for RNs’ continuous competence development with regard to the changing demands in the field. Therefore, organisation of RNs’ competence development needs to be better and more distinct, especially in GC.

5.6. Financial support

In the past (0–5) years, half of all RNs were not given a paid leave of absence during continuing education. Furthermore, the employer had not paid for most of the RNs’ expenses for travels, allowance, accommodation, study literature, or other costs. Bergman (1994) showed that no matter where RNs (n = 288) worked, financial insecurity was an obstacle for RNs' competence development. This may affect RNs’ competence development negatively. An appropriate financial infrastructure for study leave is important. Furthermore, it might generate other gains, such as improved motivation and attendance for education. It can hardly be a coincidence that several specialist programmes in Elderly Care have been terminated in the past years (Domfors, 2005).

5.7. Competence utilisation

In both groups, RNs’ competence was perceived as well used, as previously reported by the Swedish Association of Health Professionals (2004). As noted previously, RNs’ used their highest competence about half of their working hours. However, considering that the RNs had worked an average of 18 years, they might have felt comfortable with the tasks they had. On the other hand, since they used their highest competence half the working time, the other half was not used. Karasek and Theorell (1990) indicated that work with wasted skills combined with low decision latitude can be discouraging and unproductive. It is noteworthy that Joseffson et al. (2006b, in press) reported that RNs in our sample perceived a low influence on decisions in a wider context at work.

Finally, it is a known fact that in Sweden, the healthcare sector has been impacted by substantial financial cutbacks (Swedish Institute, 2004). This has led to measures such as staff reductions, high work load, and a lower quality of care (Sandström, 2000; Arnetz, 2001). When considering the employers’ financial resources for competence, it is important to bear in mind that the Swedish government has made a decision to start up a plan known as “competence accounts” (Ministry of Industry, Employment, and Communications, 2000). The idea is that employees can save money for their own competence development. So far, the competence...
accounts have not been put into effect due to uncler-

It is important to make competence development
flexible and cost-effective for RNs and employers. It is
also critical to overcome the gap between the RNs' exis-
ting competence and the RNs' requested and
required competence. The question of accreditation of
actual competence must also be solved. In addition, the
possibilities for competence development need to be
adapted for older staff (Swedish Work Environment
Authority, 2004). Therefore, competence development
ought to be achieved by means of tighter collaboration
between RNs, managers in municipal elderly care, and
the educational centres. Further studies are required in
the subject to ensure that care receivers receive essential
and appropriate skilled nursing in municipal elderly care.

In conclusion, this study highlighted the education of
RNIs and their need for competence in municipal elderly
care. It is particularly pertinent for managers in elderly
care and politicians. The majority of RNIs lacked
fundamental nursing qualifications up to a bachelor's
degree and few had taken adequate specialist qualifica-
tions. RNIs in DC had a greater desire to invest more in
their own competence development. RNIs in GC were
more motivated to invest in competence development by
seeking another position or attaining greater authority
to make important decisions at work. Hence, it is
important to create the necessary conditions for RNIs'
specialisation and education in elderly care.

6. Methodological considerations

It is questionable if this study’s findings can be
generalised to the wider nursing audience. However,
these findings may reflect the perceptions of RNIs'
working in similar conditions. Considering that dramatic
restructuring and reforms of elderly care were done in
Sweden, a large proportion of the references are Swedish.

The usage of the questionnaire in which the respon-
dents only answered in domains determined by the
researcher might be a weakness (Polit and Beck, 2004).
On the other hand, participants were given an opportu-
nity to add their own alternatives in Tables 2 and 3, and
comments at the end of the questionnaire. Few had added
their own alternatives, which may be due to the fact that
the questionnaire covered most of the RNIs' domains. The
internal loss of data was neither replaced nor imputed,
since the overall percentage of missing data was low, and
since such an approach artificially deflates variability.

7. Conclusions and implications

The main purpose of this study was to describe RNIs'
perceptions of needs and possibilities for competence
development in municipal elderly care. This was
accomplished by comparing RNIs working in DC with
those working in GC. The main findings showed that
most of the RNIs perceived that they were not lacking or
were hardly lacking knowledge required for their current
positions in the examined domains. However, RNIs in
GC reported to a higher degree than RNIs in DC a lack
of knowledge in the areas of dementia, falls, and fall
injuries. RNIs in DC perceived greater possibilities for
competence development and to see clearly their further
developing in work. Most of the RNIs perceived a high
level of agreement with the local management regarding
the areas that comprise RNIs’ competence. At the same
time, most of them they had no supervision. The
utilisation of RNIs’ competence was high in both groups
but even then, their highest competence was used half of
the working hours. RNIs required a better organisation
for their competence development at work and this
requirement was perceived as even greater in GC. In
both groups, the employers contributed poorly from a
financial standpoint to RNIs’ continuing education.

The county council is always responsible for the care
provided to older people in municipal elderly care (Beck-
Friis, 2003; Ministry of Health and Social Affairs,
2005a, b). Thus, it is important to bear in mind that the
responsibilities of municipalities in Sweden go as far as
providing medical care up to the RN level. Therefore, it
is an urgent matter to create the necessary conditions for
RNIs’ post-registration training opportunities in munici-
pal elderly care. This is especially important since
continuing education has an impact on patient care
(Farley, 1987; Barriball et al., 1992; Hogston, 1995;
Wood, 1998), such as enhanced individualised care and
research centred practice.

There are four specialist nursing programmes that are
relevant to the duties in clinical elderly care in Sweden
(SFS, 1993). The main program is Elderly Care Nursing,
but there is also Primary Health Nursing (Public health
nurse), Psychiatric Care Nursing, and General Health
Care with an emphasis on surgical, medical or oncolo-
gical nursing (SFS, 1993). In addition to specialist
nursing programmes, RNIs can raise their competence
levels by taking supplementary nursing courses, which
are usually 5 weeks of fulltime study. Finally, compe-
tence development ought to be achieved by means of
tighter collaboration between the educational centres
and managers in municipal elderly care. How to create
the conditions necessary for developing the competence
of RNIs in municipal elderly care merits further
investigation.

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