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Interdependent empowerment in residential care homes: perspectives of first-line managers, care workers, and relatives

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ABSTRACT

Purpose: This study examines factors that facilitate or limit empowerment within Swedish residential care homes based on the perspectives of first-line managers, care workers, and residents' relatives. Empowerment among formal and informal supporters may create conditions for residents' empowerment and self-determination.
Methods: Secondary analysis was conducted using data from two projects across 19 residential care homes, including six group interviews with 24 care workers, 16 individual interviews with relatives, and 19 interviews with first-line managers. Structural and psychological empowerment was used as an analytical framework.
Results: Empowerment was shaped by structural conditions such as time, staffing, decision-making authority and everyday interactions. Care workers and managers described how limited resources and authority reduced their ability to meet professional standards and policy expectations. Relatives often felt excluded, which weakened their influence and affected residents' opportunities for self-determination. Empowerment is interdependent across roles: constraints experienced by one group can limit the others, while supportive structures can strengthen empowerment across the system. At times, tensions arose regarding whose influence should take precedence in decisions.
Conclusion: Strengthening structural conditions and supportive relationships at all organizational levels is essential for sustainable work environments and high-quality, person-centered care, particularly for residents who depend on others in decision-making.

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Introduction

The global population is ageing, and residential care services face persistent challenges linked to underfunding, staff shortages, high turnover, and increasingly complex care needs (Eurofound, 2020; OECD, 2020; Jurij et al., 2023; Sturmberg et al., 2024). These conditions influence care quality, residents' autonomy, and the well-being of the workforce. Insufficient staffing, limited time, and rising care complexity contribute to missed or fragmented care (Ingard et al., 2024b; Ludlow et al., 2021). In the end, these factors may limit residents' empowerment, as evidenced by reduced self-determination and satisfaction with care. Empowered care workers with good working conditions use empowering strategies to improve residents' empowerment (Laschinger et al., 2010).

In Sweden, older adults often live at home longer, meaning those who enter residential care tend to have extensive physical or cognitive impairments (Jönson & Harnett, 2018; National Board of Health & Welfare [NBHW], 2021). National legislation emphasises self-determination, participation, and person-centred care (National Board of Health & Welfare [NBHW], 2012; SFS, 2001:453), placing expectations on care workers and managers to support residents' decision-making and autonomy (Lindmark et al., 2023). However, limited resources and fixed routines often make these ambitions difficult to realise from policy to practice (Harnett, 2010; Ingard et al., 2024b; Ingard, 2025).

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Meeting these policy goals requires certain organisational and relational conditions. Supportive leadership, adequate staffing, and collaboration with relatives are central for self-determination, particularly in dementia care (Erlandsson et al., 2023; Haugen et al., 2019; Mali, 2019). Empowered staff also report higher job satisfaction and healthier work environments, which support person-centred care (Engström et al., 2011; Laschinger et al., 2010; Silén et al., 2019). When staff lack time, resources, or influence, meeting residents' needs becomes difficult, and turnover further weakens continuity and trust (Eurofound, 2020; Spilsbury et al., 2024). Such conditions can create moral distress, and many care workers consider leaving despite finding the work meaningful (Ingard et al., 2024b; Lindmark et al., 2025). Managers face similar pressures, with organisational structures and staffing problems affecting their ability to support staff (Hagerman et al., 2019; Lindmark et al., 2023).

Relatives also play an important role in daily decisions, but many feel excluded, which can lead to gaps in participation and unmet care needs (Haugen et al., 2019; Holmqvist et al., 2022; Ulmanen, 2025). Collaboration between staff and relatives works best when communication and responsibility are shared (Jang, 2020). Residents also view relatives as key partners who help them communicate with staff (Lao & Low, 2019). When relatives are supported, they can contribute meaningfully to residents' self-determination (Holmqvist et al., 2022).

Despite the strong policy focus on self-determination, it remains unclear how the conditions required to support these ambitions are experienced across roles in residential care. Earlier research shows that empowering residents often depends on the support provided by staff (Lin et al., 2022). Relatives may also interpret autonomy and well-being differently from care personnel, especially in situations involving care refusal or cognitive impairment (Mortensen & Nåden, 2024). However, most studies focus on single stakeholder groups, and few have examined how empowerment is experienced across roles within the same setting.

This study explores factors that facilitate or limit empowerment in residential care homes from the perspectives of first-line managers, care workers, and relatives. By bringing these perspectives together, we examine how structural and psychological empowerment are experienced across roles and how these conditions influence opportunities to support residents' self-determination. In terms of implications and added value for the field, this study builds on Laschinger et al. (2010) empowerment framework and also includes empowerment of first-line managers and residents' relatives in the eldercare setting. We examine how empowerment conditions are described across these roles within the same residential care settings. To address this aim, we conducted a secondary analysis of two qualitative datasets collected in the same care homes.

Empowerment as a theoretical framework

Based on and inspired by Figure 1, Laschinger et al. (2010) shows the theorised interdependence of the importance of each stakeholder group's empowerment.

There are numerous conceptualisations of empowerment (Adams, 2003; Barnes & Bowl, 2001; Zimmerman, 2000), many of which attempt to capture the complexity of the concept through a holistic approach. However, there is no clear consensus on how empowerment should be defined.

In this study, we adopt the concept of empowerment as proposed by Laschinger et al. (2010), as it connects the empowerment of care workers with the potential for empowerment among residents. Laschinger et al. (2010) empowerment framework includes both structural and psychological empowerment. It builds on Kanter (1977) ideas about structural empowerment, which focuses on providing care workers with access to information, support, resources, opportunities for growth, and both formal and informal power. When care workers have these resources and support at work, they can also experience psychological empowerment, as outlined by Spreitzer (1995). Psychological empowerment refers to the feeling that one's work is meaningful, characterised by competence, autonomy, and a sense of impact (Spreitzer, 1995). Laschinger et al. (2010) argue that access to structural empowerment improves these internal feelings, leading to greater autonomy, job satisfaction, and a sense of influence. Empowered stakeholders in residential care are more likely to support residents. They can also help foster residents' empowerment, which may contribute to greater satisfaction and self-determination. In this study, we utilise this framework to examine how empowerment is experienced and enacted across various roles in residential care. Empowerment may also contribute to workplace well-being, understood as a combination of emotional, relational, and functional aspects of health and satisfaction (Ruggeri et al., 2020; Soh & Zarola, 2016).

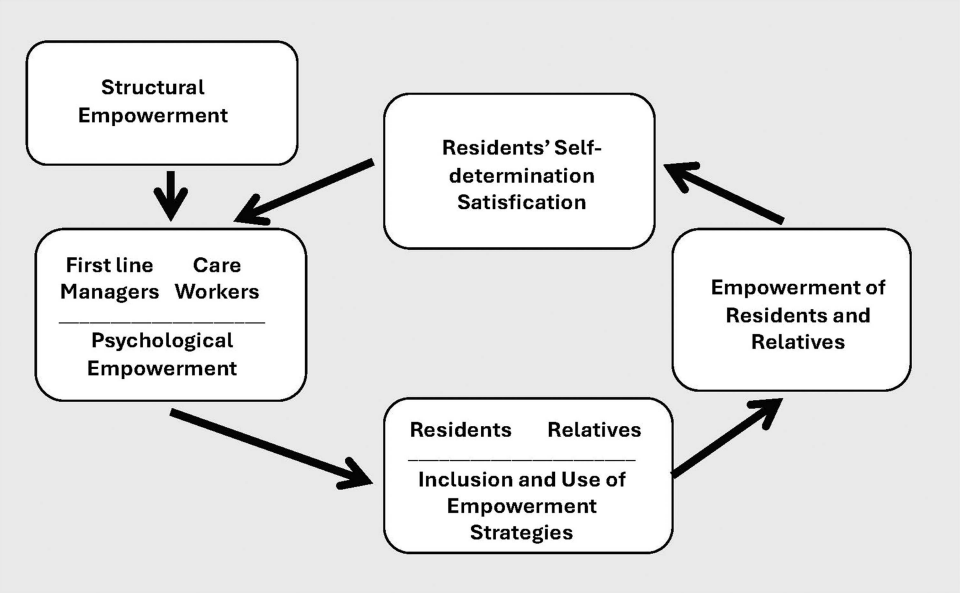

Figure 1. Conceptual model of interdependent empowerment in residential care, inspired by Laschinger et al. (2010). Note: Structural empowerment influences the psychological empowerment of first-line managers and care workers, which creates better conditions for involving residents and relatives. Feedback from residents and relatives may also strengthen staff and managers' psychological empowerment, supporting residents' self-determination and satisfaction.

Methods

Design, data sources, and sample

This study is based on a secondary analysis of two qualitative datasets collected in 2021–2022 across 19 residential care homes in three Swedish municipalities, which varied in size, geographical location, and the proportion of for-profit providers. Secondary analysis was chosen to enable a cross-stakeholder examination of empowerment within the same care homes and time period, using existing, complementary accounts from first-line managers, care workers, and relatives. This approach allowed a theory-informed re-analysis aligned with the study aim while avoiding additional participant burden. The two datasets were generated in separate but related research projects conducted by the authors and focused on different participant groups: one included care workers and relatives, whereas the other focused on first-line managers. By bringing these datasets together, the study combines three perspectives within the same organisational context and time period. This enables a broader analysis of the conditions for empowerment in residential care, based on material that would otherwise remain separate. Following Heaton (2008) and Ruggiano and Perry (2019), secondary analysis can strengthen qualitative research by generating new knowledge from existing data, provided it is done transparently and ethically.

In this article, the term "residential care" refers specifically to Swedish long-term care homes for older adults (*särskilt boende för äldre*, SÄBO). These facilities offer housing, social care, and nursing services around the clock and are regulated by the Swedish Social Services Act (SFS, 2001:453). They follow a social care model, and access is granted through a needs-based assessment.

Care workers and managers were interviewed on site in the care homes. Managers also helped establish contact with relatives of residents, who were interviewed in their homes, workplaces, at cafés, or at the university. An overview of the full dataset is provided in Table I.

Data material

The data concerning relatives consists of interviews where the relatives of residents living with dementia were asked how they perceived the residents' possibilities, conditions, and capabilities for self-determination as well as their own potential to support the residents' self-determination. These questions

Table I. Data characteristics from three stakeholder groups in the same residential care homes (2021–2022).

Characteristic	Care workers ($n = 24$)	Relatives ($n = 16$)	First-line managers ($n = 19$)
Type of interview	6 focus group interviews	16 individual interviews	19 individual interviews
Role/relationship	23 assistant nurses 1 occupational therapist	6 spouses, 6 daughters, 2 sons, 1 sister, 1 close friend	17 operations/unit managers 2 team leaders
Age	Range 24–63 years	No avaible data	Range: 35–61 years
Gender	23 women 1 man	14 women 2 men	17 women 2 men

Note: Data is derived and linked to previous published article, where more background information about participants is available (see Ingard et al., 2024b, Lindmark et al., 2023).

also led to answers that addressed the relatives' lack of resources and support as well as their interpretation of the opportunities for care workers to support the residents. Inclusion criteria for relatives were having a relative or close friend living with dementia at a nursing home (for-profit or not-for-profit) in one of the three selected municipalities. Excluded were cases in which the resident had only somatic health problems (Ingard et al., 2024b).

The focus group interview data were collected from care workers in residential care homes. In the focus group interviews, we asked the informants about their experiences of working with residents living with dementia and their approaches to supporting them. We also asked about how the obligation to work for residents' self-determination impacted their health (Ingard et al., 2024a). Inclusion criteria for group interviews with care workers were that they should work at a ward with residents living with dementia at a nursing home (for-profit or not-for-profit) in one of the three selected municipalities. Temporary workers were excluded. The interview guides for relatives and care workers focus on residents' self-determination rather than empowerment. However, self-determination is one component in empowerment. In this study, we interpreted the data using empowerment theory (Laschinger et al., 2010).

First-line managers were defined as the direct line managers for care workers in daily operations, with personnel responsibility including staff appraisals. Inclusion required holding this role in a participating care home for at least 6 months at the time of data collection. Higher-level managers or roles without direct staff responsibility were excluded. Regarding data on first-line managers, the interview guide explored their views on their work environment, focusing on job demands, resources, well-being, and trust in superiors and the broader organisation. While the empowerment framework did not guide the creation of the interview guide, it did include questions about how managers create relationships with care workers and manage conflicts (Lindmark et al., 2023). Although the empowerment framework did not guide the development of the interview guide, its emphasis on leadership, support, and access to resources overlaps with these topics.

Data analysis

We used directed qualitative content analysis (Hsieh & Shannon, 2005), guided by Laschinger et al. (2010) empowerment framework, which combines Kanter's structural empowerment and Spreitzer's psychological empowerment (Figure 1). Transcripts were coded according to predefined categories (resources, support, information, autonomy, meaningfulness, competence, and impact). Data that did not fit these categories were coded inductively.

The analysis was performed separately for relatives, care workers, and first-line managers to clarify differences and similarities. Structural and psychological empowerment were examined within each group. For care workers, the analysis addressed resources, managerial support, training opportunities, meaningfulness, autonomy, competence, and perceived influence over daily practice. For first-line managers, it focused on resources and information, decision-making authority, support from superiors, and their ability to shape the work environment and empower staff. Relatives were analysed as representatives of residents with dementia, with attention to formal and informal power, supportive interactions, communication, and access to resources.

This study was a secondary analysis of two previously collected datasets. TL and ST had conducted the original analysis of the manager interviews. In the secondary analysis, TL carried out the initial re-coding of this material, after which other authors reviewed selected excerpts, categories, and emerging themes. The

analysis of the care worker and relative interviews was conducted by CI, ST, and MS, with TL providing feedback on selected excerpts, categories, and thematic interpretations. All authors discussed coding decisions and interpretations throughout the process to ensure coherence across the three participant groups and to align the analysis with the focus on structural and psychological empowerment. After completing the group-specific analyses, all authors contributed to synthesising the findings across groups to clarify whether the empowerment conditions were connected.

Ethical considerations

The Swedish Ethical Review Authority approved the studies (reg. no. 2021-00121 and reg. no. 2021-00067). The authors collected and analysed the original material and had full access to the anonymized transcripts.

Participants received written and verbal information about study aims, voluntary participation, and the right to withdraw at any time. Written consent was obtained from all interview participants. The data was anonymized in accordance with GDPR and stored so that only members of the research group could access it. The study was conducted in accordance with the ethical approvals granted for the two original projects. Participants were informed that their anonymized interview data might be used for future research purposes. This secondary analysis, built on already published interview material, was complemented with a few quotes from the datasets.

Findings

This section presents the findings on how empowerment is experienced by individuals who are able to grant self-determination to residents, specifically relatives (REL), care workers (CW), and first-line managers (FLM) in residential care homes. Quotes from participants are labelled with their group abbreviation followed by their participant number (e.g., REL 7, CW 3, FLM 11). For each group, we describe factors that facilitate or limit structural and psychological empowerment.

Relatives: advocates or bystanders?

Relatives were strongly affected by what they observed in the daily care of their loved ones and by how they themselves were received by staff and managers. Many described a tension between the ideals of person-centred care and the reality of routine-driven work, which often left them with little possibility of influencing situations where residents' needs were overlooked. Structural restrictions, such as rules regarding outdoor access, staffing shortages, and the need to prioritise the group, meant that some residents could only go outside with a relative present, while those without nearby family were frequently confined indoors. Witnessing such limitations without being able to intervene reduced relatives' psychological empowerment and created frustration and worry about residents' well-being.

Sometimes relatives' influence supported their own sense of empowerment but reduced residents' autonomy. Care workers occasionally cooperated with relatives to persuade residents to do things they resisted, which relatives viewed as acting in the residents' best interest. In these moments, relatives could feel increased influence even when residents' choice was limited:

> *Yes, but not to make the decision over her head, but rather influence her so that it is a good decision. But my mother … we might have to convince her a little because the staff never force [her]. I've never seen them do that … but they saw what she needed, but she did not want any help. So then we had a little discussion, my mother and I—it is great that someone helps you when you have difficulty reaching the top of your head and doing laundry and such. And in the end she thought so too.* (REL 3)

Relatives described feeling particularly powerless (low in formal power) when they believed staff treated their loved ones incorrectly, such as when residents were confined to their rooms:

> *They didn't take good care of her … they had locked her in her room … because she yelled and screamed … it was Christmas Day … but you think about how many times this happened when no one knew about it, because in this case a friend happened to come to visit her and then the staff rushed to unlock the door … and there she was sitting on the floor because she couldn't even walk.* (REL 7)

Relatives also described feeling concerned when medication was used to manage behaviour instead of relational care, especially when they lacked involvement in these decisions. Relatives did not get enough information or formal power in this case:

> *She has been mentally unwell. They've tried changing medications, but I've been thinking the whole time that it's not just the medications, it's also how you treat her that might be able to calm her down as well.* (REL 16)

Several relatives also felt unable to support their loved ones when communication declined and they received limited information from staff. Some questioned whether staff had time to read life stories meant to guide care:

> *So, I don't think all the staff have read it [i.e., the life story]. Not the ones who are working now, anyway. Possibly when she [i.e., the resident] was new there. And yes, the contact person read it, I know. And we have proven that it exists for whoever has become the new contact person. Then I don't know, but I don't think all the staff read it. I find it hard to believe that they actually have the time.* (REL 10)

Communication barriers, related both to residents' cognitive decline and to staff members' limited Swedish proficiency, sometimes made it difficult for relatives to stay informed or involved:

> *Well, she cannot actively convey what she wants to do. She has gotten past that part ... It was probably more in the beginning, when there was a more stable staff group and more people who spoke Swedish … She can't convey that "Now I would like to go out into the yard and take a walk"—she cannot convey such things, but the staff must take the initiative.* (REL 10)

Some relatives described feeling supported and taken seriously when managers invited them into conversations and acknowledged their concerns, which strengthened their psychological empowerment. Regular updates, such as messages or photos, also helped relatives feel involved in everyday care, even when the moments shared were emotionally complex:

> *Well, they sent this one on the app and then wrote, "Greetings from K, newly showered." And then I thought that it was probably not a funny situation. But then I thought that it was rather honest of them to send pictures in which she is not only laughing but smiling and happy.* (REL 12)

In this case, the relatives feel involved in the care because they have been informed about their loved one's daily life. However, the residents themselves may perceive the care workers' actions as forcing them to do things they do not want to do. Residents themselves may not always welcome being photographed or shown in vulnerable moments.

Care workers: between guidelines' ideals and everyday constraints

The group interviews with care workers focused on the work for residents' self-determination. Working in line with guidelines was time-consuming, and care workers needed time to discuss situations that conflicted with policy documents, but this was rarely done due to a lack of resources and support. These constraints made it difficult for them to align practice with their values, and several described this tension as affecting their well-being. Limited time, support, and involvement in decision-making also constrained their structural empowerment, reducing their sense of influence over everyday care. The high demands outlined in the policy documents were often seen as unrealistic:

> *But guidelines and such things are not really the reality. One would wish that they [i.e., policymakers] could come and look one day and see how it is. Because I don't think they know … But that's not how reality works, but that's the price we have to pay. Like me, as an assistant nurse, because we have to make sure it is nice.* (CW 2)

However, some care workers expressed a wish to be more involved in policy-related work, seeing such involvement as a way to grow professionally and gain more influence over practice. By doing so, they may become more empowered as they learn and grow, including psychological empowerment through increased competence and its impact on their work.

> *It's fun to do something else, like [work with the value-based ethics from the guidelines]. But then it's always good, I think, to be reminded a little of that … yes, but it's there, then you figure it out.* (CW 3)

A recurring theme was moral distress. In the example below, relatives insisted that a dying resident be sent to the hospital. Care workers believed he would be better cared for in the residential home, but their judgement was overridden. The resident died in a hospital corridor, which caused significant distress among staff:

> *When the man passed away … they notified the nurse and those who were working that he was palliative … that is, dying, but she (his relatives) wanted to send him to the hospital. And he died somewhere in the corridors instead of dying at home in bed … she was hysterical … and then relatives like them have a lot of power, things can go so wrong.* (CW 6)

This situation illustrates how relatives' influence sometimes conflicted with care workers' professional values, leaving staff with responsibility but little real authority. Moments like these reduced their psychological empowerment by undermining their sense of competence and meaningful impact. Care workers described stress, time scarcity, and resource limitations that impeded their ability to support residents. Residents' behaviour and the limited time available for unskilled colleagues contributed to this. These pressures were visible to relatives as well, who sometimes noted how poor working conditions shaped the care residents received. For care workers, such moments underscored the gap between what they believed constituted good care and what they were able to carry out.

First-line managers: leadership in the shadow of structural barriers

The first-line managers described that their ability to carry out leadership responsibilities was closely tied to organisational conditions such as having decision-making authority and access to information, support, and resources. When these structural elements were present, managers appeared more motivated and engaged, whereas the lack of such conditions made the role feel overwhelming and reduced their sense of control in the organisation.

Time pressure was a central topic. Managers described being pulled in multiple directions, with administrative duties preventing them from being present on the floor. This reduced their psychological empowerment, as they felt unable to practice the relational leadership they valued:

> *We have a lot more administration … We have many systems to handle … So, the administrative part, I think, complicates close leadership. I find that there is a tendency for it to be extremely important for one's leadership to be a natural leader … At the same time, many distractions arise. These are difficult to combine.* (FLM 11)

Another major challenge was the lack of decision-making power in key areas such as recruitment and staffing, despite having broad formal responsibility for care quality:

> *We have full responsibility for maintaining quality, but we do not get to choose the staff. We are the ones who have to deal with the consequences, but we have no tools.* (FLM 4)

Similar to the experiences described by care workers, this gap between responsibility and authority contributed to frustration and a sense of disempowerment, as managers lacked the structural conditions needed to influence the areas for which they were held accountable. This was particularly evident when political ambitions or policy reforms were passed down without sufficient resources or guidance:

> *Now comes the third requirement from politics that we should reduce our hourly employees … it is an enormous challenge … they have put this on us, the first-line managers, to solve. But no, we do not have the resources.* (FLM 18)

Such top-down decision-making weakened their sense of influence and made it harder to feel in control of their own leadership practice.

Support systems played an important role. Managers who had reliable coordinators, assistant managers or superiors described this as vital for coping with daily demands. Delegation was also seen as a way to manage workload and empower staff:

> *I like to delegate, to lift others. That makes you grow. I have a team leader that I can put some work on, and they think that is fun. Then they get another task and grow with it.* (FLM 17)

Recruiting and retaining competent staff was a persistent concern. The managers emphasised that having the right personnel was crucial not only for care quality but also for their own sense of empowerment as leaders.

> *The most difficult thing is getting competent residential care home staff … To get educated, not just educated, but also the right personnel. We can see that it is getting worse.* (FLM 4)

Based on our interpretation, when staff lacked the necessary skills or experience, managers' opportunities to delegate or focus on development work were limited. Their efforts often shifted towards basic supervision and troubleshooting rather than empowering staff or residents.

A few managers also reflected on the role of residents' relatives, noting both positive and negative experiences. Some highlighted the value of relatives as a resource, while others described challenges in meeting relatives' expectations or dealing with conflicting views about the residents' care. One manager believed residential care homes would benefit more from uplifting the residents' relatives: *Relatives are an incredible resource, which has been somewhat forgotten here.* (FLM 10).

Despite these challenges, many managers described their relationships with staff and residents as a key source of motivation and job satisfaction: "*I love working with caregiving … The staff bring joy to work, and the residents bring joy to work*" (FLM 9). These descriptions show how psychological empowerment can be supported by relational aspects of the role, even when structural conditions are limited.

Empowerment: interdependence

Across all three groups, empowerment appeared as a shared process rather than an individual experience. Managers who lacked decision-making power found it more challenging to empower staff; care workers who were stretched for time struggled to build relationships with residents; and relatives who felt excluded had fewer opportunities to contribute to care or advocate for their loved ones. Table II summarises how structural and psychological empowerment manifested in each group, illustrating the interdependence that shapes everyday care.

Discussion

This study examined how empowerment is shaped in residential care by bringing together the perspectives of care workers, relatives, and first-line managers from the same setting. Care workers described how time pressure, staff shortages, and policy demands made it difficult for them to act in line with their values or deliver person-centred care. Relatives often felt excluded when they lacked information or were not recognised as partners. First-line managers highlighted a broad range of responsibilities but limited authority and resources, which reduced their ability to lead, support staff, and maintain quality standards. Although the challenges differed, all three groups described a similar pattern in which limited structural empowerment led to reduced psychological empowerment and a diminished sense of influence over daily care.

The findings suggest that empowerment in residential care is relational and interdependent rather than role-specific. Strengthening conditions for one group can enhance possibilities for others, while structural weaknesses tend to diminish empowerment across levels. This aligns with Laschinger's model, illustrating how structural empowerment shapes psychological empowerment, particularly in dementia care, where residents rely on others to safeguard their autonomy.

To meet policy goals, care workers and managers require adequate time, support, and realistic expectations to safeguard their well-being and work in accordance with person-centred principles. Relatives' calls for clearer information, recognition of their knowledge, and stronger involvement highlight opportunities to improve collaboration. When all three groups have better structural conditions, the potential for residents' autonomy and high-quality care is strengthened. Building empowerment around residents is therefore not only valuable for staff and relatives but essential for sustainable and ethically grounded residential care, particularly for people living with dementia who depend on others in daily decision-making.

Table II. Key components of structural and psychological empowerment among relatives, care workers, and first-line managers.

	Relatives	Care workers	First-line managers
Structural empowerment	• Inclusion in care planning and care. • Reception of timely and clear information. • Recognition and involvement from staff and managers.	• Enough staff to allow time for quality care. • Practical support and guidance from colleagues and supervisors. • Allowed to make decisions and given opportunities to develop skills.	• Authority and influence to hire and assign staff. • Support from coordinators and higher management. • Control over budget and resources.
Psychological empowerment	• Feel respected and listened to by staff. • Believe their input makes a real difference for the resident. • Confident to speak up and influence care decisions. • Feel secure and valued in their role.	• Feel that work is meaningful and matches personal values. • Experience competence through skills, feedback, and recognition. • Have autonomy, some freedom to choose how to deliver care optimally. • See that their work has a positive impact on residents.	• Feel in control of daily operations. • Experience autonomy and trust in their leadership role. • Feel motivated by positive relationships with staff, residents, and families.
Interdependence	Can support or challenge care workers and managers; a strong partnership can improve care, but exclusion can undermine staff efforts, which can affect the residents.	Empower and support relatives, ensure resident well-being, and rely on managers for resources and direction.	Empower staff through delegation and trust, involve relatives in care, and depend on higher-level support for resources and decisions.
Risks when lacking empowerment	Feel ignored, powerless, anxious, or unable to advocate for their loved one, and not contributing with knowledge or other resources.	Feel overworked, undervalued, stressed, or unable to meet care standards; risk of moral distress and burnout.	Feel frustrated, isolated, or overwhelmed; struggle to motivate or empower staff; risk of losing control over care quality.

Experiences of empowerment among relatives, care workers, and managers

Relatives

Given the significant role relatives play in decision-making for residents, they need conditions that allow them to be effectively empowered (Holmqvist et al., 2022; Ingersoll-Dayton et al., 2003). Support from care workers and managers can strengthen relatives' influence, but there are limits to how much responsibility can be placed on them. Swedish policy emphasises residents' right to self-determination (Lindmark et al., 2023). However, relatives in our study often lacked the information, involvement, and recognition required to uphold this right.

According to Laschinger et al. (2010), structural empowerment emerges when individuals have access to information, support, and resources. When relatives gain empowerment, their participation becomes both more constructive and more aligned with the interests of residents (Hamann, 2014). Kitwood (2019) emphasises that person-centred care relies on understanding the resident's history and preferences; in dementia care, relatives are often the primary carriers of this knowledge (Ingard et al., 2024b). Without their meaningful involvement, residents' autonomy risks being undermined. Our findings suggest that empowering relatives through clear communication, shared responsibility, and recognition of their role enhances not only their own engagement but also the overall quality of care.

Care workers

The findings show that time pressure, staff shortages, and routine-driven work limited the ability of care workers to support residents' self-determination. This is consistent with previous research showing that insufficient staffing, lack of continuity, and rising care complexity contribute to missed or fragmented care (Ingard et al., 2024b; Ludlow et al., 2021; Spilsbury et al., 2024). In line with Laschinger et al. (2010), these constraints reflect limited structural empowerment, as staff lacked the resources, support, and influence

needed to work according to person-centred principles. Some care workers described how their professional judgement was overridden by organisational or familial expectations, as in the case where a dying resident was transferred to the hospital against their advice. Such situations weakened psychological empowerment by undermining their sense of competence.

Care workers also expressed a desire to participate more in policy and development work, viewing this as a means to gain influence and advance their professional growth. Research has shown that opportunities for involvement, autonomy, and support strengthen both structural and psychological empowerment and improve well-being (Engström et al., 2011; Laschinger et al., 2010; Silén et al., 2019). The findings underline that person-centred care depends not only on staff attitudes and competence but also on organisational structures that allow workers to act in line with residents' needs and their own professional values.

Co-producing care: empowerment gains and ethical risks

Relatives' information, support, and influence largely arise through their interactions with care workers. For care workers to provide this, they themselves need conditions that support structural and psychological empowerment (Laschinger et al., 2010). Earlier research has shown that shared efforts in daily tasks and decision-making can strengthen relatives' self-efficacy and communication with staff (Ingersoll-Dayton et al., 2003; Jang, 2020), and our findings support this. When care workers invite relatives into dialogue and acknowledge their knowledge, relatives described feeling more included and influential.

At the same time, collaboration may create ethical dilemmas. Efforts to reassure relatives sometimes risked compromising residents' dignity, for example, through photos or updates shared during vulnerable situations. While such practices increase transparency for relatives, they can reduce residents' autonomy and psychological empowerment, especially in dementia care, where preferences are not always clearly expressed (Mortensen & Nåden, 2024). Collaborative attempts to persuade residents to shower or accept help could also empower care workers' competence and relatives' influence, while limiting the residents' influence over their own care. This tension highlights how empowerment can become unevenly distributed and how well-intentioned collaboration may inadvertently limit autonomy for the person receiving care.

Managers

Our findings show that first-line managers' ability to lead effectively is constrained by challenges such as workforce shortages, fragmented support, and a lack of decision-making power, which has also been shown in previous international and Swedish research (Eurofound, 2020; Lindmark et al., 2023; OECD, 2020; Sturmberg et al., 2024). Lack of time, administrative overload, and insufficient resources restricted their presence in everyday care practice, which managers viewed as central for meaningful leadership. This aligns with studies showing that structural empowerment is vital for managers' well-being and leadership capacity in residential care (Hagerman et al., 2019).

Support systems made a substantial difference in managers' daily experience. Consistent collaboration with coordinators, assistant managers, or trusted superiors helped managers cope with daily challenges and maintain psychological well-being. Conversely, a lack of support often resulted in feelings of isolation, leaving managers to make difficult decisions alone, which could further undermine their motivation and empowerment (cf. Laschinger et al., 2010).

The findings show that managers often face competing expectations from staff, relatives, and external stakeholders. Some viewed relatives as valuable partners, while others struggled with conflicting demands. Earlier research has demonstrated that different groups in residential care may perceive autonomy and care needs in distinct ways (Haugen et al., 2019; Mortensen & Nåden, 2024). By examining these perspectives within the same setting, our study demonstrates how such differences manifest in everyday practice and how managers' ability to handle them depends on having sufficient time, support, and decision-making authority. When managers are structurally and psychologically empowered, they can support staff more effectively and involve relatives in ways that strengthen person-centred care.

Interdependence and implications for policy and practice

Our findings reflect broader systemic challenges in residential care that have been documented internationally, including limited resources, reduced autonomy, and high staff turnover (Eurofound,

2020; OECD, 2020; Sturmberg et al., 2024). Earlier studies link these conditions to lower job satisfaction and difficulties in retaining staff (Jurij et al., 2023; Lindmark et al., 2025). While this research rarely explicitly uses the concept of empowerment, it points to similar mechanisms: when resources, support, and influence are restricted, the overall structure and well-being of stakeholders are negatively influenced. These patterns can be understood in relation to broader organisational structures. As highlighted by Lindmark (2024), care workers and first-line managers operate under high expectations without corresponding structural support. Procurement and governance systems rarely include explicit requirements for staff empowerment or working conditions, despite their central role in sustaining person-centred care. This policy gap contributes to the difficulty of realising ideals such as continuity and shared decision-making in everyday practice. In dementia care especially, where residents depend on others to safeguard their self-determination, insufficient structural support weakens the conditions needed to enact these ambitions (Erlandsson et al., 2023; Haugen et al., 2019).

Earlier research has emphasised that effective collaboration requires shared communication and responsibility (Jang, 2020) and that residents, particularly those with cognitive impairment, depend on relatives to communicate their wishes (Lao & Low, 2019). Our findings suggest that relatives are not always recognised as partners, which can limit both their own empowerment and the resident's ability to uphold self-determination.

This study also contributes to the theory of empowerment. Laschinger's model primarily describes how empowerment flows from organisational structures to individual workers and then affects their ability to empower residents. Our findings extend this logic by showing that empowerment in residential care operates across several relational layers. Managers' structural conditions influence care workers, whose empowerment shapes the involvement and influence of relatives, who in turn support residents' autonomy. This creates an interdependent chain of empowerment that is not strictly linear but involves reciprocal effects across roles. This study demonstrates that empowerment is a shared process and that weaknesses at any point in the chain can limit residents' opportunities for self-determination.

Strengthening structural conditions would benefit all groups. More time, supportive leadership, and clearer authority would improve care workers' and managers' ability to meet policy expectations and uphold person-centred care. Improved conditions would also increase relatives' confidence and sense of influence as representatives of residents. Because residents, relatives, care workers, and managers are interdependent, strengthening empowerment in one group can reinforce empowerment in the others. Policy development, therefore, needs to draw more directly on the knowledge and everyday experiences of those who support residents, ensuring that practice is consistent with policy ambitions (Ingard, 2025).

Methodological considerations

This study has several methodological strengths and weaknesses that should be taken into consideration. One clear strength is the use of a secondary analysis of qualitative data from two projects, including interviews and focus groups with relatives, care workers, and first-line managers at the same care homes. This approach enabled the examination of empowerment from multiple perspectives while also reducing the burden on participants. Using existing data in this manner can be viewed as an ethically responsible approach in social research (Heaton, 2008; Ruggiano & Perry, 2019). The analysis is also grounded in a well-established theoretical framework (Kanter, 1977; Laschinger et al., 2010; Spreitzer, 1995), which enhances the analytical depth and the study's relevance to an international audience.

However, there are some important limitations. Most notably, the study does not include direct interviews with residents. Instead, relatives are used as proxies, especially for residents with cognitive impairment. This approach made it possible to capture perspectives that might otherwise be overlooked, but it cannot fully replace the residents' voices, particularly those of individuals without actively involved relatives. The original interviews were conducted to explore the perspectives of each group separately; it was only afterwards that we recognised the value of bringing these perspectives together to explore empowerment in a broader and more integrated way. This secondary analysis enabled us to revisit the material with new questions and examine shared and contrasting experiences across roles within the same

care setting. The results are also somewhat specific to the Swedish context. Organisational and legal frameworks can vary significantly across countries, which may limit the transferability of findings.

Conclusion

This study demonstrates that empowerment is not only an individual experience but also a collective process shaped by the everyday interactions among care workers, managers, and relatives of residents in residential care homes. A good climate for cooperation reduces the risk of conflicts between stakeholders by creating a common direction, where the empowerment of one group does not come at the expense of another but where co-creation strengthens the whole. When any of these groups lack structural or psychological empowerment, it can undermine not only their own well-being and ability to contribute but also the residents' autonomy and quality of life. In particular, the opportunities for care workers and managers to provide person-centred care are closely linked to the support and resources available to them. At the same time, relatives' sense of inclusion and partnership is essential, especially for residents who cannot advocate for themselves. Our findings underline the need for policy and organisational strategies that strengthen both the structural and the psychological empowerment of all groups involved in care. By ensuring that care workers, managers, and relatives have the support, information, and decision-making opportunities they need, it becomes possible to move closer to the goal of truly person-centred and high-quality care for older adults in residential care settings.

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Author contributions

CRediT: **Cecilia Ingard:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing; **Tomas Lindmark:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing; **Maria Sjölund:** Conceptualization, Supervision, Writing – review & editing; **Sven Trygged:** Conceptualization, Supervision, Writing – review & editing.

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Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request. As this is a secondary analysis, more data are available in previously published articles (Ingard et al., 2024a, 2024b; Lindmark et al., 2023).

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