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**SUPPORTING OLDER PEOPLE'S
INDEPENDENT LIVING AT HOME
THROUGH SOCIAL AND HEALTH
CARE COLLABORATION**

by

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ABSTRACT

This study was undertaken to describe and explore independent living among older people from the point of view of social and health care collaboration. Its purpose was to increase understanding about the resources of older home care clients and to investigate aspects of social and health care collaboration in home care provision. This was a cross-sectional study that used a descriptive and comparative design.

The data for the research were collected among home care clients (aged 65 or over) and their professional carers in one municipality in Western Finland. Open-ended interviews were conducted with 21 older clients, who were asked about their everyday coping resources and their experiences of multi-professional collaboration in care provision. Data analysis was based on the method of content analysis. In addition, 25 home care professionals – 13 home service workers, 11 home health care nurses and one medical doctor – described their experiences of multi-professional collaboration. These data were collected in focus group interviews and analysed using the method of content analysis. These results and the earlier literature were then used to develop a structured questionnaire for purposes of analysing and comparing the views of home care clients and professionals on multi-professional collaboration in care provision. Following the completion of pilot tests, the questionnaire was sent out to 200 home care clients and to 570 carers: 485 home care workers, 81 home health care nurses and 4 doctors. Responses were received from 120 clients (60%) and 370 professional carers (65%). Group differences were analysed using cross-tabulations, Pearson's Chi-Square Test and Fisher's Exact Test.

The older home care clients described their resources in terms of a sustained sense of life control and will. They derived strength in managing everyday life from their leisure activities and social networks, but on the other hand they were greatly challenged by the conditions imposed by outsiders on their everyday life, by their deteriorating health and their loneliness. The results showed that the care provided by professionals sometimes conflicted with older clients' expectations and did not always support the clients' own resources. Professionals took care-related decisions and actions on behalf of their clients, even though the clients themselves stressed the importance of retaining their sense of life control and will. Factors hampering multi-professional collaboration in supporting client resources included the difficulties that care professionals had in identifying those resources and threats to those resources, communication problems, the lack of clear goals as well as care professionals' contrasting views and ways of working. Clients' and care professionals' views on care provision differed statistically significantly ($p < 0.05$). Clients had lower assessments than care professionals of the support provided for independence and the provision of physical, psychological and social care.

The research highlights a number of challenges for the development of collaboration in home care services. Importantly, steps are needed to strengthen clients' expertise of their own life, to promote a more client-driven and goal-oriented approach to care provision, to clarify the roles and responsibilities of professional care providers and to improve methods of communication. The results of this work strengthen the knowledge base of gerontological nursing science and provide valuable information that can be used in social and health care education as well as in administrative practice.

Key words: home care, multi-professional collaboration, older client, resource

Sini Eloranta

SOSIAALI- JA TERVEYDENHUOLLON YHTEISTYÖ IKÄIHMISTEN KOTONA ASUMISEN TUKEMISESSA

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TIIVISTELMÄ

Tässä tutkimuksessa tarkasteltiin ikäihmisten kotona asumista sosiaali- ja terveydenhuollon yhteistyön näkökulmasta. Tutkimuksen tarkoituksena oli lisätä ymmärrystä iäkkäiden kotihoidon asiakkaiden voimavaroista arjesta selviytymisen näkökulmasta, ja tutkia miten asiakkaiden hoito sosiaali- ja terveydenhuollon yhteistyönä toteutuu. Tutkimus oli poikkileikkaustutkimus, jossa sovellettiin kuvailevaa ja vertailevaa tutkimusasetelmaa.

Tutkimusaineisto kerättiin yhden länsisuomalaisen kunnan kotihoidon asiakkailta (≥ 65 v.) ja heitä hoitavilta ammattihenkilöiltä. Kotihoidon 21 iästä asiakasta kuvasivat omia voimavarojaan arjesta selviytymisen näkökulmasta sekä kokemuksiaan hoidon toteutumisesta ammattihenkilöiden yhteistyönä. Aineisto kerättiin avoimella haastattelulla ja analysoitiin sisällön analyysillä. Lisäksi 25 kotihoidon ammattihenkilöä: 13 kotipalvelun työntekijää, 11 kotisairaanhoidajaa ja lääkäri kuvasivat kokemuksiaan iäkkään asiakkaan hoidon toteutumisesta ammattihenkilöiden yhteistyönä. Aineisto kerättiin fokusryhmähaastattelulla ja analysoitiin sisällön analyysillä. Näiden tulosten sekä aikaisemman kirjallisuuden perusteella laadittiin strukturoitu kyselylomake, jolla analysoitiin ja vertailtiin asiakkaiden ja ammattihenkilöiden näkemyksiä siitä, miten asiakkaiden hoito sosiaali- ja terveydenhuollon yhteistyönä toteutui. Esitestausten jälkeen kyselylomake lähetettiin 200 kotihoidon asiakkaalle ja 570 heitä hoitavalle kotihoidon työntekijälle: 485 kotipalvelun työntekijälle, 81 kotisairaanhoidajalle ja 4 lääkärille. Kyselyyn vastasi 120 asiakasta (60 %) ja 370 ammattihenkilöä (65 %). Ryhmien välisten erojen tarkastelussa käytettiin ristiintaulukointia, Pearsonin khin neliötestiä ja Fisherin tarkan todennäköisyyden testiä.

Iäkkäiden asiakkaiden kuvauksissa voimavarat muodostuivat elämänhallinnan tunteesta ja toimintatahdon säilymisestä. Asiakkaat ammensivat arkeen voimaa harrastuksista ja sosiaalisesta verkostosta, mutta ulkopuolisten asettamat elämisen ehdot, terveydentilan heikkeneminen sekä yksinäisyys asettivat ikäihmisen ja hänen voimavaransa suurten haasteiden eteen. Tulokset osoittivat, että ammattihenkilöiden toiminta oli osittain ristiriidassa ikäihmisten omien odotusten kanssa, eikä se kaikilta osin tukenut asiakkaiden omia voimavaroja. Ammattihenkilöt tekivät hoitoon liittyviä päätöksiä ja toimintoja asiakkaiden puolesta, vaikka asiakkaille itselleen oli tärkeää elämänhallinnan tunne ja toimintatahdon säilyminen. Asiakkaiden voimavarojen tukemista moniammatillisena yhteistyönä vaikeuttivat ammattihenkilöiden vaikeus tunnistaa asiakkaiden omia voimavaroja sekä niitä uhkaavia tekijöitä, tiedon kulun ongelmat, tavoitteeton ja epäyhtenäinen tapa toimia sekä ammattihenkilöiden vastakkain asettuvat näkemyserot ja toimintatavat. Asiakkaiden ja ammattihenkilöiden näkemykset toteutetusta hoidosta erosivat toisistaan tilastollisesti merkitsevästi ($p < 0.05$). Asiakkaat arvioivat sekä itsenäiseen toimintaan tukemisen että fyysisen, psyykkisen ja sosiaalisen tuen toteutuneen työntekijöitä huonommin.

Yhteistyön kehittämishaasteita kotihoidossa ovat asiakkaan oman elämänsä asiantuntijuuden vahvistaminen, toimintakulttuurin muuttaminen asiakaslähtöiseksi tavoitteelliseksi toiminnaksi, ammattihenkilöiden roolien ja vastuun selkiyttäminen sekä tiedon kulun menetelmien kehittäminen. Tutkimus vahvistaa gerontologisen hoitotieteen tietoperustaa ja tuottaa uutta tietoa, jota voidaan soveltaa sosiaali- ja terveystieteen koulutuksessa ja johtamisessa.

Avainsanat: iäkäs asiakas, kotihoito, moniammatillinen yhteistyö, voimavara

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LIST OF ABBREVIATIONS, FIGURES AND TABLES**ABBREVIATIONS**

C	Clients
ETENE	National Advisory Board on Health Care Ethics
HSW	Home service worker
HHN	Home health care nurse
P	Professionals
STAKES	National Research and Development Centre for Welfare and Health
WHO	World Health Organisation

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LIST OF ORIGINAL PUBLICATIONS

This thesis is based on the following publications, which are referred to in the text by their Roman numerals from I to V:

- I. Eloranta S, Routasalo P, Arve S. 2008. Personal resources supporting living at home as described by older home care clients. *International Journal of Nursing Practice* 14, 308-314.
- II. Eloranta S, Arve S, Routasalo P. 2008. Multiprofessional collaboration promoting home care clients' personal resources: perspectives of older clients. *International Journal of Older People Nursing* 3, 88-95.
- III. Eloranta S, Welch A, Arve S, Routasalo P. A collaborative approach to home care delivery for older clients: Perspectives of home care providers. Accepted for publication in *Journal of Interprofessional Care*.
- IV. Eloranta S, Welch A, Arve S, Viitanen M, Isoaho H, Routasalo P. Older home care clients' and professionals' perceptions of clients' psychological well-being and care. Accepted for publication in *Journal of Clinical Nursing*.
- V. Eloranta S, Arve S, Isoaho H, Routasalo P. Home care from the perspective of older clients and their professional carers. *Archives of Gerontology and Geriatrics*. In press.

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1 INTRODUCTION

The focus in care delivery for older people has increasingly shifted towards community care (WHO 2002, Thomé et al. 2003, Stenzelius et al. 2005, Markle-Reid et al. 2006, Jones et al. 2007). Today, the proportion of people aged 65 or over who receive home care is much higher than the corresponding proportion of those who receive care through residential institutions (Anderson & Hussey 2000). In Finland, the government has set the target that by 2012, 91–92% of older people should be able to live at home independently or with suitable social and health care services, mainly home help and home health care services. No more than 3% should live in residential institutions. (STM and Suomen Kuntaliitto 2008.) In 2008, 11.2% (about 47,000 people) of the Finnish population aged 75 or over received home care on a regular basis (Stakes 2008).

Gerontological nursing care thus faces two significant challenges if it is to successfully support independent living in the ageing population. Firstly, the care of older people is traditionally based on a biomedical, illness-centred approach that focuses on the evaluation of disabilities and their severity. Less attention is given to people's own resources, which in this sense remain very much unused. (cf. WHO 1980, 2004.) While ageing has often been characterised as a process of progressive biological changes resulting in a growing risk of chronic disease and cognitive and functional impairment (Khaw 1997), ageing is now increasingly seen as a positive period of life: this modern view places ever greater emphasis on individuality, dignity and strengths (Koskinen 2004, Kangasniemi 2005, Jyrkämä 2007). For care professionals, this focus on people's own resources in promoting independent living at home requires a philosophical shift from a position of 'doing for' to one of 'doing with' older people (Brown et al. 2006). In other words, individuals must be supported to take a more active role in their care and to maintain their independence within the community. This will require new professional skills and competencies to identify older people's own resources and their subjective experience of the qualities or strategies that are needed to maintain one's well-being and independence. The use and exploitation of people's own resources cover all areas of life, such as health and well-being, housing and social activity. The resource-oriented approach focuses on health promotion and on expanding the individual's positive potential for health. (Tornstam 1982, Atchley 2000, Mathieson et al. 2002, Caelli et al. 2003, Drageset et al. 2008.)

Secondly, the way in which home care is delivered for older people is profoundly changing. The integration of social and health care services has taken centre stage in both the policy and practice arenas. (Plochg & Klazinga 2002, Nies 2006, Hills et al. 2007.) The needs of older people are many and varied, and it is impossible for any one professional to assume full responsibility: social and health care collaboration is needed (Hultberg et al. 2005, Nies 2006, WHO 2006). In this collaboration, professionals with

different training backgrounds co-ordinate their expertise in providing care for their shared clients. It provides a safe nexus for the exchange of knowledge and opinions, as well as a framework for reaching a consensus about appropriate health care delivery for a particular client or client cohort. (Davies 2000, Farrell et al. 2001, Housley 2003, Leathard 2003, Valvanne 2006.)

This study strengthens the knowledge base of gerontological nursing science and provides new information on how to support independent older people's independent living at home through multi-professional social and health care collaboration. More specifically, the aims of this study are to increase understanding about the resources of older clients and to investigate aspects of social and health care collaboration in home care provision. For the purposes of this research, home care is defined as comprising both home help and home health care provided by local authorities, with professional care providers collaborating to produce the services and home health care needed by the older client. Older clients or older people are defined as those aged 65 or over who receive home care on a regular basis.

2 HOME CARE FOR OLDER PEOPLE

The world's population is ageing. In the European Union, projections are that by 2015, one-third of the population will be aged 60 or over and more than 5% will be 80 or over (Eurostat 2008). At the end of 2007, the total population of Finland numbered 5.3 million, and 16.5% of the population were over 65 years of age. Finland has one of the world's fastest growth rates for the elderly population, with the share of people aged 65 or over expected to rise from 16% in 2002 to 26% in 2030. (Statistics Finland 2007.) These trends of population ageing will put social and health care services under increasing pressure in all countries.

As in many other countries, the main goal of old age policy in Finland is to promote the well-being and functional capacity of older people and to ensure that as many of those people as possible can live independently in their own homes (Government Programme of Prime Minister Matti Vanhanen's second cabinet 2007, Jones et al. 2007, Ministry of Social Affairs and Health 2007a, 2008b). According to the Finnish Government Programme and framework programmes for the development of services for older people, key areas of focus must include home help and home health care, which are the cornerstones of community care services for the elderly.

The provision of home help services is defined in the law as consisting of the performance of or assistance with functions and activities related to housing as well person care and attendance. Furthermore, the aim of home help services is to foster a sense social security. (the Social Welfare Act 710/1982.) Staff involved in home help services have different qualifications and training backgrounds, and include professional groups such as home aides, practical nurses and assistant nurses.

In home health care services, the idea is that that physicians, home care nurses and assistant nurses provide treatment and nursing care to clients who despite their illness are still healthy enough to manage independently at home. Home health care or home nursing comes under health care services and is supervised by the medical profession. (the Primary Health Care Act 66/1972.) The law does not define the exact content of home health care services, but it is possible to provide even quite complex and demanding nursing care at the client's home.

Staff working in home help services and home health care come from different training backgrounds. Earlier definitions have described the difference by saying that the care provided through home help services comes naturally as an integral part of the service: this is something anyone can do and indeed was previously done by older people themselves, whereas most home health care or home nursing tasks are beyond their skills. (Malin 1996.) Nowadays home health care clients are becoming ever older, they

often have multiple diseases and require extensive help. Care workers' job description has consequently become more and more complicated, requiring greater collaboration with home health care staff to deal with clients' health problems. (Tedre 1999, Perälä et al. 2006.) It is recognized that the traditional disease-specific approach may not be appropriate for older people with multiple needs. Indeed many health care professionals have increasingly shifted their attention away from the elimination of diseases and concentrated instead on developing interventions that take into consideration the individual's biography, including the role of families and communities. (Glendinning & Rummery 2003, Hubbard & Themessl-Huber 2005, Lynch et al. 2006.)

Home services cover a wide range of activities from preventive and rehabilitative care to palliative terminal care (Tedre 1999, Thóme et al. 2003). Most service packages are tailored to meet each individual client's needs (Ala-Nikkola 2003, Tenkanen 2003, Grönroos & Perälä 2005, Vaarama 2006). Typically, the services are grouped into the categories of home help services, home health care or home nursing, basic care provision and various auxiliary services (Algera et al. 2004, Paasivaara 2004). Older people receiving care in their homes have more disabilities and more complex health care needs than they used to earlier (Modin & Furhoff 2002, Aylward et al. 2003, Axelsson & Elmståhl 2004, Mitchell et al. 2005, Johansson 2005). The heaviest service users are older women who live alone and who have multiple chronic diseases and lowered functional capacity (Modin & Furhoff 2002, Tepponen 2003, Fortinsky et al. 2004, Muurinen & Raatikainen 2005, Stakes 2007a). Recent studies also indicate that loneliness, depression, dementia and other cognitive diseases are on the increase (Hellström et al. 2004, Markle-Reid et al. 2006, Larsson et al. 2006, Stakes 2007b). Older clients need most help with housework, cooking, hygiene, carrying and moving outside (Hellström & Hallberg 2001, Hellström et al. 2004). Repair and alteration work in the client's home can also be performed. Older clients also receive support for independent living from other social and health care professionals, such as social workers, nutritionists, physiotherapists and occupational therapists. (Hammar 2008.)

There are marked country differences in the content and organisation of home care (Thóme et al. 2003, Algera et al. 2004, Lewinter 2004, Reed et al. 2005). In the United States and Canada, for example, home care is financed through insurance-based home care and community care programmes for older people, such as 'Medicare and Medicaid Home Health' and the 'Medicaid Waiver program' (Arundel & Glouberman 2001, Fortinsky et al. 2004). In most countries, the public sector is involved in organising and delivering social welfare and health care services. The Finnish system is mainly financed from the public purse, and it covers the whole population. The system is decentralised in the sense that municipalities (of which there are 348 in 2009) are responsible for the provision of social and health care services to local residents (the Primary Health Care Act 66/1972, the Social Welfare Act 710/1982). Local authorities can produce

and provide the services independently, in collaboration with other local authorities, or outsource service provision to private companies or the third sector (Voutilainen et al. 2007). Experimental legislation passed in 2006 and the temporary amendments made to the Social Welfare Act (1428/2004) and the Primary Health Care Act (1429/2004) allowed for the integration of home help services and home nursing into home care even in those municipalities where social and health care services had not been merged.

Collaboration in home care is particularly important to older people, for a number of reasons. First, it is these people who are most likely to have multiple social and health care needs, which are influenced by physical, psychological, social and environmental factors that require multiple service responses (Glendinning 2003, Rummery & Glendinning 2003, Thóme et al. 2003, Hultberg et al. 2005, WHO 2006, Nies 2006, Ryan et al. 2009). Second, older people are frequent users of health services and recent research has shown that frequent users of health services are also more likely to use social services (Keene et al. 2001, Thóme et al. 2003, Markle-Reid et al. 2006). Third, health professionals often have to take account of social needs when deciding which services to refer older people to (Dempsey & Bekker 2002). A further reason why the collaborative approach to care delivery is pertinent for older people is that the population is ageing rapidly and older persons themselves are demanding a better quality of care (Vaarama & Pieper 2006). In the light of these developments it is not surprising that the collaboration of social and health care services for older people has taken centre stage in both the policy and practice arena in many countries, as in Finland (Plochg & Klazinga 2002, Glendinning 2003, Leichsenring 2004, Hultberg et al. 2005, Vaarama & Piper 2006, Nies 2006, Hills et al. 2007). In 2006, about half of all Finnish municipalities had integrated their home help and home health care services (Tepponen 2009).

The data for this study were collected in a municipality where services for older people are provided by two separate organisations, i.e. home help services and home health care services. This division has since been discontinued. In 2001, local authorities in Finland embarked on a new initiative to improve the existing social and health care structure by introducing a multi-professional model of collaboration aimed at eliminating the existing dual system of care and improving the quality of service delivery by focusing on a client-centred approach (Kosklin et al. 2002). This initiative resulted in the establishment of a conjoint approach to health care for older people, a culture of collaboration where social and health care professionals work together with clients. Implicit in developing such a culture of care has been a commitment to shared governance in client assessment, care delivery and evaluation. (Vaarama & Piper 2006.)

3 BACKGROUND OF THE STUDY

The literature review for this study was based on searches conducted in the MEDLINE PubMed, MEDLINE Ovid, CINAHL, SocINDEX and Cochrane library databases as well as manual searches. These searches covered the period from 1998 to March 2009. They were limited to studies published in the English language, including an abstract and concerning home-dwelling older people (≥ 65 years of age) or multi-professional social and health care collaboration and reporting results from empirical studies. In addition, a search was carried out on the MEDIC database to identify articles and studies published in the Finnish and Swedish languages.

The literature review is divided into two main parts. The first part is aimed at defining the concept of “resource”. This is followed by an investigation of the resources of home-dwelling older people. The search terms used were: ‘aged OR aging OR old* OR elder* OR geriatric*’ AND ‘resource’ AND ‘home* OR home-dwell* OR home-liv*’. First, the titles of the articles identified by the search were reviewed and the abstracts of the relevant articles were read. All duplicate articles were removed. Next, the whole articles were read, their relevance assessed and the final 21 articles selected. Manual searches were then conducted by reviewing the reference lists of these articles to identify relevant publications: these searches produced five further studies. The final material thus comprised 26 articles or studies (Table 1). The abstracts of these articles or studies are summarised (in Appendix 1.).

Table 1. Literature searches on the resources of older home-dwelling people

Keywords	aged aging old* elder* geriatric*	AND	resource*	AND	home* home-dwell* home-liv*	
Databases searched	MEDLINE PubMed	MEDLINE Ovid	CINAHL	SocINDEX	Cochrane	Medic
Number of matches	881	588	1095	785	0	17
Number accepted	21					
MANUAL SEARCH						
Number accepted	5					
Total number accepted	26					

The literature review was then continued by exploring multi-professional social and health care collaboration: multi-professional collaboration as a concept and the maintenance of multi-professional collaboration in the context of primary and community care, especially home care. This search used the terms: ‘multi-professional* OR inter-professional* OR multidisciplinary* OR interdisciplinary* OR interprofessional relation*’ AND ‘team* OR group* OR care group* OR team work* OR care team* OR nursing team* OR collaboration* OR co-operation* AND ‘community health service* OR community health nurs* OR home care* OR home nurs*’. First, the titles of the articles identified

were reviewed and the abstracts of the relevant articles were read. All duplicate articles were removed. Then, the whole articles were read, their relevance assessed and the final 32 articles selected. Manual searches were conducted by reviewing the reference lists of these articles to find relevant publications: 10 further studies were found. The final material comprised 42 articles or studies (Table 2). The abstracts of these articles or studies are summarised in Appendix 2.

Table 2. Literature searches on multi-professional collaboration

Keywords	multi-professional* inter-professional* multidisciplinary* interdisciplinary* interprofessional relation*	AND	team* group* care group* team work* care team* nursing team* collaboration* co-operation*	AND	community health service* community health nurs* home care* home nurs*	
Databases searched	MEDLINE PubMed	MEDLINE Ovid	CINAHL	SocINDEX	Cochrane	Medic
Number of matches	638	630	891	81	0	44
Number accepted	32					
	MANUAL SEARCH					
Number accepted	10					
Total number accepted	42					

3.1 Resources of home-dwelling older people

3.1.1 *The concept of resource*

The concept of resources of older people have gained increasing research attention in recent decades. In the 1980s, resources received growing attention in social gerontological research with the emergence of the modern view on ageing, which emphasises people's resources, strengths and generally the positive sides of ageing (O'Rand 2001, Weiss & Bass 2002, Koskinen 2004, Jyrkämä 2007). In the 2000s, the number of publications in this field has continued to increase (e.g. Malterud et al. 2001, Karisto & Kontinen 2004, Koskinen 2004, Hokkanen et al. 2006, Forssén 2007). It has been considered important that research can demonstrate what these resources of older people actually are. This will allow social and health care staff to take the best possible advantage of these resources and to encourage older people to apply them in their everyday life. (Koskinen et al. 2007.)

Resource is a complex and multifaceted concept. The term derives from the Latin 'resurgere', which means 'to rise again, to spring up anew'. Similar definitions are found in modern dictionaries which define resource as 'person's ability to cope with a situation or capability in meeting difficulties' and 'capability or reserve which people can draw on when necessary' (MOT Collins English Dictionary 2000, Oxford English Dictionary 2008). Tornstam (1982, 60-61) defines resources as 'material, personal and mental qualities or phenomena that are known and that can be consciously used to benefit society or the individual'. Diener & Fujita (1995) say that resource can be a material, social or

personal characteristic that a person possesses and that he/she can use to make progress towards his or her personal goals. They suggest that people tend to have goals that are relevant to their strongest resource. Resources help fulfil one's physical and psychosocial needs and thereby also help achieve a sense of competence or mastery. (Diener & Fujita 1995, Dean et al. 2008.) Malterud et al. (2001) coined the concept of 'personal health resources', which they defined as 'the individual's subjective experience and perception of qualities or strategies which he/she thinks maintain his/her health and independence. This model emphasises the client-centred perspective, focusing on self-assessed personal resources. In the nursing literature, resource has been defined as 'factors that support coping in everyday life' (Pelkonen 1994, Hokkanen et al. 2006).

The concept of 'empowerment' is often used in the literature synonymously with resources. This concept describes a social process of recognizing, promoting and enhancing peoples' abilities to meet their own needs, solve their own problems and mobilise the necessary resources in order to feel in control of their lives. (Gibson 1991.) It has been suggested that the empowered individual has discovered his/her own resources (Siitonen 1999) and that he/she is able to make informed choices and generally contribute to society in a meaningful way (Thursz et al. 1995).

In this study, the concept of 'resources' is defined as the individual's subjective experience of the qualities or strategies that are needed to maintain one's well-being and independent living at home.

3.1.2 Resources supporting living at home

The literature review identified several resources of home-dwelling older people. These resources can be divided into two main categories, viz. personal and environmental resources (Diener & Fujita 1995, Rogers 1997, Koskinen et al. 2007) (Table 3).

Table 3. Personal and environmental resources of home-dwelling older people

Resources	Author and year
Personal resources	
Experience of health	Pietilä & Tervo 1998, Roine et al. 2000, Hokkanen et al. 2006, Burr & Mutchler 2007, Koskinen et al. 2007, Reichstadt et al. 2007
Sense of life coherence	Knipscheer et al. 2000, Loft et al. 2003, Johannesen et al. 2004, Sparks et al. 2004, Windle & Woods 2004, Forssén & Carlstedt 2006, Hokkanen et al. 2006, Koskinen et al. 2007, Saevareid et al. 2007, Reichstadt et al. 2007, Ravanipour et al. 2008
Positive outlook on life	Rissanen 1999, Roine et al. 2000, Backman 2001, Bryant et al. 2001, Malterud et al. 2001, Hokkanen et al. 2006, Forssén 2007, Koskinen et al. 2007, Reichstadt et al. 2007
Environmental resources	
Domestic environment	Pietilä & Tervo 1998, Windle & Woods 2004, Elo 2006, Hokkanen et al. 2006, Koskinen et al. 2007, Reichstadt et al. 2007
Social environment	Pietilä & Tervo 1998, Rissanen 1999, Takkinen & Suutama 1999, Koskinen & Ylikulppi 2000,
* Social contacts	Roine et al. 2000, Backman 2001, Bryant et al. 2001, Malterud et al. 2001, Johannesen et al.
* Social activities	2004, Sparks et al. 2004, Elo 2006, Hokkanen et al. 2006, Kulla et al. 2006, Koskinen et al. 2007, Reichstadt et al. 2007, Dean et al. 2008, Valta 2008
Cultural environment	Pietilä & Tervo 1998, Koskinen & Ylikulppi 2000, Bryant et al. 2001, Routasalo & Pitkälä 2004, Forssén 2007, Koskinen et al. 2007

Personal resources

The personal resources of home-dwelling older people are related to the experience of health, a sense of life coherence and positive outlook on life.

Health as a resource is understood in terms of physical, cognitive and psychological well-being, functional capacity and balanced interaction between humans and the environment (Pietilä & Tervo 1998, Roine et al. 2000, Hokkanen et al. 2006, Koskinen et al. 2007, Reichstadt et al. 2007). Adequate health status and functional capacity are necessary for maintaining independence because these characteristics relate to the capacity to meet the needs of daily living (Burr & Mutchler 2007). Most crucial of all are the individual's own personal experiences and interpretations of the meaning and significance of health. When older people assess their own health, they usually do so by comparing themselves to age peers and against several different factors, particularly their ability to manage activities of everyday living, their symptoms and the inconvenience caused by those symptoms. Some illnesses and symptoms are such that people adjust and adapt, and there are also ways in which to compensate for disabilities. (Bryant et al. 2001.) For example, older people with a decreased competence in activities of daily living (ADL) may experience a need to adapt their behaviour to the level of environmental stress. This adaptive behaviour is expected to promote subjective well-being. (Knipscheer et al. 2000.) Many older people rate their health as quite good in spite of their illness (Idler et al. 2000, Roine & Tarkka 2000, Bryant et al. 2001, Menec & Chipperfield 2001, Leinonen 2002, Koskinen et al. 2007, Sims et al. 2007, Savikko 2008). Older people's assessments of their health is reflected in their use of health care services (Menec & Chipperfield 2001), and they predict future health and the subsequent development of life expectancy (Benyamini & Idler 1999, Idler et al. 2000).

Sense of life coherence as a personal resource refers to the individual's experience of being able to influence events that are meaningful to their own life and to control variable life situations (Knipscheer et al. 2000, Loft et al. 2003, Johannesen et al. 2004, Sparks et al. 2004, Windle & Woods 2004, Forssén & Carlstedt 2006, Hokkanen et al. 2006, Koskinen et al. 2007, Reichstadt et al. 2007, Ravanipour et al. 2008). Sense of coherence as a coping resource reflects the extent to which an older person finds life to be meaningful (motivational and emotional disposition), manageable (readiness to control and influence events) and comprehensible (cognitive disposition) (Saevareid et al. 2007). It also promotes the ability to endure stressful situations. The stronger the individual's sense that they can manage different life changes, the greater their resources to cope with the losses that follow with ageing, such as the deterioration of health and functional capacity. (Häggman-Laitila 1999, Ruoppila 2002.)

A positive outlook on life is associated with a strong sense of confidence in one's own personal capacities (Rissanen 1999, Roine 2000, Malterud et al. 2001, Hokkanen et al.

2006). People with a positive outlook are also more likely to maintain and improve their health and physical conditions (Backman 2001, Malterud et al. 2001), to look forward in their life and take a positive attitude to ageing (Backman 2001, Koskinen et al. 2007). It has been found that a positive attitude is conducive to feelings of mastery, self-esteem and confidence (Gernerud & Olsson 2004, Forssén 2007), improves quality of life (Vaarama 2006) and strengthens people's vitality. It also alleviates loneliness, promotes relaxation and helps endure physical pain (Forssén 2007). Finally, a positive outlook on life contributes to positive perceived health and successful ageing (Bryant et al. 2001, Forssén 2007, Reichstadt et al. 2007).

Environmental resources

Home-dwelling older people's environmental resources derive from the domestic, social and cultural environment.

The domestic environment is a major source of well-being in older people (Windle & Woods 2004, Hokkanen et al. 2006). The experience of attachment and belonging to a place is particularly important (Koskinen et al. 2004, 2007, Nykänen 2007). Home has a very special meaning to older people, and indeed many older people would prefer to live in their own home for as long as possible (Koskinen et al. 2007). Home provides security, refuge and a place for expressing one's individuality and freedom (Kirsi 2001, Tenkanen 2003, Elo 2006, Nykänen 2007). This is a place where people can still have a positive experience of themselves, even though their vitality is on the decline (Tenkanen 2003). Older people spend up to around 70% of their time at home, and this is where they can most comfortably feel they are in control. The opportunity to live in a familiar environment, surrounded by one's belongings, allows for a longer autonomous life expectancy. (Nykänen 2007.) For older people, the secure home environment and access to home aides means they can manage independently with their daily routines, despite their advancing age and loss of functional, cognitive and sensory capacities (Fielo & Warren 2001, Ritzel et al. 2001, Ayis et al. 2003, Elo 2006, Reichstadt et al. 2007). This interactive mechanism between personal resources and environmental factors has become an important tool in environmental planning activities for functionally dependent older people (Knipscheer et al. 2000). Old age is a time of multiple losses, and in this situation the home may be the last and only point of anchorage that allows ageing individuals to retain their autonomy and identity (Knipscheer et al. 2000). Home is also an important place of memories and life history (Pietilä & Tervo 1998, Elo 2006, Koskinen et al. 2004, 2007).

The social environment as a resource consists of two main dimensions: social contacts and social activities. Home-dwelling older people are integrated in the community and they highly value social contacts with other people (e.g. friends, family, neighbours, service providers) as well as the opportunity to take part in social activities (Pietilä & Tervo 1998, Rissanen 1999, Takkinen & Suutama 1999, Koskinen & Ylikulppi 2000,

Roine et al. 2000, Backman 2001, Malterud et al. 2001, Johannesen et al. 2004, Elo 2006, Hokkanen et al. 2006, Kulla et al. 2006, Reichstadt et al. 2007, Dean et al. 2008, Valta 2008). Social contacts help to create a sense of security, provide opportunities for companionship and intimacy, and strengthen identity construction and self-esteem (Bondevik & Skogstad 1999, Bryant et al. 2001, Koskinen et al. 2007). Those who are socially active and who have meaningful activities, also report high levels of well-being (Bryant et al. 2001, Shilling & Wahl 2002, Nezlek et al. 2002, Bertera 2003, Sparks et al. 2004, Windle & Woods 2004, Routasalo et al. 2006, Walker 2006, Low & Molzahn 2007). Cattani et al. (2005) found that older people who engage in social group activities have an enhanced sense of well-being and connectedness to the community, and therefore they are less likely to experience social isolation (Aday 2006, Collins 2006). Social isolation may lead to depression, loneliness and early institutionalisation in older people (Tijhuis et al. 1999, White et al. 1999, Routasalo & Pitkälä 2004, Savikko 2008).

The cultural environment as a resource is understood in a broad sense as comprising the individual's whole complex and multidimensional life sphere. It includes the individual's own cultural identity as well the aesthetic dimension, i.e. experiences gained from art and the natural environment. (Koskinen & Ylikulppi 2000, Pitkälä et al. 2004a.) The cultural resources of older people are also closely tied up with their lived lives and the experience and wisdom they have accumulated over time (Pietilä & Tervo 1998, Koskinen 2007). Older people are carriers of culture and traditions, performing cultural tasks by handing down traditions to the next generation, leaving imprints of younger people (Koskinen 2004, 2007). It has been found that cultural experiences such as those gained through music, dance, literature and art are important sources of strength and comfort as well as greater self-esteem through a sense of self-recognition and being heard, and feelings of competence and independence. At the same time, these experiences help to alleviate the sense of isolation and loneliness. (Bryant et al. 2001, Hays & Minichello 2005, Forssén & Carlstedt 2006, Forssén 2007, Koskinen et al. 2007, Savikko 2008, Routasalo et al. 2009.)

3.2 Multi-professional collaboration in home care

3.2.1 The concept of multi-professional collaboration

Multi-professional collaboration is an integral part of social and health care. It began to attract increasing interest in the 1970s and 1980s with the recognition that no one person can have the skills and/or the knowledge to deliver high quality care (Barr et al. 1999, Barton & Mulley 2003, Leathard 2003). In the 1990s, social and health care professionals began to work more and more closely together in the context of community-based care and home care (Brown et al. 2003, King & Ross 2003, Leathard 2003, Rummery & Coleman 2003).

Both elements in the concept of multi-professional collaboration are multifaceted and multidimensional (Isoherranen 2005). ‘Multi-professional’ emphasises the aspect of expertise. It implies the bringing together of expertise from many different fields and a crossing of boundaries between those fields. All experts have their own areas of expertise, and in their collaboration those different skills and knowledges are brought together to the benefit of the common good. (Housley 2003.) Multi-professional collaboration is considered to generate a new kind of expertise that cuts across professional and organisational boundaries (Saaren-Seppälä 2004).

‘Collaboration’, then, has crucial part to play in how multi-professional expertise is deployed and developed (Karila & Nummenmaa 2001). This is again a complex concept that has escaped precise definition (Henneman et al. 1995). In dictionaries, ‘collaboration’ is defined as ‘the act of working with another or others on a joint project’ (MOT Collins English Dictionary 2000, Oxford English Dictionary 2008). Roshelle and Teasley (1995, 70) define collaboration as a ‘coordinated, synchronous activity that is the result of a continued attempt to construct and maintain a shared conception of a problem’. It is a process in which professionals exchange information, weigh alternative courses of action and share resources. Collaboration is based on a sharing of power and responsibility in which the aim is to exchange information on a reciprocal and equitable basis and to increase knowledge, understanding and skills. (Walsh et al. 1999, Einbinder et al. 2000, Hubbard & Themessl-Huber 2005.)

‘Multi-professional collaboration’ brings together a range of people from different specialisms and with different areas of expertise to work towards a common objective. By pooling their resources they can achieve something they could not achieve on their own. (Housley 2003.) There exists no clear and universally accepted definition for multi-professional collaboration, and there are numerous related concepts in use, including inter-professional, interdisciplinary, multidisciplinary, team working, cross-boundary working, partnership working, interaction and joint working (e.g. Payne 2000, Farrell et al. 2001, Scholes & Vaughan 2002, Webster 2002, Leathard 2003, Hubbard & Themessl-Huber 2005, Atwal & Caldwell 2005, Nolan & Hewison 2008). ‘Multi-professional collaboration’ is a key term that refers to the interaction between the professionals involved, albeit from different backgrounds, but who have the same joint goals in working together (Leathard 2003). Multi-professional collaboration is about creating a new way of working. Recognition of the core areas of expertise of each profession and the blending of core skills is necessary to enable the team to act as an integrated whole and to share responsibilities. This will help to achieve a client-centred approach where all professionals and clients are listened to and involved in decision-making. (Freeman et al. 2000, Wilson & Pirrie 2000, Leathard 2003, Hubbard & Themessl-Huber 2005.)

In the social and health care context, ‘multi-professional collaboration’ is described as the joint process of communication and decision-making with the express goal of satisfying the client’s wellness and illness needs while respecting the unique qualities and abilities of each professional (Henneman et al. 1995, Nolan & Nolan 1998, Housley 2003). Through their collaboration experts also work to develop, complement and expand upon their own expertise. Multi-professional collaboration can be exercised in very different kinds of settings, such as administrative planning or the day-to-day care of clients. This implies a focus on the client’s own needs and resources and putting the client at the very centre of collaboration. (Scholes & Vaughan 2002, Leathard 2003, Isoherranen 2005, Hokkanen et al. 2006, Vaarama & Pieper 2006, Salmelainen 2008.)

In this study, multi-professional collaboration is defined as the collaboration of social and health care professionals in the home care context. In this collaboration professionals from different educational backgrounds coordinate their expertise in providing care for their shared older clients, pursuing the same joint goals and working alongside the older client.

3.2.2 The client at the centre of multi-professional collaboration

The aim of home care collaboration is to organise, coordinate and manage care provision so that the care and services offered to the client are integrated in a way that benefits the client the most (Parkinson 2004, Hammar 2008). In the Finnish home care system, social and health care services work together to prepare a care and service plan for each client, which specifies the needs for care and services, the targets and the means of reaching them (the Act on the Status and Rights of the Social Welfare Client 812/2000). The need for care and services is assessed as extensively as possible, taking account of the various aspects of functional capacity, the elderly client’s life situation and personal resources as well as the day-to-day living environment. In the assessment of needs for care it is important to consider the remaining resources of older clients and any shortcomings that should be specifically addressed in designing home care and services. (Koponen 2003, Vaarama 2006.) It has been found that the absence of a shared view on the client’s need for care and services tends to hamper efforts at appropriate care provision (Adamsen & Tewes 2000, Lasalvia et al. 2000, Attree 2001, Hallström & Elander 2001, Reed et al. 2002, Ala-Nikkola 2003, Tenkanen 2003, Muurinen & Raatikainen 2005, Hammar 2008). However, older clients are themselves the best qualified experts to give a longitudinal view of their health status and their health and social care needs (Themessl-Huber et al. 2007). In addition, the closest relatives of clients play a major role in supporting living at home, and therefore it is necessary to listen to what they have to say as well (Janlöv et al. 2005, Büscher 2007, Salin 2008). In short, the views of both clients, their closest relatives and professionals must be taken into account when planning care and services (Hancock et al. 2003, Cameron et al. 2007, Hammar 2008).

It has proved difficult for older clients to weigh the benefits they gain from the collaboration of social and health care services (Brown et al. 2003, Andersson et al. 2004, Paljärvi et al. 2003). A comparative study by Brown et al. (2003) looked at older clients whose care was provided via integrated health and social services and those who had care delivered in the traditional way. They found no major differences between these two groups in relation to their satisfaction with the services they received. The clients had little interest in who delivered their services, so long as they received what they felt they were entitled to or needed to support them. However, recent studies have found that clients are satisfied with the service they receive from multi-professional teams, particularly with the emotional aspect of care (Ljungberg et al. 2001, Beech et al. 2004, Hek et al. 2004, Lincoln et al. 2004). There is only little reliable evidence on the impacts of collaborative interventions on outcomes of care (e.g. Cochrane library), although mostly those outcomes have been positive (Schmitt 2001). Collaboration has been found to improve independence, health status, well-being, quality of life and older client's independent management at home (Bernabei et al. 1998, Sommers et al. 2000, Elkan et al. 2001, Schmitt 2001, Kinnunen 2002, Cheung & Ngan 2005, Markle-Reid et al. 2006, Vaarama 2006, Mitton et al. 2007, Joubert et al. 2008, Melis et al. 2008, Toljamo et al. 2008). Collaboration could improve standards of care by reducing duplication and gaps in service provision and by enabling better continuity and consistency of care. Seamless collaboration provides a safe nexus for the exchange of knowledge and opinions and a framework for reaching consensus about appropriate care delivery for a particular client or client cohort. (Miller et al. 2001, Koponen 2003, Leathard 2003, Tepponen 2003, Andersson et al. 2004, Perälä et al. 2006, Valvanne 2006, Santana et al. 2007, Salmelainen 2008, Xyrichis & Lowton 2008, Tepponen 2009.) It enables the provision of quality care, thus avoiding unnecessary admissions of clients to hospital or long-term care (Hughes et al. 2000, Sommers et al. 2000, Elkan et al. 2001, Landi et al. 2001, Reech et al. 2004, Toljamo et al. 2008).

3.2.3 Factors influencing the maintenance of multi-professional collaboration

Factors influencing the maintenance of social and health care collaboration can be grouped into two categories, i.e. factors related to professionals and factors related to the organisation (Brown et al. 2003, Rummery & Coleman 2003, Lim 2008, Xyrichis & Lowton 2008). Seamless collaboration requires shared power and commitment (Rummery & Coleman 2003, Valvanne 2006, Bélanger & Rodriguez 2008, Xyrichis and Lowton 2008), mutual respect and trust for all the professionals involved, and the ascribing of equal value to their role and contribution to current collaborative practices (Freeman et al. 2000, Cook 2001, King & Ross 2003, Rummery & Coleman 2003, Steward et al. 2003, Hek et al. 2004, Hubbard & Themessl-Huber 2005, Büscher 2007, Hills et al. 2007, Bélanger & Rodriguez 2008, Huxley et al. 2008, Lim 2008). A positive interpersonal relationship helps to create an inspiring work environment for professionals,

and a climate of mutual respect and trust is fundamental to effective teamwork (Cook et al. 2001, Cashman et al. 2004, Dieleman et al. 2004, Hek et al. 2004). If trust and enthusiasm for collaborative working arrangements are to be maintained, then one side will not be able to completely take over the process; it has to be a joint activity in which both sides stand to benefit (Rummery & Coleman 2003).

Regular meetings with a shared vision and clear goals impact the levels of teamwork that are obtainable within a team and consequently the team's overall effectiveness (Poulton & West 1999, Freeman et al. 2000, Cook et al. 2001, Enderby 2002, Rummery & Coleman 2003, Valvanne 2006, Bélanger & Rodriguez 2008, Xyrichis & Lowton 2008). Ideally, a group of professionals will meet regularly and have open and collegial communication about each client, exchanging information, analysing the client's social and health care needs, developing a treatment plan and collaborating in its implementation (Freeman et al. 2000, Farrell et al. 2001, Steward et al. 2003, Hubbard & Themessl-Huber 2005, Valvanne 2006, Mahmood-Yousuf et al. 2008, Xyrichis & Lowton 2008). This can only be achieved when each professional within the group understands why and how they are doing what they are. Such an approach places the client at the centre of practice initiatives, and may usurp the traditional power bases and hierarchies of knowledge that exist within the current system. (Borrill et al. 2001, Scholes & Vaughan 2002.)

Organisational support for professionals predicts overall team effectiveness and is powerfully related to the quality of collaborative working (Poulton & West 1999, Borrill et al. 2000, San-Martin-Rodriguez et al. 2005, Bélanger & Rodriguez 2008, Xyrichis & Lowton 2008). Organisational support includes the ways that organisations allocate human and material resources and assign work that either supports or inhibits collaboration (Valvanne 2006, Bélanger & Rodriguez 2008, Lim 2008). Collaboration is possible on the condition that enough time is allowed for it and that this has been taken into account in the job assignments of the people involved (Nummenmaa et al. 2006, Valvanne 2006, Bélanger & Rodriguez 2008, Lim 2008). Effective collaboration is supported by shared work premises (Cook et al. 2001, Davey et al. 2005, Hubbard & Themessl-Huber 2005, Xyrichis & Lowton 2008), team composition and size (Perälä et al. 2006, Xyrichis & Lowton 2008), procedures and a coherent work culture (Enderby 2002, Reilly et al. 2003, Stewart et al. 2003, Hills et al. 2007, Nummenmaa et al. 2007, Bélanger & Rodriguez 2008) and clients' records and communication systems (Hubbard & Themessl-Huber 2005, Bélanger & Rodriguez 2008, Lim 2008), good leadership and management systems (Enderby 2002, Steward et al. 2003, Hubbard & Themessl-Huber 2005, Nummenmaa et al. 2007, Lim 2008, Tepponen 2009) and multi-professional training (Freeman et al. 2000, Paukkunen et al. 2001, Allan et al. 2005, Valvanne 2006, Huxley et al. 2008). It has been found that home care is still a highly constrained and regulated service in which professionals have to walk a tightrope between the organisation's norms,

savings and client's own wishes (Andersson et al. 2004). The main factors enhancing the maintenance of collaboration are described in Table 4.

Table 4. Main factors enhancing the maintenance of multi-professional collaboration

Factors related to	Author and year
Professionals	
Role understanding and valuing	Freeman et al. 2000, Cook et al. 2001, King & Ross 2003, Rummery & Coleman 2003, Sholes & Vaughan 2002, Stewart et al. 2003, Hek et al. 2004, Hubbard & Themessl-Huber 2005, Hills et al. 2007, Bélanger & Rodriguez 2008, Huxley et al. 2008, Lim 2008
Shared vision, clear goals and commitment	Poulton & West 1999, Freeman et al. 2000, Cook et al. 2001, Enderby 2002, Sholes & Vaughan 2002, Rummery & Coleman 2003, Valvanne 2006, Cameron et al. 2007, Bélanger & Rodriguez 2008, Xyrichis & Lowton 2008
Open communication	Freeman et al. 2000, Sholes & Vaughan 2002, Stewart et al. 2003, Hubbard & Themessl-Huber 2005, Valvanne 2006, Mahmood-Yousuf et al. 2008, Xyrichis & Lowton 2008
Organisation	
Adequate human and material resources	Cook et al. 2001, Davey et al. 2005, Hubbard & Themessl-Huber 2005, Valvanne 2006, Bélanger & Rodriguez 2008, Lim 2008, Xyrichis & Lowton 2008
Shared procedures and coherent work culture	Enderby 2002, Reilly et al. 2003, Stewart et al. 2003, Perälä et al. 2006, Hills et al. 2007, Bélanger & Rodriguez 2008
Shared records and communication systems	Hubbard & Themessl-Huber 2005, Bélanger & Rodriguez 2008, Lim 2008
Effective leadership and management systems	Enderby 2002, Stewart et al. 2003, Hubbard & Themessl-Huber 2005, Lim 2008, Tepponen 2009
Multi-professional training	Freeman et al. 2000, Allan et al. 2005, Valvanne 2006, Huxley et al. 2008

Regardless of the country, system or setting, there is evidence that collaboration always is complex. It is fraught with problems such as communication difficulties, incompatibilities between different theoretical and knowledge bases, and professional hierarchies, most particularly the dominance of the medical profession (Freeman et al. 2000, Schmitt 2001, Brown et al. 2002, Scholes & Vaughan 2002, Glendinning 2003, Glendinning & Rummery 2003, Hubbard & Themessl-Huber 2005, Davey et al. 2005, Valvanne 2006, Nolan & Nolan 2008, Salmelainen 2008). The lack of understanding of one another's roles and contributions, responsibilities and tasks as well as the absence of clear goals are thought to contribute to the appearance of such conflicts (Payne 2000). A collaborative approach to care delivery requires a fundamental change in ways of thinking (Bull & Roberts 2004, Hubbard & Themessl-Huber 2005), and this change is a slow process to which there are no shortcuts. The necessary changes to working culture and underlying attitudes will take even longer to complete (Brown et al. 2003, Hubbard & Themessl-Huber 2005, Vaarama 2006).

3.3 Summary

Older people's resources have received increasing research attention in recent decades, in large part as a result of the growing influence of the modern view on ageing. Previous studies have shown that personal and environmental resources are important for the independence of older people. Personal resources derive from experiences of health,

a sense of coherence and a positive outlook. Environmental resources derive from the domestic, social and cultural environment. It has been considered important that research can demonstrate what these resources of older people actually are. This will allow social and health care staff to take the best possible advantage of these resources and to encourage older people to apply them in their everyday life.

Multi-professional collaboration is generally seen as an effective means of delivering care to older home care clients. Factors that influence the maintenance of multi-professional collaboration can be categorised into two main groups, viz. organisational and professional factors. In practice, however, given the different kinds of management structures and cultures involved, it is extremely difficult to get social and health care professionals to work together as effectively as possible. Nonetheless, despite these difficulties, collaborative care provision is still a very promising way forward when seeking to meet the challenges of an ageing society.

4 AIMS OF THE STUDY

The purpose of this study is to explore ways of supporting older clients' independent living at home through multi-professional social and health care collaboration. Its aims are (1) to increase knowledge and understanding of older clients' own resources that support their independent living at home and (2) to investigate how home care is actually delivered through multi-professional social and health care collaboration.

More specifically, the tasks addressed in this research were as follows:

1. To describe the resources of older clients that support their independent living at home and to identify factors that enhance and threaten those resources (Papers I, IV).
2. To describe, explore and compare older clients' and professionals' perceptions of the collaborative approach to care delivery with a view to supporting client's independent living (Papers II, III, IV, V).
3. To explore and compare older clients' and professionals' perceptions of the collaborative approach to care delivery (Papers IV, V).

5 MATERIAL AND METHODS

5.1 Methodological approach

This descriptive and comparative cross-sectional study is concerned with how multi-professional social and health care collaboration can help older clients manage independently at home. The research was carried out in three successive phases between 2006 and 2009 among older clients and their professional carers, i.e. HSWs, HHNs and physicians (Figure 1).

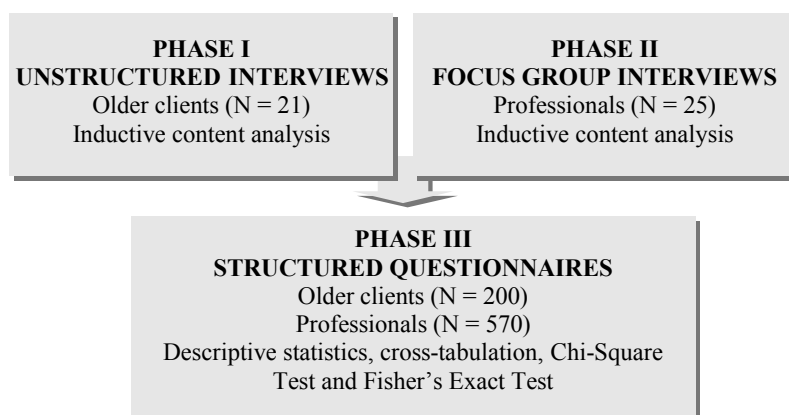


Figure 1. The study design

In **Phase I**, the main aim was to describe the resources of older clients and factors that enhance and threaten those resources. In addition, the aim was to describe clients' own experiences of how the collaborative approach to care delivery supported their independent living (sub-aims 1, 2, Papers I, II).

In **Phase II**, the main aim was to describe professionals' experiences of how the collaborative approach supported client's independent living (sub-aim 2, Paper III). The questionnaire for Phase III was developed on the basis of the interview results in the first and second phases.

In **Phase III**, the main aim was to establish whether the trends emerging from the interview data can be found in a larger sample. In addition, new research tasks were addressed in this, the last phase of the study (sub-aims 1, 2, 3, Papers IV, V).

5.2 Setting and sampling

The older clients (aged 65 or over) and their professional carers were recruited from one home care district in an urban region of southwestern Finland in all phases of the study.

In **Phase I**, the participants consisted of 21 regular clients of home care services. They were recruited by convenience sampling from among people who were assumed to have significant information about the field under investigation (Miles & Huberman 2001). The following selection criteria were applied: voluntary participation, ability to discuss everyday matters in a coherent way, and oriented in place and time. The participants' mean age was 83.5 years, ranging from 75 to 91. Four of the participants were male and 17 female. Three of them lived together with a spouse and the rest lived on their own (Papers I, II).

In **Phase II**, the participants consisted of 25 home care professionals on social and health care teams: 13 HSWs (home aides and practical or assistant nurses), 11 HHNs (public health nurses or registered nurses) and one physician. Convenience sampling was used since this method is appropriate for reaching informants with specific knowledge of interest (Miles & Huberman 2001). The following selection criteria were applied: voluntary participation, in full-time employment and experience of working as a member of a team. The participants' mean age was 43 years, ranging from 27 to 56, with 24 female and one male participant. Their mean experience of working in elderly care was 11 years, ranging from 2 to 26 (Paper III).

In **Phase III**, the participants consisted of a random sample of 200 out of the total of 1,885 clients receiving home care in 2007. Systematic sampling was used and the questionnaire was mailed to one-tenth of the clients receiving regular home care (Burns & Grove 2005). The sample size was determined on the basis of a power calculation using NCSS/PASS 2004 software (NCSS, Kaysville Utah, USA). A reminder was sent to all non-respondents after one month. A total of 120 clients returned the completed questionnaire, giving a response rate of 60%.

All professionals involved in the study (N=570) received a corresponding questionnaire. A reminder was e-mailed to all participating groups after one month. A total of 370 professionals (65%) returned the completed questionnaire: 308 of the 485 HSWs (63%), 60 of the 81 HHNs (74%), and 2 of the 4 physicians (50%). Table 1 in Paper IV shows the demographic details of the respondents. The demographic data for all respondents in different phases of the study are summarised in Table 5.

5.3 Data collection

In **Phase I**, the data were collected in unstructured interviews (Seidman 1998) with 21 clients. Home service personnel served as contact persons. The researcher informed them personally and by letter about the practical aspects of the study (Appendix 3). First, the participants were approached with a covering letter, delivered by home service personnel to those who met the inclusion criteria and who were willing to participate and to share their experiences. The covering letter explained the aims of the study and how it

Table 5. Demographic data for all respondents in different phases of the study

	Phase I	Phase II	Phase III
Clients (n)	21		120
<i>Gender</i>			
Female	17		99
Male	4		20
<i>Age (yrs)</i>			
Mean	83.5		84
Range	75-91		67-96
<i>Education</i>			
Primary or less			97
Secondary or more			21
<i>Living</i>			
Alone	18		108
With spouse or someone else	3		10
<i>Need for daily help</i>			
Yes			81
<i>Able to go outdoor daily</i>			
Yes			53
<i>Able to walk a minimum of 0.5 kilometres</i>			
Yes			31
Professionals (n)		25	370
<i>Gender</i>			
Female		24	363
Male		1	7
<i>Age (yrs)</i>			
Mean		43	45
Range		27-56	17-64
<i>Education</i>			
Home aide		5	98
Practical nurse		6	164
Registered nurse		10	35
Physician		1	2
Other		3	69
<i>Workplace</i>			
Social Services Department		13	303
Health Department		12	62
<i>Work experience in elderly care (yrs)</i>			
Mean		11	14
Range		2-26	0.5-34

would be conducted. The participants were also told where they could get any additional information they needed (Appendix 3). Voluntary and willing participants returned the signed covering letters along with their contact information to the researcher via the home service personnel. The researcher then contacted the subjects by telephone and arranged to interview them in their homes.

In **Phase II**, the data were collected in focus group interviews with 25 home care professionals on social and health care teams: 13 HSWs (home aides and practical or assistant nurses), 11 HHNs (public health nurses, registered nurses and specialised nurses) and one physician (Kitzinger 1995, Taylor & Bogdan 1998). The participants were recruited by the head nurses from home help and home health care service. The researcher informed them personally about the practical aspects of the study. First, the participants were approached with a covering letter delivered by the contact nurses which

explained the aims of the study and its method (Appendix 3). Voluntary participants returned the signed covering letters along with their contact information to the researcher by mail. The subjects were then contacted by telephone and group interviews were arranged during working hours in the participants' workplace. Five focus groups were formed to discuss the participants' experiences. The focus groups ranged in size from four to six participants (Table 6).

Table 6. The focus groups participants

	Home service workers (n)	Home health care nurses (n)	Physicians (n)	Total (N)
Group 1	3	2		5
Group 2	5	1		6
Group 3	1	5		6
Group 4	1	2	1	4
Group 5	3	1		4
Total (N)	13	11	1	25

In **Phase III**, the data were collected by structured postal questionnaires (Papers IV, V). The questionnaires were specially developed for this study on the basis of the interviews (clients $n = 21$, professionals $n = 25$) conducted for this survey (Papers I, II, III) as well as the findings of earlier studies (Tilvis et al. 2000, Pitkälä et al. 2001, 2004, Muurinen 2003, Routasalo et al. 2004a, Muurinen & Raatikainen 2005, de Witte et al. 2006).

The questionnaires (Appendix 4) covered three domains: 1) background factors, 2) perceptions of the care provided by professional carers and 3) questions about clients' psychological well-being. The questionnaires for clients and professionals only differed in their background items, and additional questions were included for professionals to ask about their views on the coordination of care (Table 7.). Responses were obtained on a five-point Likert scale from well (5) to not so well (1) and fully agree (5) to fully disagree (1). Number 0 represented the choice "not applicable" in the clients' questionnaire and "don't know" in the professionals' questionnaire.

Table 7. Questionnaire domains and items (see also Appendix 4)

Domain	Variables	Item numbers in clients' questionnaire	Item numbers in staff questionnaire
1) Background factors		1-8	1-5
2) Care provided by professionals carers	Clients' resources	9-17	6-14
	Collaborative relationship	18-26	15-23
	Coordination of care		24-30
	Motivating independent actions	27-30	31-34
	Physical care	31-47	35-51
	Psychological care	48-54	52-58
	Social care	55-64	59-68
3) Psychological well-being	Psychological well-being	65-70	69-74

5.4 Data analysis

The data from the unstructured and focus group interviews were analysed using the methods of qualitative inductive content analysis (Sandelowski 2000). The analysis was initiated while data collection was still underway. A sentence or part of a sentence containing a term or phrase central to the research problem was chosen as the unit of analysis. The inductive content analysis was carried out step by step as the data were conceptualised (Cavanagh 2000, Burns & Grove 2005). First, the transcripts and field notes of the focus groups were read several times in order to achieve data immersion. Second, the statements relevant to the research tasks were identified, marked, and clustered into groups. Finally, the clusters were named on the basis of the content. The richness of qualitative data lies in the raw data, and that is why the researcher went back to the raw data in the last phase of the analysis to ascertain overall accuracy.

The survey data were analysed using descriptive statistics based on frequencies and percentages. The differences between the clients and the professionals were determined with cross-tabulation, Pearson Chi-Square Test and Fisher's Exact Test (when the assumptions of the Chi-Square Test were not met). (Polit & Beck 2004, Burns & Grove 2005.) Differences between clients' and professionals' background factors and study variables were examined with one-way analysis of variance when the background factors were dichotomous. One-way analysis of variance (ANOVA, *post hoc* comparisons with Tukey's HSD test) was also used for variables with more than two categories. Correlations between continuous background factors and study variables were examined with Spearman's correlation coefficient. Because there were no statistically significant differences between clients' and professionals' background factors in relation to the study variables, these groups were combined. The options "not applicable" and "don't know" were excluded before the analysis. The analyses are based on a two-point scale. Statistical analysis was performed using SPSS® 15.0 software (SPSS In., Chicago, IL, USA), and statistical significance was set at p -values ≤ 0.05 (Polit & Beck 2004, Burns & Grove 2005).

5.5 Ethical considerations

This research adhered to the general principles of research ethics. The participants' human rights, autonomy, anonymity and confidentiality were respected throughout the research process. The participants were treated in such a way that they could decide for themselves whether or not to participate in the study. (World Medical Association Declaration of Helsinki 2000, ETENE 2001, Burns & Grove 2005.) Approval for the research protocol was obtained directly from the social welfare and health care organisations concerned.

In the unstructured and focus group interviews, the participants were informed both orally and in writing that participation was voluntary and that they had the right to withdraw

at any time. Written informed consent was obtained from all participants, and all information was treated confidentially. At the beginning of the interviews the researcher once more explained to the interviewees the aims of the study, that their participation was voluntary and that they could withdraw from the study at any time. To the clients, it was made clear that their decision on whether or not to participate would have no effect on their care. The researcher interviewed the participants personally and also transcribed all the interviews. The data have not been made available to anyone else.

In the questionnaires, covering letters were attached in which the participants were informed about the purpose of the study and the principles of anonymity, confidentiality and voluntary participation. The letters included the researcher's contact information and the supervisor's names and affiliation. The participants were asked to return the questionnaire without any identifying information. The data analysed contained no information through which the respondents could have been identified. The questionnaires were mailed directly to the researcher, who opened the envelopes. All questionnaires will be destroyed once the study has been completed.

6 RESULTS

This chapter presents the results of the study. Only the main findings according to the research tasks are introduced while the more detailed results are presented in the original papers I-V.

6.1 Older clients' resources and factors that enhance and threaten their resources

Older clients' resources

The clients' resources consisted of *a sense of control over one's life* and *a determination to remain active* (Paper I). Sense of control over one's life as a resource was manifested in the clients' desire to remain in their own homes and in their ability to influence the course of their own lives. It was important for them to be able to make decisions about their own lives without being influenced by outsiders.

The determination to remain active was manifested in the way that the clients went about their everyday activities. They wanted to and strove to do everything they still were able to do on their own: they would not give in and not accept help with their everyday tasks until they had exhausted their own resources. Activity provided a source of meaning and purpose for their lives, and idleness was frowned upon.

Factors enhancing resources

Factors enhancing clients' resources were their involvement in *leisure activities* and *social networks* (Paper I). The clients continued to engage in many leisure activities and hobbies. At home, they read books, listened to music, did crossword puzzles and needlework, and had pottery projects. Outside the home, they engaged in various outdoor activities and visited the gym. Outdoor activities were particularly important to the clients, and they also very much enjoyed the supervised gym sessions arranged by HC professionals. Some of them were no longer able independently to participate in activities outside their homes unless transport was provided by HC professionals or relatives.

The clients' social networks consisted of close relatives, friends and HC professionals. The support provided by the social network was manifested in emotional and practical support. Support by close relatives, such as the spouse, children and grandchildren, consisted typically of caring and caretaking. Close relatives were also described as a source of meaning in life. They also provided practical help in managing with everyday situations, such as finances, doing the shopping and preparing food. Some clients received visits from close relatives far less often or had no surviving close relatives at all. In these cases social contacts with friends and HC professionals were essential. The clients said they needed a listener and someone to talk to. Regular visits by professionals served to enhance the clients' feeling of safety and cheered them up.

Factors threatening resources

Factors threatening clients' resources included *the conditions imposed on their everyday life by outsiders, declining health and loneliness* (Paper I). Conditions imposed by outsiders included the care-related actions and decisions taken by professionals in lieu of their clients. For example, the professionals were known to perform basic care tasks on behalf of the clients, even though they could have coped, at least to some extent, on their own. Furthermore, HC personnel sometimes completely ignored the expectations and opinions of their clients. In addition, the clients said they were visited by several different professionals during any given week, and they never knew at what time of the day they would arrive. This limited the clients' lives to such an extent that they did not always dare to make any other arrangements for that day.

Declining health threatening the clients' own resources and 68% of the clients, felt themselves sick (Papers I, IV). The analysis of the clients' interviews showed that changes in health condition were manifested in reduced mobility and increased infirmity following hospital care. Mobility problems made it harder for the clients to take part in leisure activities and social events and even forced them to give them up. The clients preferred to stay at home rather than go somewhere where they might inconvenience other people. They described the period of recovery following hospital care as one when their strength was considerably diminished for a long time. Some said they had never managed to restore their former strength.

Loneliness also threatening the clients' own resources and 54% of the clients suffered from loneliness at least sometimes (Papers I, IV). The analysis of the clients' interviews showed that experiences of loneliness were related to the passing away of a person close to oneself and to not having anyone to converse with. The clients explained how they had managed well until the death of a close person, such as a spouse or a child, but this had caused a sense of intense loneliness and a feeling that one's own life was entirely worthless. Another cause of loneliness was not having anyone to talk to. The clients longed for someone with whom they could talk about what had happened during the day, for instance. The need to share one's thoughts and the longing for company were at their most intense in the evenings and during weekends. (Figure 1 in Paper I). In addition, 62% of the clients felt depressed. However, the professionals indicated significantly more often than the clients that their clients felt depressed ($p = 0.006$) and suffered from loneliness ($p < 0.001$) (Table 2 in Paper IV).

6.2 The collaborative approach to care delivery with a view to supporting clients' independent living

The analysis of the clients' interviews showed that the collaborative approach to care delivery consisted of four perspectives: *expertise, communication, decision-making* and

responsibility (Paper II). Collaboration was based on the expertise of three groups of professionals: HSWs, HHNs and physicians, whose approach was expert-driven. The HSWs were seen as being responsible for cleaning and assisting with errands such as doing the shopping. They helped with personal hygiene and medication. The HHNs mainly saw to the safe administration of medication. They followed-up on the clients' health by asking how they felt and by measuring their blood pressure, weight and blood sugar, for instance. The physician was in charge of treating ailments and related medication. She/he would arrange additional examinations at the hospital when necessary.

Communication between HSWs and HHNs involved weekly meetings where they shared information concerning the care of their clients. None of the clients had knowledge about what was discussed at these meetings. Communication with the physician was normally conducted via the HHNs. If the clients had something they wanted to say to the physician, this was first disclosed to the HHN, who would then inform the physician. The physician would then give his/her reply to the HHN, who would again report it to the client. If the client wanted to talk with the physician directly, for instance about the treatment of an ailment, the HHN would make an appointment at the health centre. Some clients had never met the physician.

The client took active part in decision-making about his or her own care at the outset of HC, when the client, their closest relative, HSW and HHN were all present at the client's home. The clients and their relatives took part in decision-making concerning visiting frequencies and hours. They were not aware of any other decision-making situation involving all the professionals at the same time.

The clients linked responsibility with collaboration, but they were uncertain which of the professionals had overall responsibility for coordination. The clients did not know which professional they were supposed to turn to when they were unsure about something or when they needed assistance.

Professionals provided *physical*, *psychological* and *social* support to their clients (Paper II). Physical support included motivation to take independent action, recognizing the clients' resources and supporting their mobility. Motivation to independent action included encouragement by the HSWs to dress without help and positive feedback for successful efforts. The HSWs used observation to determine the clients' resources in everyday activities. Problems arose when new workers who were not yet familiar with the clients failed to recognize their resources. Supporting mobility included outdoor activities and supervised exercises at the gym. The HSWs assisted clients' functioning by taking regular walks with them. Some clients were unable to move outside the home without such support. The professionals informed the interviewees about and encouraged them to participate in supervised gym exercises. The practical arrangements were made

by professionals, who enrolled those who were willing to participate and arranged for taxi transportation, for instance.

Psychological support included efforts to create and increase a sense of trust and security. The availability of HC service and regular health checks increased the clients' sense of security. However, the professionals involved in collaboration were constantly changing and they worked under constant time pressure, which meant they did not have enough time to listen to or talk with the clients.

Social support meant encouragement to engage in leisure activities and to meet other people. The professionals told the clients about various leisure activities and encouraged them to participate in events outside the home, such as groups and field trips for older people. One of the clients said that the group meeting he had been encouraged to attend had become the highlight of his week (Figure 1 in Paper II). However, the clients (49% disagree) and the professionals (41% disagree) were somewhat critical about the staff's knowledge of clients' leisure activities and other interests (Table 1 in Paper V).

Analysis of the professionals' interviews indicated that the collaborative approach to care delivery consisted of three perspectives: *collegial consensus*, *a consistent approach to client care* and *sharing of information* (Paper III). Although professionals held strong beliefs about the importance of collegial consensus on client intervention and health care management, translating that belief into clinical practice at times proved problematic. Difficulties surfaced in one main area, i.e. conflict resolution. Each professional group considered the client's situation from the vantage-point of its own educational background. They were keen to follow their own preferred course of action, and sometimes it was difficult to reach consensus on the client's overall situation. Differing opinions caused some tension between the professional groups, as well as competition as to who was in the right.

A consistent approach in working for the client was reflected in the agreement about and commitment to working in the same way to support the client's independent living and own resources. The professionals described the client's resources as "*the client's ability to manage everyday activities*". They had decided, for example, that they would not perform daily functions with which the clients could cope independently. The professionals found that motivation was important to encouraging clients to maintain their independence in activities of daily living. There was a shared goal that '*the clients can live at home for as long as possible*', but the goal for the individual client's care was not elaborated.

In the questionnaire, clients and professionals differed widely in their assessment of whether professionals took into consideration the clients' abilities (clients (C) 33%, professionals (P) 75%, $p < 0.001$). In addition, clients (36% disagree) were more critical than professionals

(14% disagree) about how the staff assess the client's performance of daily functions ($p < 0.001$). Clients also were more critical than professionals in their assessments of staff efforts to motivate them to independent action and to provide positive feedback when they were successful in independently performing activities of daily living ($p < 0.001$). In respect of motivating clients when they were able to perform independent actions, the majority in both groups were satisfied, however, the percentage difference was considerable ($C = 52\%$, $P = 79\%$, $p < 0.001$) (Table 3 in Paper IV). The analysis of the professionals' interviews showed that this consistent approach to client care was impeded at times, though, by the professionals' attitudes and behaviours (Paper III).

The sharing of information emerged as a hierarchical structure of information collection, in which the information was passed on by formal and informal methods. The professionals described a hierarchical structure of information collection, with the information sharing being primarily a bottom-up, from the HSW to the HHN and to the physician with little, if any, lateral-mutual decision-making about client management. The physician rarely met the clients, but the information usually reached the physician through the HHN who represented the clients and the HSWs. Consequently, HSWs felt that they did not always receive enough information about the medical and nursing care situation of the client.

Formal information was passed on in weekly meetings and by telephone. In weekly meetings, the HHNs and the HSWs shared information about clients' health status and ability to continue living at home. Telephone consultations were arranged to address everyday concerns and problems. However, the absence of formal documentation of a client's health status was a concern expressed by professionals. Moreover, the lack of formal documentation of a client's health status and a common patient information system hindered use of current client information. The informal information was passed on via notebooks kept at each client's home. Notebooks were used to record and share information about changes in health status and interventions performed by professionals. The HSWs had a pivotal role in assessing clients' day-to-day health status as they spent more time at a client's home observing daily activity management. During a short visit, a nurse and a physician saw a client's situation in connection with treatments, such as nursing a leg sore, so they relied on the notebook.

In the questionnaire survey, both groups ($C = 34\%$, $P = 44\%$ disagree) were somewhat critical about whether all staff are continuously aware of the client's health condition and his/her needs for care. Professionals (53%) were more critical than clients (39%) in their assessment of whether all staff are informed without delay about changes in the client's health condition and in his/her need for care ($p = 0.008$). On the other hand, clients were more critical than professionals in their assessment of whether staff talk enough with the client ($p = 0.001$) and their closest relatives about their needs for care ($p < 0.001$). Furthermore, 71% of the professionals believed that the staff ensure that the clients'

closest relatives are adequately informed about changes in their health condition and in their need for care without delay, whereas among clients only 55% shared this opinion ($p = 0.002$) (Table 2 in Paper V).

6.3 The collaborative approach to care delivery

Physical care

There were statistically significant differences between the two groups in their overall assessments of physical care, with clients showing a more critical attitude than professionals ($p \leq 0.003$). However, both groups were generally satisfied with the management of medication (C = 88%, P = 97%), personal hygiene (C = 77%, P = 95%) and health care (C = 69%, P = 93%), although clients were more critical than professionals ($p < 0.05$). Clients had significantly more criticisms than professionals about dental, hearing and eyesight care and the level of support for the client's movement outside the home ($p < 0.001$) (Table 4 in Paper IV).

Psychological care

Clients rated their psychological care significantly lower than did professionals ($p < 0.001$). The biggest differences between the two groups were found in relation to security (C = 56%, P = 89%, $p < 0.001$) and old time recollections (C = 39%, P = 72%, $p < 0.001$). The client group was also more critical than the professional group about determining the client's mood. In addition, only 28% of the clients thought that professionals were concerned about the client's feeling of loneliness, compared to 55% of the professionals ($p < 0.001$) (Table 5 in Paper IV).

Social care

Both groups identified problems in motivating clients' relatives to participate in their care (C = 44%, P = 58 %, $p = 0.029$). Clients were critical about the level of support provided by professionals in motivating them to engage in same age community groups and associated social activities outside the home. The professionals themselves did not feel there was any problem in these areas ($p < 0.001$) (Table 6 in Paper IV).

Coordination of care

In the area of coordination of care, about half (54%) of the professionals believed that they regularly assessed together how the client's goals have been achieved and the suitability of the nursing intervention. In addition, about half of the professionals (55%) felt that they together assessed their own efforts to support the client's functional capacity. 68% disagree that the staff have named a home care worker who coordinates their shared client's care (Table 3 in Paper V).

7 DISCUSSION

This section discusses the strengths and limitations of the study, its main results, conclusions, and presents suggestions for clinical practice and future research.

7.1 Strengths and limitations of the study

The most important criteria in assessing the strengths and limitations of a study are its validity and reliability (Polit & Beck 2004). Validity is a measure of the truthfulness and accuracy of the study in relation to the phenomenon of interest. Although validity can never be fully and exhaustively proved, it is always possible to support the extent to which the research measures what it is intended to measure. Reliability represents the consistency of information obtained in the study and is associated with the methods used to measure research variables. (Burns & Grove 2005.)

In the section below, the validity and reliability of the interview data are examined through the concept of trustworthiness (credibility, transferability, dependability, confirmability) (Polit & Beck 2004). The discussion then continues with an evaluation of the validity (internal and external validity) and reliability of the questionnaire survey (Burns & Grove 2005).

7.1.1 *Trustworthiness of interview data*

Trustworthiness in qualitative research refers to methodological soundness and adequacy (Strauss & Corbin 1998, Rolfe 2006). In this study trustworthiness was assessed in terms of credibility, transferability, dependability and confirmability (Holloway & Wheeler 2002, Polit & Beck 2004).

Credibility was enhanced by using data and method triangulation in order to gain a thorough picture of collaborative home care (Polit & Beck 2004). The results of the open interviews with clients (Papers I, II) and the focus group interviews with social and health care professionals (Paper III) revealed both complementary and concordant elements that strengthen the credibility of this research. An examination of the experiences of family members would have further enhanced credibility in that success in the home care of older people is often dependent on family members contributing to collaborative care. Confused and speech-impaired clients as well as those with dementia symptoms were also excluded from data collection, as their participation would have required collecting data from family members.

Credibility was also increased by conducting pilot interviews, both for the unstructured (n = 1) (Papers I, II) and for the focus group interviews (n = 1) (Paper III) (Polit & Beck 2004). The pilot interviews indicated that it was in fact quite easy for the informants

to discuss their experiences about the phenomenon under study. It is possible that an abstract concept such as ‘resource’ is too difficult for older people to understand. For purposes of data collection, therefore, the interviews were designed to resemble ordinary conversations, and instead of ‘resources’ the interviewer referred to the respondents’ ‘ability to perform daily tasks’. It may also be difficult for clients to describe care provision in terms of professional collaboration since at least part of that collaboration remains invisible to them. However the object in this research was to gain as genuine an account as possible of the collaboration that clients themselves see and experience in their homes. The purpose was to give older people a voice and to incorporate their perspective in the debate on collaborative social and health care provision.

Credibility was also enhanced by the researcher’s personal knowledge and experience of the context of the study and elderly nursing care: this experience was useful throughout the process, but particularly in interviewing the participants and in asking follow-up questions (Janlöv et al. 2005). On the other hand, this pre-understanding may also bias the research (Miles & Huberman 2001). Every effort was made to avoid this kind of bias by being aware of its threat and by keeping an open mind.

To ensure the credibility of both the unstructured (Papers I, II) and the focus group interview (Paper III) data, all the interviews were conducted by the researcher, who allowed sufficient time for the interviews so as to be able to build up trust with the informants. No more than two interviews were conducted per day in order to avoid interviewer fatigue. The unstructured interviews were conducted at the clients’ homes, and the researcher felt that she had the opportunity to properly familiarize herself with the client. Only one client wanted to have his spouse present during the interview, but the spouse remained passive throughout. A few client interviews had to be stopped because of a telephone call or a home visit by the client’s HCW, but they were soon resumed after the interruption. Since some of the interviewees were in poor health, it was important to take into account their limited resources. The group interviews were arranged during working hours in the participants’ workplace, and they proceeded without interruption. The focus groups consisted of natural heterogeneous work teams, since the purpose was to learn about the views of people who worked together in teams. One risk involved in this arrangement is the potential lack of trust among team members, which will adversely affect intragroup interaction (Kitzinger 1995). However there were no indications in this study of any such conflict factors, but the discussion flowed smoothly. Meeting the clients and the professionals more than once would have increased credibility, as the researcher would have been able to become more closely acquainted with the participants. Unfortunately, this was not possible for practical and economic reasons. However, the researcher felt that all the interviewees spoke openly, indicating that they felt comfortable and enjoyed talking about their experiences and valued the interest shown in their opinions.

Transferability refers essentially to the generalisability of the data, that is, the extent to which the findings can be transferred to other settings or groups (Polit & Beck 2004). In this study, the data were collected in an urban region which represents a typical setting for Finnish public home care. The city has a population of around 175,000, with 17% of the population aged 65 or over and 12% of the elderly population receiving regular public home care service in 2007. In Finland, responsibility for the provision of social and health care rests with the local authorities (the Primary Health Care Act 66/1972, the Act on the Status and Rights of the Social Welfare Client 812/2000). In 2000, 81% of all health care services delivered were provided by the public sector, 3% by non-governmental organisations and 16% by private companies (Salonen & Haverinen 2003); the figures for social services were 78%, 17% and 6%, respectively (Partanen 2002). The results must be viewed critically because the data for the study were collected from home care services in just one municipality, yet social and health care collaboration is quite common throughout the country.

One central transferability issue concerns the recruitment of informants (Morse 1991). The informants for the unstructured (Papers I, II) and focus group interviews (Paper III) were selected on the basis of a set of inclusion criteria. The original papers as well as the current synthesis describe the inclusion criteria as well as the background data of the participants in the study so that the reader can critically assess the transferability of the findings to other similar situations (Polit & Beck 2004). The number of informants was decided in advance, and the risk of selection was reduced by recruiting the informants from all four geographical areas in the municipality. The risk of selection bias was increased by allowing all the informants to make their own decision on whether or not to participate. The informants were motivated to participate in this study, and they described their experiences and views very well. However due to the small sample size the results cannot be generalised to represent the whole study population. On the other hand, the main purpose of this study was to gain in-depth information about the phenomena under investigation rather than to generalise the findings to a particular target population (Polit & Beck 2004, Burns & Grove 2005). However, the results are consistent with those of earlier studies and are therefore likely to have wider relevance.

The *dependability* of the results from both the unstructured (Papers I, II) and the focus group interviews (Paper III) are enhanced by the inclusion of a transparent description of the research strategies and the procedures of analysis (Polit & Beck 2004). The data were analysed carefully, not only by classifying the transcribed data but also by going back to the original data-gathering situation, re-listening to the interview tapes to make sure the voice of the informants was properly represented. It is possible that the researcher's experience of geriatric nursing care has influenced both the course of the interviews and the process of data analysis. This is typical of all qualitative research, but it is important above all that it is recognized (Polit & Beck 2004). To keep in check the influence of

the researcher's advance understanding and attitude, the progress of the analysis was constantly reviewed by a second researcher, who also critically examined the categories abstracted from the analyses (Cavanagh 1997). The keeping of a field diary also helped the researcher to reflect on her own action. Using a second researcher to categorise the data might have helped to increase the dependability of the study, but this was not possible for economic reasons. Letting the participants read and comment on the results would also have increased the dependability of the results. However, the results were affirmed through discussions with two other researchers and five experienced nurses in elderly care (Holloway & Wheeler 2002). Their experiences were very similar to those reflected in the results.

Confirmability was assured by documenting the procedures for checking and rechecking the data throughout the study. The associations between the data and the results are reported in the original papers (Papers I, II, III) so that the reader can follow the researcher's reasoning based on the authentic excerpts and the categories extracted from them (Polit & Beck 2004). In the process of analysis special care was taken not to let the researcher's personal views and experience affect either the analysis or the findings. The confirmability of the unstructured interview (Papers I, II) findings was discussed with five experienced nurses in older person care and the home care professionals who were working with the participants. The experienced nurses and the home care professionals recognized the results as manifested in the data analysis. The participants' experiences were very similar. The results of the focus group interviews (Paper III) were affirmed by observation of interactions between HSWs and HHNs in their weekly meetings (n = 4).

7.1.2 Validity and reliability related to the questionnaire survey

Internal validity

Internal validity refers to the degree to which an instrument measures what it is supposed to measure. Three types of internal validity are typically reported: content, construct and criterion validity. (Polit & Beck 2004, Burns & Grove 2005.)

The *content validity* of the questionnaire in this study was ascertained in several ways. First, the questionnaire was developed on the basis of the findings from Phase I and Phase II (Polit & Beck 2004) and earlier research (e.g. Muurinen 2003, Muurinen & Raatikainen 2005, Routasalo et al. 2004a). Secondly, before data collection, the content validity of the questionnaire was evaluated in a two-phase pilot study. First, the clarity of the questions was assessed by an expert panel of five registered nurses (Polit & Beck 2004, Burns & Grove 2005). Based on these assessments, some items were reworded to reduce bias, and the covering letter was modified to be more informative. Second, the questionnaire was piloted with clients (n = 21) and professionals (n = 32). The respondents in this pilot study were as identical as possible to those in the actual data

collection. Based on the feedback received, some items were reworded to reduce bias, and the layout of the questionnaire was improved. In addition, the questions concerning psychological well-being had been used in earlier studies since 1989 and their content validity had been shown to be good (e.g. Tilvis et al. 2000, Pitkälä et al. 2001, 2004b).

Construct validity determines whether the instrument actually measures the theoretical construct it is intended to measure. This is the most complex and difficult type of validity. (Polit & Beck 2004, Burns & Grove 2005.) The construct validity of this study could have been enhanced by using a previously validated instrument. This, unfortunately, was not possible. The use of a validated instrument together with the standardization of the group of clients and care professionals as well as clients' need for care would serve to increase the generalizability of the results. Even though an increasing number of studies have been published in recent decades on the resources of older people and multi-professional collaboration, no appropriate questionnaire was available for use in this study. Therefore, the questionnaire was specially designed on the basis of the findings from the unstructured and focus group interviews (Phases I, II) and the existing literature. On the basis on this, the questionnaire included questions concerning respondents' perceptions of the care provided by the professional carers (psychological well-being, clients' resources, collaborative relationship and coordination of care, motivating independent actions, physical, psychological and social care).

Criterion validity means that the results obtained by the instrument can be proportioned to and reflected against the results obtained by another instrument measuring the same research topic (Nummenmaa et al. 1997). In this study, such reflection was impossible because the literature search yielded no instrument that could have been used in this study. This was the first time that the questionnaire was used for data collection, and it has to be developed further before it can be shown to be a valid instrument. To obtain an overall picture of the phenomenon under study, the data were collected from both clients and social and health care professionals. Criterion validity could have been further enhanced by exploring family members' experiences, since they are an important resource in the home care of older people and an integral part of these people's everyday life. However at this stage it was decided that the focus should be exclusively on the clients' subjective experiences: these cannot be substituted by proxy assessments (Voutilainen 2004).

External validity

External validity refers to the generalisability of the research findings beyond the sample used in the study (Polit & Beck 2004, Burns & Grove 2005). This study was conducted in one social and health care district in an urbanised Finnish region that can be thought to represent a typical home care district. The external validity of this study could have been strengthened by collecting the data from more than one municipality with arrangements for collaborative social and health care provision. However the decision to focus on this

target group was motivated by the knowledge that the authorities in the municipality concerned were in the process of integrating home help and home health care services. In this study the specific interest was to learn about clients' and professional carers' experiences of how these services had worked before and how they worked after integration. The present study used a cross-sectional design, but it could be followed up in a longitudinal setting to see how the collaboration develops and unfolds.

In Finland, as in many other countries, most home care users are older adults (e.g. Markle-Reid et al. 2006). Retirement age is 65 years, which represents the point in life at which society considers people should exit the labour market. In many different contexts, therefore, the 65-year limit is used to define when people become 'older people'. In this study, the clients were females and males aged 65 or over because the aim was to provide rich data and to explore the perceptions of different age groups of the phenomenon under study. The older people's assessments might have been different had the data been collected only among the oldest old, i.e. those aged 85 or over, for in this age group the need for outside care and assistance often increases very sharply. It is known that advancing age adversely affects functional capacity, and it is also harder for older people to complete postal questionnaires. Therefore, in order to ensure a sufficient number of potential respondents, the age limit was set at 65 years. Earlier studies have shown that postal questionnaires are a reliable tool of data collection even among older people (Routasalo et al. 2003). The mean age of the clients was 84 years, compared to the national average of 77.9 years for home care clients (Stakes 2007a). The mean age of the professionals was 45 years. The majority of them were female. Most of them worked in the Social Services Department, and in this sense represented typical Finnish home care personnel (Perälä et al. 2006). All these similarities support the generalisability of the present results to other home care districts. On the other hand, this study did not cover the whole of Finland, which may undermine generalisability (Burns & Grove 2005). About half of the local authorities around the country have integrated their home help and home health care services (Vaarama & Pieper 2006). However, different countries have quite different welfare regimes, and therefore further studies are needed before any generalisations can be made from the results to other types of countries, communities and organisations.

Another important aspect with regard to external validity is sample size (Polit & Beck 2004). In this study, the postal survey was sent to 200 clients and 570 professionals. The overall response rate was quite high (C = 60%, P = 65%) (Burns & Grove 2005). The sample of professionals (n=370) represented the total permanent home care personnel, whereas the client sample (n = 120) was based on a power calculation. Home care services had a medical staff of four doctors, but only two of them returned the questionnaire. The views and opinions of doctors are therefore not very well represented. External validity could also have been enhanced by increasing the size of the client sample to match

the size of the care professionals sample. The issue of sample size was discussed with the persons in charge of home care and it was decided that since clients include large numbers of people who are in very poor health, they should not be burdened with a postal questionnaire. Therefore power analysis was used to determine adequate sample size. The main tool of statistical analysis was Fisher's exact test. Power analysis showed that in Fisher's exact test with a significance level of 0.05, group sample sizes of 120 and 370 achieved 89% power. In power analysis the null hypothesis was that both group proportions are 0.70. The alternative hypothesis was that the proportion in group 2 is 0.55. After power analysis, the questionnaire was randomly distributed to 200 older clients among the total of 1,885 clients registered as recipients of both home help and home health care services in 2007. This meant that no information was available about the participants' cognitive capacity. It is possible that only the healthiest clients have been able to complete the questionnaire, whereas those with limited capacity or disability may not have been in a position to share their experiences. No conclusions can be drawn about those who failed to respond because background data are not available on these people. In addition, whenever questionnaires are used for data collection it is impossible to know for sure who has completed them. If relatives, for instance, have helped clients complete the questionnaire, this will obviously affect the results.

Reliability

The reliability of an instrument can be tested with Cronbach's alpha coefficient (Polit & Beck 2004, Burns & Grove 2005). However since sum variables were not constructed in this study, Cronbach alpha values were not measured. Instead, the decision was made to retain the original items and to analyse the data item-by-item. This can be justified on grounds of it being more informative for the reader and allowing the informants' voice to be heard. The questions about psychological well-being have shown excellent test-retest reliability when read ministered within two weeks (Kappa value 0.80-1.00) (Tilvis et al. 2000, Pitkälä et al. 2001, 2004b).

The length of the questionnaire may also have a bearing on the reliability of the results (Burns & Grove 2005). In this study, the questionnaires included 70-75 items. It is possible that the length of the questionnaire and respondent fatigue have affected the reliability of the responses. Another factor that may have detracted from reliability is that some of the statements in the questionnaire were quite difficult and required recall. In spite of the length and difficulty of the statements, the questionnaires had been carefully filled out and there were only few missing data items. In addition, none of the respondents contacted the researcher or the supervisor by phone to ask for more information about the questionnaire. A stamped and addressed envelope was attached to the client questionnaire so that the respondents could return the forms directly to the researcher. The professionals returned the questionnaire directly to the researcher via in-house mail. The views of clients and staff regarding care are an important indicator of

the quality of care. However, since these views are subjective and susceptible to cultural norms and expectations, they are very difficult to measure reliably. As a consequence, any generalisations from the results must be made with caution. Further studies should work with larger samples and in different cultures to gain a fuller and more in-depth understanding about these issues.

7.2 Discussion of results

7.2.1 Older clients' resources

Older clients' resources consisted of a sense of control over one's life and a determination to remain active. As has been reported in earlier studies, a locus of control over one's life, the maintenance of individual lifestyles and independent activity are important resources in ageing (Johannesen et al. 2004, Sparks et al. 2004, Hokkanen et al. 2006, Koskinen et al. 2007, Reichstadt et al. 2007, Valta 2008). All this applies to home care clients as well. These clients emphasised the importance of independent functioning (functional health) and active engagement with life (social health) (Phelan et al. 2004), which reflects the essence of successful and active ageing (e.g. WHO 2002, Phelan et al. 2004). However, the clients also felt that professionals took decisions and performed care-related actions on their behalf, even though they felt it was important for them to maintain a sense of control and a determination to remain active. This result is supported by the earlier finding that professionals often make decisions concerning the client's care based on what they believe and think is best for the client and what they think it is the client wants (Cahill 1999, Chevannes 2002). However, the present findings indicate that to some extent at least, the course of action taken by professionals in their day-to-day work conflicts with older people's expectations and is not fully supportive of the client's own resources. It is important for older people to maintain their self-care behaviour style and autonomy (Železnik 2007). Involving clients in their own care and related decision-making helps to boost their confidence in their own resources. This requires a philosophical shift from the 'doing for' and 'telling clients what to do' to the collaborative paradigm: asking clients what are important for them and what they are willing to do and working collaboratively with them (Brown et al. 2006, Bodenheimer 2008). This paradigm shift throws up a new challenge in which professionals have to reconcile their own expert opinions with the clients' own views of what is best for them. Older people are the best experts of their own life, and they are in the best position to assess their own resources and the factors that impact their quality of life. It is important to support clients on their own terms so that they can themselves make the best decisions about their health (Peters 2000, Bodenheimer 2008).

Leisure activities and social networks were important sources of strength for older people's everyday life. Earlier studies have found that older people particularly

appreciate their relationships with family, friends, neighbours and care providers as well as meaningful activities (Backman 2001, Bryant et al. 2001, Malterud et al. 2001, Elo 2006, Hokkanen et al. 2006, Kulla et al. 2006, Forssén 2007, Koskinen et al. 2007, Savikko 2008). Older people are socially integrated in the community around them (Sparks et al. 2004, Koskinen et al. 2007), but in this study deteriorating health and loneliness presented huge challenges for older people and their resources. In keeping with earlier results (Holmén et al. 1992, Savikko 2008), this study revealed high rates of self-reported depression and loneliness. In addition, two-thirds (68%) of the clients felt ill. It has earlier been reported that high self-rated health is an important resource in old age (e.g. Koskinen et al. 2007, Reichstadt et al. 2007). Home care services today are targeted at increasingly old and frail clients (Modin & Furhoff 2002, Mitchell et al. 2005). The biological process of ageing has various consequences that are reflected in different areas of everyday life. Ageing also involves various losses: a deterioration of health and functional capacity, illnesses, losses of social roles and deprivation of social interaction. Even though health and functional capacity decline with advancing age, this varies widely from one individual to the next. Experiences of the deterioration of health are also influenced by the older person's capacity for adjustment and coping resources as well as the support available. In terms of resource thinking it is particularly important to bear in mind that people even in very poor health and poor physical condition can improve the quality of their life through various adaptive mechanisms and in so doing increase their satisfaction with their own health and their opportunities for successful ageing (Atchley 2000, Koskinen 2004). Home care professionals have an important role to play in supporting older people in this process of adjustment and adaptation. The effective provision of support requires an understanding of the specific nature and complexities of old age. For instance, professionals can encourage older people to analyse different avenues of change and to promote various positive aspects and minimise negative aspects. Old people themselves can focus their remaining resources on what they think is most important and necessary for them personally and in this way maintain the conditions for a good life. It is particularly important to accept the idea that despite the losses suffered in one area, there may still be continued improvement in others (Atchley 2000, Saarenheimo 2004, Koskinen 2004).

In this study, care professionals reported more depression and loneliness among clients than the clients themselves. Professionals have some difficulty identifying those clients who actually suffer from loneliness and who have a low level of psychological well-being. It is important to bear in mind that distressing feelings lead to impaired psychological well-being and quality of life and increase early institutionalisation of older clients (Tilvis et al. 2000, Harris 2007). It may be difficult for clients to speak about their internal experiences, such as distressing feelings. However, those feelings are real, and only clients themselves can say for sure if they are suffering negative feelings. Home

care professionals have a primary role to play in identifying factors that may threaten older people's resources, as their regular home visits put them in an ideal position to form an overall picture of their situation and how it is changing. It is important therefore that they encourage clients to talk about their own situation and feelings so that they can identify any threats to clients' resources well ahead of time. HC workers must also have the knowledge, sensitivity and the opportunity to provide well-targeted support. In the search for ways in which to support older people's resources, it is particularly important to be aware of the key significance of individual preferences. Older people must have the opportunity to engage in activities that appeal to them personally, whether those activities are physical exercise, outdoor pursuits, listening to music or theatre-going. Older people do not constitute one homogeneous group: the hopes and wishes of people aged 65 may differ widely from those aged 85.

7.2.2 Multi-professional collaborative approach to home care delivery

The collaborative approach to care delivery with a view to supporting clients' independent living

The professionals in this study were willing to accept the introduction of a collaborative approach to care delivery for their clients. However, some clients had never met the home care physician. As is known from earlier studies, home care clients today tend to have more disabilities and more complex health needs than was previously the case (Aylward et al. 2003, Axelsson & Elmståhl 2004, Johansson 2006). This means that home care staff must work closely on a daily basis with the physician. Assessment of the client's needs for medication and security, early diagnosis, steps to prevent illnesses from deteriorating and early intervention are all important aspects of home care, and it is crucial that physicians work alongside clients and other staff to provide integrated assessment and care management. Could closer assessments of clients' health status and need for rehabilitation by a doctor in connection with home visits provide an effective early intervention into declining health and functional capacity and in this way help to reduce acute hospital admissions? Personal visits to clients in their homes would allow doctors to learn more about their elderly patients, to see for themselves how they are coping in their everyday environment and in this way to form a clearer and more realistic picture of the client. This picture would help the doctor understand what the HHNs are saying when they are reporting back from their home visits. There is an obvious need for a preventive perspective in home care so that the need for more intensive help and assistance can be postponed. As has been reported in an earlier study, active interaction between the physician and other staff can significantly contribute to maintaining clients' health status (Sommers et al. 2000).

Earlier studies on social and health care collaboration have found that the process of multi-professional collaboration often involves conflicts and tensions between different

professional groups (e.g. Glendinning & Rummery 2003, Hubbard & Themessl-Huber 2005). The results of this study revealed one further source of tension, i.e. the inability of professionals to resolve their disagreements and conflicts in a manner that is most beneficial to client care. If the members of the care team do not show respect for the expertise of other staff groups and if they do not understand each other's role and contribution to the care process, then it is impossible for them to forge a seamless process of collaboration and democratic decision-making (e.g. Hills et al. 2007, Bélanger & Rodriquez 2008, Huxley et al. 2008). The findings of this study make us wonder whose expertise in the end informs decision-making about the client's care if the different professionals groups involved have to compete about whose views on the client's situation are the most accurate. Does the decision ultimately rest with the person who has the highest education or with the individual with the strongest personality, or with the person who is most closely familiar with the client's everyday situation? Will the decision be influenced by the organisation's norms and cost-cutting ambitions (cf. Andersson et al. 2004), or is decision-making informed by the traditional notion which says that the care provided by home care workers is a job that anyone can do, which means it is easily overshadowed by health care (see Tedre 1999)? However, supporting older people to cope in their everyday life is crucial to these people's independence, and it is a job that requires a high level of skills and competencies and that deserves greater respect and appreciation than it currently receives (Grönroos & Perälä 2006). Furthermore, we may also ask whether anyone actually hears the client's voice and whether decision-making is ultimately based on their views? If the provision of care were based on the client's situation, then there would be no rivalry and competition between professional groups because in that case these groups would share and contribute their expertise to achieving the common goal, to making sure the client's best interests are served. By working together, they could achieve something that they cannot achieve by themselves. (Housley 2003.)

This conflicting situation may lead to one professional group dominating the others, causing these other groups to feel that they do not have equal status or power within the care team (Glendinning & Rummery 2003). One way to improve this situation is to make sure that all the parties involved are familiar with one another's work, knowledge and skills and that they agree not only on a shared goal, but also on a clear division of labour and responsibilities (Paukkunen et al. 2003). Multi-professional collaboration is often set as the ideal objective that in itself is considered to generate value added to the organisation's decision-making (Nikander 2003). However, if the forms of collaboration do not provide an open and equal forum of exchange for the professionals involved, a locus for the development of a new understanding and new skills, then they may easily become frustrated and consider collaboration useless. It will always take time before the professionals speak a common language and before they have the answers they need to the questions of power and responsibility. Collaboration comes about gradually,

with the growth of a common working culture, in which working methods, values and goals are integrated to best serve the client's interests. (Paukkunen et al. 2003, Bélanger & Rodriquez 2008, Xyrichin & Lowton 2008.) It is also important that staff have the opportunity to improve and develop their collaboration. This is further underscored by the fact that under the current educational system, practical nurses are trained to work in social and health care services. They are better equipped than home aids to work with and support home care clients, but do not have as extensive training as home health care nurses. The clear definition of roles and responsibilities makes everyone's job so much easier: it allows everyone to put their professional skills and competencies to the best possible use and at the same time recognize their limits.

The professionals in this study had agreed that they would work together in the same way in developing a consistent approach to supporting the client's own resources. A significant result of this study from a development point of view was that despite their collaboration, care professionals were unable consistently and systematically to provide client care and to support their remaining resources. Some of them recognized and took notice of the clients' own resources, others failed to do so. Some of the clients, too, felt that staff did not always show enough interest in their life and their activities. However, it is known that the client's individual situation is the foundation for all nursing care, and the only way to provide effective support for independent living at home is through a sound knowledge and understanding of the life of the people concerned (Routasalo et al. 2004a). It is important to bear mind that older people need help not only at home, but also in their activities outside the home. However, even though there is strong research evidence on the positive impacts of various group activities, for instance, only limited effort has been invested in developing such activities that take account of older people's special needs (e.g. Cattan et al. 2005, Aday 2006, Collins 2006, Savikko 2008). Practical nursing should aim to find answers to the question of how efforts to prevent the loss of resources and functional capacity and to strengthen them could be incorporated as an integral part of home care provision. One answer to improving the situation might be for home care staff to work closely with people from municipal culture and sports departments as well as voluntary organisations to design and implement various activities. It would also be useful to have closer cooperation in this area with vocational institutions and polytechnics.

Both the clients and the professionals in this study linked communication to collaboration, but both groups also identified shortcomings in communication. This result is in line with earlier findings, which have shown that the lack of open communication is a significant barrier to seamless collaboration (Wilson & Pirrie 2000, Glendinning & Rummery 2003, Hubbard & Themessl-Huber 2005, Perälä et al. 2006). Our findings showed that a hierarchic structure of information collection and dissemination provides little opportunity for each professional to play an active role in the decision-making process,

even though each professional group has a particular area of expertise about their clients' health care status. This may involve the risk that the information concerning the client does not reach all professional groups, or even that the information may change on the way as each group assesses the situation against its own educational background and emphasises its own perspective. The physician's presence at the weekly meetings of other professionals would help to create a smoother flow and exchange of information. Furthermore, it would be important to arrange these meetings at the client's home.

Notebooks that are kept at each client's home contain extremely important information about the client, but none of this information is documented in the client's official records. It has been suggested that shared patient records would contribute to more effective collaboration (Hubbard & Themessl-Huber 2005, Bélanger & Rodriguez 2008, Lim 2008). As it is, this important information may not receive the attention it warrants in the planning and implementation of the client's care. This study indicated that about one-third (34%) of the clients and almost half (44%) of the staff felt that the information concerning the client's health condition and service needs was not always up-to-date. However, it is crucial that those involved in care provision have current information about the client's situation, and they must bring this information up-to-date before making a home visit (Andersson et al. 2004). Documentation must be updated in order to avoid any mistakes, to gain an accurate evaluation of the situation and to ensure the continuity of care. This also ensures constant access to real-time information about the client's situation. Electronic documentation has important benefits in avoiding duplication and saving time.

The collaborative approach to care delivery

The clients and professionals in this study had widely differing views on the collaborative approach to care delivery. Overall, clients had more critical assessments than professionals about the care delivered. Interestingly, earlier comparative studies on home care provision have shown that older people have more positive assessments of the care provided than professional carers (Rissanen et al. 1999, Paljärvi et al. 2003), but the results here do not lend support to this. The high satisfaction scores recorded for older clients have earlier been explained by reference to the hardships suffered by the generation who today are 75 or over: given their history and background, they are inclined to think that 'things could be worse' (Vaarama 2006). The environment of home care is changing and clients today are increasingly demanding and better informed. The noticeable lack of involvement on the part of clients in identifying their social and health care needs can be attributed to the continuing dominance of the traditional paternalist baseline in which the decision-making process for care delivery is primarily the domain of the professional, with limited input from the client. Research continues to show that clients are often excluded from collaborating with professionals to identify their health care needs and determine health care management options (Healy et al. 2002, Ala-

Nikkola 2003, Beech et al. 2004, Andersson et al. 2004, Nies 2006). In the light of this continuing discrepancy in perceptions of what constitutes associated social and health care needs, there is a need to explore further ways by which the provision of health care for older people who wish to remain in their home can be re-framed as a collaborative enterprise of 'client-with-professional'. This notion of client-with-professional strongly suggests the need to include the client in all aspects of the decision-making process regarding health care assessment and health care interventions (Brown et al. 2006). The client's role has changed from that of a passive object of care into an active party in the process of negotiation about his or her care. In practice, what this change means is that the negotiation between clients and professional carers produces agreement about care and service provision. This will require a new attitude and new kinds of interaction skills on the part of professional carers so that a dialogue-like process of negotiation can be set up with clients. The role of clients in this process is to contribute their own views, to ask questions and possibly to suggest alternative courses of action. The professional's role is to support and facilitate, approaching the client from the vantage-point of the questions they have asked and from their current life situation. The aim ultimate is to offer viable alternatives and to create an individually tailored plan of care and service provision that clients can successfully implement in their everyday life and that satisfies the principles of evidence-based care. (Poskiparta et al. 2001, Hendersson 2003, McCormack 2004, Nolan et al. 2004.)

The clients in this study also had criticisms of many areas of care with which they had previously been satisfied, such as the availability of assistance with physical needs (Paljärvi et al. 2003, Muurinen & Raatikainen 2005), and which home care staff themselves feel they have best been able to meet (Grönroos & Perälä 2006). Clients' perceptions of quality are reflected through the care they have actually received, and there is a need to discuss whether the quality of care and services have dropped as clients' criticisms now extend to areas that used to be well-covered. As Andersson et al. (2004) point out, there is an element of tension between the objectives set for the quality of home care (e.g. Ministry of Social Affairs and Health 2007b, 2008a,b). It is impossible to provide quality care as long as professionals have to work under constant time pressures and as long as staff turnover levels are as high as they are (Rissanen et al. 1999, Paljärvi et al. 2003, Tenkanen 2003, Andersson et al. 2004). With culture and customs in constant flux, serious thought has to be given to the question of how to secure the conditions for successful ageing: it can no longer be taken for granted that our methods of helping older people will continue to work from one decade to the next. The older generations of the future have lived in a very different kind of world than the people who today are the clients of home care. The challenge for professional carers is to learn new skills and acquire new knowledge. It is time now to unlearn the earlier ways of thinking and earlier practices and to discover new approaches to working with

older people, because home care is an increasingly demanding environment and the demands imposed on employee skills and competencies are ever greater (Grönroos & Perälä 2006). Professionals working in home care need to have skills and competencies both in the field of gerontological nursing and social work and in geriatrics. In their day-to-day work, gerontological nursing professionals draw upon the knowledge produced by nursing science and on gerontological knowledge in supporting their client's own resources, in promoting their health and functional capacity, and in preventing and treating illnesses, as well as upon professional knowledge and the ethical principles of nursing care (e.g Ethical Guidelines of Nursing 1996, ETENE 2008).

Although the professionals in this study said they defined the goals and designed nursing interventions to support clients' functional capacity on the basis of clients' existing resources, only half of them (54%) regularly assessed the achievement of those goals. The results of this study lend support to previous findings which show that it is often difficult to obtain comprehensive assessments and to monitor changes in clients' health status (Kodner et al. 2000). This is an alarming result: if staff do not regularly assess to what extent goals are achieved from the client's perspective, then it is also impossible for them to evaluate how nursing interventions enhance their clients' outcomes. It is important to bear in mind that older clients' situation and health status may change very quickly and that these changes may interfere with the client's ability to live independently at home. It is obvious that ongoing health assessment through regular home visits is of great value in reducing or delaying the need for hospital care (Bernabei et al. 1998, Elkan et al. 2001, Stuck et al. 2002, Brown et al. 2003). Professionals may require training in how they can follow-up and evaluate their interventions to make sure that they have the desired effect and are relevant to individual clients. Through regular home visits, systematic assessment and effective interventions, particularly those that focus on clients' individual needs, professionals may be able to enhance their clients' ability to live independently at home. In practice, this means that there is a need for valid assessment tools which include physical and psychosocial dimensions and which also take account of the client's perspective. Valid indicators can provide systematic, objective and comparable information about the client's overall situation. As it is, assessments of functional capacity are quite limited in their scope and disjointed, and no single uniform measure of functional capacity is in common use. However, the most widely used measures of functioning such as Activities of Daily Living (ADL), Mini Mental State Examination (MMSE), Geriatric Depression Scale (GDS) and Mini Nutritional Assessment (MNA) do allow for adequate assessments of functional capacity in older clients if a battery measure is used that covers the different dimensions of functioning. (Voutilainen & Vaarama 2005.) These scales of functional capacity can be used to systematically assess, monitor and compare the resources of older people to cope with different activities of everyday living. The assessment of functional capacity is an integral part of evaluating

older people's need for help and the impact of services. However the most important source of information here are older people themselves. And the best way to find out about older people's views and experiences of their functional capacity and the possible sources and causes of change is to interview and observe them (Voutilainen 2004).

Older clients who develop a need for regular home care not only require help and assistance with activities of daily living, but this also marks a major turning point in life towards diminished abilities and serves as a reminder that the end of life is approaching. (Efrainsson et al. 2001, Aronson 2002, Janlöv et al. 2005.) Home care services can help to support clients' adjustment and adaptation to their own ageing and improve their quality of life, provided that the service is client-driven, that it respects the patient's autonomy, that it is competent, professional, friendly and empathetic (Vaarama 2006). Clients who are visited and treated in their home may experience this as an intrusion into their personal territory. Every home is an individual expression of its owner and its owner's personal life history. In this environment it is easy and natural to get to know the client as an individual, to listen to their stories and browse through their photographs. It is important to respect the client's emotions, thoughts and desires and to hear what they have to say about their needs for care and services. These are the needs and expectations that must be met in care. This is the only justification for social and health care services.

In line with international recommendations and national old age policy (Ministry of Social Affairs and Health 2008b), plans are now in place in Finland to further increase the availability of services designed to support independent living at home. Home services are absolutely crucial to the independence of home-dwelling older people. Given the importance attached to independent living at the policy level, it is important to listen to the critical comments that old people themselves have about the success of care delivery. This study highlights the perspective of older people, on which there is still a scarcity of information in the context of collaborative home care. These comments and views must be adopted as the starting-point for the further development of the various service organisations in society. Even though ageing is a biological process, it always takes place in a social environment. Indeed it is important that society can provide adequate and appropriate home care so that older people can live a fulfilling life in the safety of their own home. Even though the former institutional emphasis in care provision has now given way to various forms of community care, it is important that different alternatives are available. It is not possible for all older people, indeed not all older people want to live in their own homes, and therefore services must also be provided in the middle ground between home care and institutional care.

7.3 Conclusions

The following conclusions are drawn from this study:

The resources of older clients and factors that enhance and threaten their resources

1. A sustained sense of life control and will proved important resources for independent living in older people. However, home care clients felt that professional carers took many care-related decisions and performed many actions on their behalf. This conflicted with older people's expectations, indicating that professionals did not in every respect support their older clients' independent use of resources.
2. Older people derived strength in their everyday life from leisure activities and social networks. Declining health made it more difficult for these people to take part in these activities and social events, and even forced them to give them up altogether. Home care services are presented with a major challenge when the resources of older people are depleted to such an extent that they no longer can move out of their home to attend activities and to meet other people. It is essential that even when their resources begin to dwindle, older people have the opportunity to engage in activities in which they are interested.
3. Declining health and experiences of loneliness represented a huge challenge to older people and their resources. Professionals have difficulty identifying those clients who suffer from loneliness and low psychological well-being. Home care professionals must have the sensitivity to identify factors that threaten older people's resources and the ability to offer timely and properly targeted support.
4. Since the ultimate aim of care is to facilitate successful ageing, it is important that increasing attention is paid to identifying the individual resources of older people and to find ways of strengthening them, since the mere existence of resources is not enough; the key is that older people can put those resources to use.

The collaborative approach to care delivery with a view to supporting client's independent living

1. Conflicting opinions among different professional groups working in home care lead to tensions and competition. If care delivery is based on each client's individual situation, no such conflicts will develop between professionals because each of them have their own area of expertise and competence that they will contribute to achieving the common objective. This is an integral part of modern old age services, i.e. recognizing questions related to ageing as a shared responsibility and a field of collaboration for different professions. To this end it is important that these professionals are familiar with the knowledge and skills of other professional groups, as well as with how they work. Clarity about mutual

roles and responsibilities is important to the success of cooperation because it allows each professional to make the best possible use of their own skills and competencies and at the same time to recognize their limits. Caring for older people and supporting them to cope independently requires a high level of professional skills and competence in which the cooperation of gerontological nursing and social work as well as geriatric medicine deserves greater appreciation. Multi-professional training and education could contribute to improving the situation. Even during basic training it would be important to teach the skills that are needed to become an expert in one's own field and to listen to experts in other fields, to put forward and defend one's own professional views and to understand the importance of dialogue in setting common objectives.

2. Within the confines of the current hierarchic structure of information collection and dissemination, different professional groups have only limited opportunity to play an active role in the decision-making process. It is necessary to develop improved methods of communication, and particularly to make sure that professionals have access to a common patient information system that would allow all team members to enter their own comments and observations about the client. This would ensure that all members of the care team have shared access to real-time information about the client.
3. It is necessary to develop professionals' skills in following-up and evaluating their interventions to make sure that those interventions have the desired effect and are relevant to individual clients. In practice, this means that professionals need to have access to valid assessment tools which take account of the client's perspective, so that the evaluation is based not only on the professionals' own assumptions. These tools can provide systematic, objective and comparable information about the client's overall situation.

The collaborative approach to care delivery

1. Clients and their professional carers had very different views about the collaborative approach to care delivery. Overall, the clients' assessments of the care they received were more critical than the professional carers' assessments. The clients also had criticisms of such areas of care with which they had previously been satisfied, such as the availability of assistance with physical activities.
2. It is a common goal for all professionals to constantly monitor and develop the quality of home care and their own work. Aspects of care where there remains scope for improvement must be given priority focus in the future, and development efforts concentrated on those areas where clients and professionals showed the most critical attitudes.

7.4 Suggestions for clinical practice and future research

This study strengthens the knowledge base of gerontological nursing science and provides new information to help support older clients living at home through multi-professional social and health care collaboration. It is certainly worthwhile to continue research into supporting the independent living of older clients through multi-professional collaboration. The number of older people is continuing to grow, and it is considered preferable that people can age in their home rather than having to be committed to institutional care. In order for us to meet the challenges of the future, we will need to develop methods of gerontological nursing that support and make the best use of older people's own resources and in this way make it possible for them to live independently at home.

The following clinical implications are drawn from this study:

Assessment of client's resources

1. Every client's resources as well as factors enhancing and threatening those resources shall be assessed from the client's point of view, listening to the client in connection with drawing up a tailored care and service plan.
2. The assessment of clients' resources shall reflect their own views and opinions.
3. Clients shall be encouraged to apply their own resources and individually-tailored support shall be made available to help them do so.
4. Clients' resources shall be assessed on a regular basis. Any threats to those resources shall be identified and any necessary changes to the care plan made accordingly.
5. Professional carers shall commit themselves to working consistently to support clients' use of their own resources.

Collaborative approach to care delivery

1. The views and opinions of clients as the best experts of their own life shall be listened to more closely, involving them as active parties in the process of negotiating about their care; this requires movement from a position of 'doing for' to 'doing with' clients.
2. A customer-driven, goal-oriented approach shall be adopted that is based on the client's individual needs for care and services.
3. The knowledge and expertise of each professional group and their contribution to multi-professional expertise shall be recognized and put to the best possible use.

4. Communications as well as the information technology used in home care shall be improved.

This study has stimulated the following ideas for further research:

1. Further empirical research is needed to explore the resources of older people. This study took just one step towards a deeper understanding of these resources in the home care context. Home care clients today are increasingly old and frail individuals who often have multiple diseases. More information is needed about the resources of frail and demented home-dwelling clients and about the factors enhancing and threatening those resources. This information is crucial to developing methods of gerontological nursing that allow for early interventions to halt the decline of these resources.
2. It would be interesting to study the impacts of interventions targeted at clients' resources on their independent living at home. More information is needed about whether and how older people's individual resources, such as their sense of control over life and determination to remain active, can be put to good use in care provision with a view to increasing their autonomy and to supporting their independent coping in everyday life. This requires a change of attitudes on the part of staff members as well as the development of new kinds of nursing methods that are based on a modern view of old age and that take account of the individual resources of older people.
3. Furthermore, it would be interesting to see what happens to older clients' own resources when they move to institutional care. This information would be important for institutional care professionals. Equipped with this information, nurses could devote more attention to identifying and supporting older people's existing resources, which can be supported in many different ways even at very advanced ages.
4. More information is needed about the factors underlying the differing views of clients and professionals on the success of multi-professional collaboration in supporting clients' resources. The absence of a shared perception between clients and professionals may greatly complicate the task of arranging home care services based on client needs. It would therefore be important to analyse and compare the views of clients and professionals about care provision not only nationally but in international settings, too. Although care systems vary from country to country, there is still much to be learned from one another.
5. Practices of collaboration in home care must be further improved and developed, and more research is needed to explore the impacts of interventions focused on collaboration on the outcomes of care.

REFERENCES

- Adamsen L, Tewes M. 2000. Discrepancy between patients' perspectives, staffs' documentation and reflections on basic nursing care. *Scandinavian Journal of Caring Science* 14, 120-129.
- Aday R, Kehoe G, Farney LA. 2006. Impact of senior centre friendships on aging women who live alone. *Journal of Women & Aging* 18, 57-73.
- Ala-Nikkola M. 2003. In hospital, at home or in institutional care? Ethnographic research on decision-making realities of old-age care. *Acta Universitatis Tamperensis* 972, University of Tampere, Tampere.
- Algera M, Francke AL, Kerkstra A, van der Zee J. 2004. Home care needs of patients with long-term conditions: literature review. *Journal of Advanced Nursing* 46, 417-429.
- Allan H, Bryan K, Clawson L, Smith P. 2005. Developing an interprofessional learning culture in primary care. *Journal of Interprofessional Care* 19, 452-464.
- Anderson GF, Hussey PS. 2000. Population Aging: A Comparison Among Industrialized Countries. *Health Affairs* 19, 191-203.
- Andersson S, Haverinen R, Malin M. 2004. Vanhusten kotihoito kolmesta näkökulmasta. Vanhukset, työntekijät ja johto integroinnin ja asiakaskeksisyyden arvioijina. *Yhteiskuntapolitiikka* 69, 481-494.
- Aronson J. 2002. Elderly people's accounts of home care rationing: missing voices in long-term care policy debates. *Ageing & Society* 22, 399-418.
- Arundel C, Glouberman S. 2001. An analysis of blockage to the effective transfer of clients from acute care to home care. A report prepared for the Health Transition Found, Health Canada. Canadian Policy Research Networks Inc. Health Network. Centre on Ageing. Available at www.homecarestudy.com (assessed 25 February 2009)
- Atchley RC. 2000. *Social Forces and Aging. An Introduction to Social Gerontology*. Wadsworth: Belmont, CA.
- Attree M. 2001. Patients' and relatives' experiences and perspectives of 'good' and 'not so good' quality care. *Journal of Advanced Nursing* 33, 456-466.
- Atwal A, Caldwell K. 2005. Do all health and social care professionals interact equally: a study of interactions in multidisciplinary teams in the United Kingdom. *Scandinavian Journal of Caring Science* 19, 268-273.
- Axelsson J, Elmståhl S. 2004. Home care aides in the administration of medication. *International Journal of Qualitative Health Care* 16, 237-243.
- Ayis S, Goberman-Hill R, Ebrahim S. 2003. Long-standing and limiting long-standing illness in older people: associations with chronic diseases, psychosocial and environmental factors. *Age and Ageing* 32, 265-272.
- Aylward S, Stolee P, Keat N, Johncox V. 2003. Effectiveness of continuing education in long-term care: a literature review. *Gerontologist* 43, 259-271.
- Backman K. 2001. Self-care of home-dwelling elderly. *Acta Universitatis Ouluensis Medica D* 624, University of Oulu, Oulu.
- Barr H, Hammick M, Koppel I, Reeves S. 1999. Evaluating Interprofessional Education: two systematic reviews for health and social care. *British Educational Research Journal* 25, 533-544.
- Barton A, Mulley G. 2003. History of the development of geriatric medicine in the UK. *Postgraduate Medicine Journal* 79, 229-234.
- Beech R, Russell W, Little R, Sherlow-Jones S. 2004. An evaluation of a multidisciplinary team for intermediate care at home. *International Journal of Integrated Care* 4, 1-10.
- Bélanger E, Rodriguez C. 2008. More than the sum of its parts? A qualitative research synthesis on multi-disciplinary primary care teams. *Journal of Interprofessional Care* 22, 587-597.
- Benyamini Y, Idler EL. 1999. Community studies reporting association between self-rated health and mortality: National studies, 1995-1998. *Research on Aging* 21, 392-401.
- Bernabei R, Landi F, Gambassi G, Sgadari A, Zuccala G, Mor V, Rubin D, Garbonin P. 1998. Randomized trial of impact of model of integrated care and case management for older people living in the community. *BMJ* 316, 1348-1351.
- Bertera E. 2003. Physical Activity and Social Network Contacts in Community Dwelling Older Adults. *Activities, Adaptation & Aging* 27, 113-127.
- Bodenheimer T. 2008. Transforming Practice. *NEJM* 359, 2086-2089.
- Bondevik M, Skogstad A. 1999. The oldest old, ADL, social network, and loneliness. *Western Journal of Nursing Research* 20, 325-343.
- Borrill C, West M, Shapiro D, Rees A. 2000. Team working and effectiveness in health care. *British Journal of Management Studies* 41, 317-333.
- Brown B, Crawford P, Darongkamas J. 2002. Interdisciplinary work in community mental health. *Nursing Times* 98, 38-39.
- Brown D, McWilliam C, Ward-Griffin C. 2006. Client-centred empowering partnering in nursing. *Journal of Advanced Nursing* 53, 160-168.
- Brown L, Tucker C, Domokos T. 2003. Evaluating the impact of integrated health and social care teams on older people living in the community. *Health and Social Care in the Community* 11, 85-94.
- Bryant L, Corbett K, Kutner J. 2001. In their own words: a model of healthy aging. *Social Science & Medicine* 53, 927-941.
- Bull MJ, Roberts J. 2004. Components of a proper hospital discharge for elders. *Journal of Advanced Nursing* 35, 571-581.
- Burns N, Grove S. 2005. *The Practice of Nursing Research. Conduct, Critique and Utilization*. 5th ed. WB. Saunders Company, Philadelphia.
- Burr JA, Mutchler JE. 2007. Residential independence among older persons: community and individual factors. *Population Research and Policy Review* 26, 85-101.
- Büscher A. 2007. Negotiating Helpful Action. A substantive theory on the relationship between formal and informal care. *Acta Universitatis Tamperensis*, 1206. University of Tampere, Tampere.
- Caelli K, Downe J, Caelli T. 2003. Towards a decision support system for health promotion in nursing. *Journal of Advanced Nursing* 4, 170-180.

- Cahill J. 1999. Patient participation – a review on literature. *Journal of Clinical Nursing* 7, 119-128.
- Cameron A, Macdonald G, Turner W, Lloyd L. 2007. The challenges of joint working: lessons from the Supporting People Health Pilot evaluation. *International Journal of Integrated Care* 18, 1-10.
- Cashman SB, Reidy P, Cody K, Lemay CA. 2004. Developing and measuring progress toward collaborative, integrated, interdisciplinary health care teams. *Journal of Interprofessional Care* 18, 184-196.
- Cattan M, White M, Bond J, Learmouth A. 2005 Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. *Ageing & Society* 25, 41-67.
- Cavanagh S. 2000. Content analysis: Concepts, methods and applications. *Nurse Researcher* 4, 5-16.
- Cheung C-K, Man-Hung Ngan R. 2005. Improving Older Adults' Functional Ability through Service Use in a home care Program in Hong Kong. *Research on Social Work Practice* 15, 154-164.
- Chevannes M. 2002. Social construction of the materialism of needs assessment by health and social care professionals. *Health and Social Care in the Community* 10, 168-178.
- Collins CC, Benedict J. 2006. Evaluation of a community-based health promotion program for the elderly: lessons from Seniors CAN. *American Journal of Health Promotion* 21, 45-48.
- Cook G, Gerrish K, Clarke C. 2001. Decision-making in teams: issues arising from two UK evaluations. *Journal of Interprofessional Care* 15, 141-151.
- Davey B, Levin E, Illife S, Kharicha K. 2005. Integrating health and social care: implications for joint working and community care outcomes for older people. *Journal of Interprofessional Care* 19, 22-34.
- Davies C. 2000. Getting health professionals to work together: There's more to collaboration than simply working side by side. *BMJ* 320, 1021-1022.
- Dean M, Grunert KG, Raats MM, Nielsen NA, Lumbers M. 2008. The impact of personal resources and their goal relevance on satisfaction with food-related life among the elderly. *Appetite* 50, 308-315.
- Dempsey O, Bekker H. 2002. 'Heads you win, tails you lose': A critical incident study of GPs' decisions about emergency admission. *Family Practice* 19, 611-615.
- de Witte L, Schoot T, Proof I. 2006. Development of the Client-Centred Care Questionnaire. *Journal of Advanced Nursing* 56, 62-68.
- Dieleman SL, Fariis KB, Feeny D, Johnson JA, Tsuyuki RT, Brilliant S. 2004. Primary health care teams: team members' perceptions of the collaboratively process. *Journal of Interprofessional Care* 18, 75-78.
- Diener E, Fujita F. 1995. Resources, personal striving, and subjective well-being. A nomothetic and idiographic approach. *Journal of Personality and Social Psychology* 68, 926-935.
- Drageset J, Nygaard HA, Eide GE, Bondevik M, Nortvedt MW, Natvig GK. 2008. Sense of coherence as a resource in relation to health-related quality of life among mentally intact nursing home residents - a questionnaire study. *Health Quality of Life Outcomes* 21, 1-9.
- Efrainsson E, Höglund I, Sandman PO. 2001. The everlasting trial of strength and patience: transition in home care nursing as narrated by patients and family members. *Journal of Clinical Nursing* 10, 813-819.
- Einbinder SD, Robertson PJ, Garcia A, Vuckovic G, Patti RJ. 2000. Interorganizational collaboration in social service organisations: A study of the prerequisites to success. *Journal of Children & Poverty* 6, 119-140.
- Elkan R, Kendrick D, Dewey M, Hewitt M, Robinson J, Blair M, Williams D, Brummell K. 2001. Effectiveness of home based support for older people: systematic review and meta-analysis. *BMJ* 323, 719-724.
- Elo S. 2006. A theory of an environment supporting the well-being of home-dwelling elderly from Northern Finland. *Acta Universitatis Ouluensis Medica D* 889. University of Oulu, Oulu.
- Enderby P. 2002. Teamworking in community rehabilitation. *Journal of Clinical Nursing* 11, 409-411.
- Eurostat 2008. Europe in figures. Eurostat yearbook 2008. European Commission. European Communities, 2008.
- ETENE 2008. Vanhuus ja etiikka. Valtakunnallisen terveydenhuollon eettisen neuvottelukunnan (ETENE) raportti. Available at www.etene.org/dokumentit/Etene_vanhuusraportti_fin%20verkko.pdf (accessed on 16 March 2009)
- ETENE. 2001. The National Advisory Board on Health Care Ethics. ETENE-publications 3/2001. Shared Values in Health Care, Common Goals and Principles. Available at www.etene.org/dokumentit/EteneENG.pdf (accessed on 15 February 2005)
- Ethical Guidelines of Nursing 1996. the Finnish Nurses Association.
- Farrell MP, Schmitt MH, Heinemann GD. 2001. Informal roles and the stages of interdisciplinary team development. *Journal of Interprofessional Care* 3, 281-295.
- Fielo SB, Warren S. 2001. Home adaptation: helping older people age in place. *Geriatric Nursing* 22, 239-247.
- Forssén A. 2007. Humour, beauty, and culture as personal health resources: Experiences of elderly Swedish women. *Scandinavian Journal of Public Health* 35, 228-234.
- Forssén A, Carlsted G. 2006. "It's heavenly to be alone!": A room of one's own as a health-promoting resource for women. Results from a qualitative study. *Scandinavian Journal of Public Health* 34, 175-181.
- Fortinsky RH, Fenster JR, Judge JO. 2004. Medicare and Medicaid home health and Medicaid waiver services for dually eligible older adults: risk factors for use and correlates of expenditures. *The Gerontologist* 44, 739-749.
- Freeman M, Miller C, Ross N. 2000. The impact of individual philosophies of teamwork on multi-professional practice and the implications for education. *Journal of Interprofessional Care* 14, 237-247.
- Gernerud L, Olsson H. 2004. Humour seen from a public health perspective. *Scandinavian Journal of Public Health* 32, 396-398.
- Gibson H. 1991. A concept analysis of empowerment. *Journal of Advanced Nursing* 16, 354-361.
- Glendinning C. 2003. Breaking down barriers: integrating health and care services for older people in England. *Health policy* 65, 139-151.
- Glendinning C, Rummery K. 2003. Collaboration between primary health and social care. From policy to practice in developing services for older people. In: Leathard A. (eds.) *Interprofessional Collaboration: From Policy to*

- Practice in Health and Social Care. Brunner-Routledge, London, 179-191.
- Government Programme of the second cabinet of Prime Minister Matti Vanhanen 19 April 2007. Available at www.vn.fi/hallitus/hallitusohjelma/fl.jsp (accessed on 5 February 2009)
- Grönroos E, Perälä M-L. 2006. Kotihoidon henkilöstön kompetenssin kokemusta selittävät tekijät. *Yhteiskuntapolitiikka* 71, 484-498.
- Grönroos E, Perälä M-L. 2005. Home care personnel's perspectives on successful discharge of elderly clients from hospital to home setting. *Scandinavian Journal of Caring Science* 19, 288-295.
- Hallström I, Elander G. 2001. A comparison of patient needs as ranked by patients and nurses. *Scandinavian Journal of Caring Science* 15, 228-234.
- Hammar T. 2008. Integrated Services in the Practice of Discharge and Home Care (PALKO) – Home-care clients' use of services and need for help, and the effectiveness and cost-effectiveness of Palko-model. Stakes, Research Reports 179. University of Tampere, Tampere.
- Hancock GA, Reynolds T, Woods B, Thornicroft G, Orrell M. 2003. The needs of older people with mental health problems according to the user, the carer, and the staff. *International Journal of Geriatric Psychiatry* 18, 803-811.
- Harris Y. 2007. Depression as a Risk Factor for Nursing Home Admission Among Older Individuals. *Journal of the American Medical Directors Association* 8, 14-20.
- Hays T, Minichello V. 2005. The contribution of music to quality of life in older people: An Australian qualitative study. *Ageing and Society* 25, 261-278.
- Healy J, Victor CR, Thomas A, Seargeant J. 2002. Professionals and post-hospital care for older people. *Journal of Interprofessional Care* 16, 19-29.
- Hek G, Singer L, Taylor P. 2004. Cross-boundary working: a generic worker for older people in the community. *British Journal of Community Nursing* 9, 237-244.
- Hellström Y, Hallberg IR. 2001. Perspectives of elderly people receiving home help on health, care and quality of life. *Health and Social Care in the Community* 9, 61-71.
- Hellström Y, Persson G, Hallberg IR. 2004. Quality of life and symptoms among older people living at home. *Journal of Advanced Nursing* 48, 584-593.
- Henderson S. 2003. Power imbalance between nurses and patients: a potential inhibitor of partnership in care. *Journal of Clinical Nursing* 12, 501-508.
- Henneman EA, Lee JL, Cohen JI. 1995. Collaboration: a concept analysis. *Journal of Advanced Nursing* 21, 103-109.
- Hills M, Mullett J, Carroll S. 2007. Community-based participatory action research: transforming multidisciplinary practice in primary health care. *Pan American Journal of Public Health* 21, 125-135.
- Hokkanen H, Häggman-Laitila A, Eriksson E. 2006. Kotona asuvien iäkkäiden ihmisten voimavarat ja niiden tukeminen – katsaus tutkimuskirjallisuuteen. *Gerontologia* 1, 12-21.
- Holloway I, Wheeler S. 2002. *Qualitative Research in Nursing*. 2nd Edition. Blackwell Publishing Company, Oxford.
- Holmén K, Ericsson K, Andersson L, Winblad B. 1992. Loneliness among elderly people living in Stockholm: a population study. *Journal of Advanced Nursing* 17, 43-51.
- Housley W. 2003. *Interaction in Multidisciplinary Teams*. Cardiff Papers. Aldershot. Ashgate, England.
- Hubbard G, Themessl-Huber M. 2005. Professional perceptions of joint working in primary care and social care services for older people in Scotland. *Journal of Interprofessional Care* 19, 371-385.
- Hughes S, Weaver FM, Giobbie-Hurder A, Manheim L, Henderson W, Kubal JD, Ulaseich A, Gunning J. 2000. Effectiveness of Team-Managed Home-Based Primary Care. A Randomized Multicenter Trial. *JAMA* 284, 2877-2885.
- Hultberg E-L, Glendinning C, Allebeck P, Lönnroth K. 2005. Using pooled budgets to integrate health and welfare services: a comparison of experiments in England and Sweden. *Health & Social Care in the Community* 13, 531-541.
- Huxley P, Evans S, Munroe M, Cestari L. 2008. Integrating health and social care in community mental health teams in the UK: a study of assessments and eligibility criteria in England. *Health and Social Care in the Community* 16, 476-482.
- Häggman-Laitila A. 1999. Terveys ja omatoiminen terveydenhoito. Kuvaileva teoria yksilöllisistä kokemuksista. *Acta Universitatis Tamperensis* 648, Tampereen yliopisto, Tampere.
- Idler EL, Russell LB, Davis D. 2000. Survival, functional limitations and self-rated health in the NHANES I Epidemiologic Follow-up Study, 1992: First National Health and Nutrition Examination Survey. *American Journal of Epidemiology* 152, 874-883.
- Isoherranen K. 2005. Moniammatillinen yhteistyö. WSOY, Vantaa.
- Janlöv A-C, Hallberg IR, Petersson K. 2005. The experience of older people of entering into the phase of asking for public home help – a qualitative study. *International Journal of Social Welfare* 14, 326-336.
- Johannesen A, Petersen J, Avlund K. 2004. Satisfaction in Everyday Life for Frail 85-year-old Adults: a Danish Population Study. *Scandinavian Journal of Occupational Therapy* 11, 3-11.
- Johansson L. 2005. Current Developments in Care of the Elderly in Sweden. The Swedish National Board of Health and Welfare. Available at www.socialstyrelsen.se/Publicerat/2004/3384/Summary.htm (accessed 15 August 2008)
- Jones K, Netten A, Francis J, Bebbington A. 2007. Using older home care user experiences in performance monitoring. *Health and Social Care in Community* 15, 322-332.
- Joubert J, Joubert L, Reid C, Barton D, Cumming T, Mitchell P, House M, Heng R, Meadows G, Walterfang M, Pantelis C, Ames D, Davis S. 2008. The Positive Effect of Integrated Care on Depressive Symptoms in Stroke Survivors. *Cerebrovascular Diseases* 26, 199-205.
- Jyrkämä J. 2007. Toimijuus ja toimintatilanteet - aineksia ikääntymisen arjen tutkimiseen. Teoksessa: Seppänen M, Karisto A, Kröger T. (toim.) Vanhuus ja sosiaalisuus. Sosiaalisuus avuttomuuden ja toimijuuden välillä. Sosiaalisuuden tutkimuksen viides vuosikirja. PS-Kustannus, Jyväskylä, 195 - 218.

- Kangasniemi J. 2005. Mitä on yksinäisyys? Teoksessa: Jokinen K. (toim.) Yksinäisten sanat: Kirjoituksia omasta tilasta, erillisyydestä ja yksin olosta. Jyväskylän yliopisto, Jyväskylä, 227-312.
- Karila K., Nummenmaa A-R. 2001. Matkalla moniammatillisuuteen. Kuvaukskohteena päiväkoti. WSOY, Helsinki.
- Karisto A, Konttinen R. 2004. Kotiruokaa, kotikatua, kaukomatkailua. Tutkimus ikääntyvien elämäntyyleistä. Palmieniakustannus. Yliopistopaino, Helsinki.
- Keene J, Swift L, Bailey S, Janacek G. 2001. Shared patients: multiple health and social care contact. *Health and Social Care in the Community* 9, 205-214.
- Khaw K-T. 1997. Healthy aging. *BMJ* 315, 1090-1096.
- King N, Ross A. 2003. Professional Identities and Interprofessional Relations: Evaluation of Collaborative Community Schemes. *Social Work in Health Care* 38, 51-72.
- Kinnunen K. 2002. Postponing of institutional long-term care in the patients high risk of institutionalisation. University of Helsinki, Faculty of Medicine. Yliopistopaino, Helsinki.
- Kirsi T. 2001. Täyttä ja menetettyä elämää. Aviovaimojen kertomuksia dementoituneen puolison hoitamisesta. Sosiaalipolitiikan ja sosiaalityön tutkimuksen aikakauslehti *Janus* 9, 293-311.
- Kitzinger J. 1995. Qualitative Research: Introducing Focus Groups. *British Medical Journal* 311, 299-302.
- Knipscheer CPM, Broese van Groenou MI, Leene GJF, Beekman ATF, Deeg DJH. 2000. The effects of environmental context and personal resources on depressive symptomatology in older age: a test of Lawton model. *Aging and Society* 20, 183-202.
- Kodner D, Sherlock M, Shankman J. 2000. Bringing managed health care home: a new service strategy for people with chronic illness and disabilities. In: Heumann LF, McCall M, Boldy DP. (eds.) *Empowering Frail People: Opportunities and Impediments in Housing, Health and Support Service Delivery*. Praeger Publications: Westport, England, 175-190.
- Koponen L. 2003. Elderly patient's transition between home and hospital - a substantive theory of coping skills and cooperation promoting these skills. Substantiivinen teoria selviytymisestä ja yhteistyöstä. *Acta Universitatis Tamperensis* 974, University of Tampere. Tampere.
- Koskinen S. 2004. Ikääntyneiden voimavarat. Teoksessa Kautto M. (toim.) *Ikääntyminen voimavarana. Tulevaisuuslonteon liiteraportti 5*. Valtioneuvoston kanslian julkaisusarja 33, 24-90.
- Koskinen S, Hakapää L, Maranen P, Piekkari J. 2007. Pohjoisten kaupunkien kolmasikäiset – millainen kuva muotoutui? Teoksessa: Koskinen S, Hakapää L, Maranen P, Piekkari J. (toim.). *Kolmasikäisten elämää kaupungeissa. Kaupunki Elvi-hankeen tutkimustuloksia*. Lapin yliopisto, Sosiaalityön laitos, Teollisen muotoilun laitos. Lapin Yliopistopaino, Rovaniemi, 333-349.
- Koskinen S, Ylikulppi K. 2000. Kyläyhteisöstä ikääntyneiden voimavara. *Kuntapuntari* 2/2000, 60-64.
- Kosklin R, Laisi M, Rauhala A, Salmiosalo E. 2002. Kotihoitomallikokeilun loppuraportti. Turun terveystoimen julkaisuja.
- Kulla G, Sarvimäki A, Fagerström L. 2006. Health resources and health strategies among older Swedish-speaking Finns – a hermeneutic study. *Scandinavian Journal of Caring Science* 20, 51-57.
- Landi F, Onder G, Russo A, Tabaccanti S, Rollo R, Federici S, Tua E, Cesari M, Bernabei R. 2001. A new model of integrated home care for elderly: impact on hospital use. *Journal of Clinical Epidemiology* 54, 968-970.
- Larsson K, Thorslund M, Kåreholt I. 2006. Are public care and services for older people target according to need? Applying the Behavioural Model on longitudinal data of a Swedish urban older population. *European Journal of Aging* 3, 22-33.
- Lasalvia A, Ruggeri M, Mazzi MA, Dall'Agnola RB. 2000. The perception of needs for care in staff and patients in community-based mental health services. The South-Verona Outcome Project 3. *Acta Psychiatrica Scandinavica* 102, 366-375.
- Leathard A. 2003. Policy overview. In: Leathard A, Horder J. (eds.) *Interprofessional Collaboration: From Policy to Practice in Health and Social Care*. Brunner-Routledge, Abingdon, England.
- Leichsenring K. 2004. Developing integrated health and social care services for older persons in Europe. *International Journal of Integrated Care* 4, 1-15.
- Leinonen R. 2002. Self-rated health in old age. A follow-up study of changes and determinants. *Studies in Sports, Physical Education and Health* 84. University of Jyväskylä, Jyväskylä.
- Lewinter M. 2004. Development in home help for elderly in Denmark: the changing concept of home and institution. *International Journal of Social Welfare* 13, 89-96.
- Lim KH. 2008. Collaboration between disciplinary teams caring for elders in Korean community settings. University of Arizona, USA.
- Lincoln NB, Walker MF, Dixon A, Knights P. 2004. Evaluation of multi-professional community stroke team: a randomized controlled trial. *Clinical Rehabilitation* 18, 40-47.
- Ljungberg C, Hanson E, Lövgren M. 2001. A home rehabilitation program for stroke patients. *Scandinavian Journal of Caring Science* 15, 44-53.
- Loft M, McWilliam C, Ward-Griffin C. 2003. Patient empowerment after total hip and knee replacement. *Orthopedic Nursing* 22, 42-47.
- Low G, Molzahn A. 2007. A replication study of predictors of quality of life in older age. *Research in Nursing & Health* 30, 141-150.
- Lynch M, Estes CL, Hernandez M. 2005. Chronic care initiatives for the elderly: can they bridge the gerontology-medical medicine gap? *Journal of Applied Gerontology* 24, 108-124.
- Mahmood-Yousuf K, Munday D, Nigel K, Jeremy D. 2008. Interprofessional relationship and communication in primary palliative care: impact of the Gold Standards Framework. *British Journal of General Practice* 58, 256-263.
- Malin M. 1996. Kotihoito Helsingissä. Vanhusten ja ja henkilöstön kokemuksia. Helsingin kaupungin tietokeskuksen tutkimuksia 7, Helsinki.
- Malterud K, Hollnagel H, Witt K. 2001. Gendered health resources and coping – A study from general practice. *Scandinavian Journal of Public Health* 29, 183-188.
- Markle-Reid M, Weir R, Browne G, Roberts J, Gafni A, Henderson S. 2006. Health promotion for frail older

- home care clients. *Journal of Advanced Nursing* 54, 381-395.
- Mathieson KM, Kronenfel JJ, Keith VM. 2002. Maintaining functional independence in elderly adults: the roles health status and financial resources in predicting home modifications and use of mobility equipment. *Gerontologist* 42, 24-31.
- McCormack B. 2004. Person-centredness in gerontological nursing: an overview of the literature. *International Journal of Older People Nursing* 13, 31-38.
- Melis R, van Eijken M, Teerenstra S, van Achterberg T, Parker S, Borm G, van de Lisdonk E, Wensing M, Olde Rikkert M. 2008. Multidimensional Geriatric Assessment: Back to the Future. A Randomized Study of a Multidisciplinary Program to Intervene on Geriatric Syndromes in Vulnerable Older People Who Live at Home. *Journal of Gerontology* 3, 283-290.
- Menec VH, Chipperfield JG. 2001. A prospective analysis use among elderly Canadians. *Canadian Journal on Aging* 20, 293-306.
- Miller C, Freeman M, Ross N. 2001. *Interprofessional Practice in Health and Social Care: Challenging the Shared Learning Agenda*. Arnold, London.
- Miles M, Huberman A. 2001. *Qualitative data analysis*. 2nd Edition. Sage, Thousand Oaks, CA.
- Ministry of Social Affairs and Health. 2008a. National Development Plan for Social and Health Care Services. Kaste Programme 2008–2011. Helsinki.
- Ministry of Social Affairs and Health. 2008b. National Framework for High-Quality Services for Older People. Reports the Ministry of Social Affairs and Health 2008:3, Helsinki.
- Ministry of Social Affairs and Health. 2007a. A roadmap for a good old age. Policy definitions for a good care and services for older people 2015. Reports the Ministry of Social Affairs and Health 2007:8, Helsinki.
- Ministry of Social Affairs and Health. 2007b. Welfare 2015 programme. Long-term objectives for social services. Reports the Ministry of Social Affairs and Health 2007:3, Helsinki.
- Mitchell L, Roos NP, Shapiro E. 2005. Patterns in home care use in Manitoba. *Canadian Journal of Aging* 24, 59-68.
- Mitton C, O'Neil D, Simpson L, Hoppins Y, Harcus S. 2007. Nurse-Physician Collaborative Partnership: a rural model for the chronically ill. *Canadian Journal of Rural Medicine* 12, 208-216.
- Modin S, Furhoff A-K. 2002. Care by general practitioners and district nurses of patients receiving home nursing: a study from suburban Stockholm. *Scandinavian Journal of Primary Health Care* 20, 208-212.
- Morse JM. 1991. *Qualitative nursing research: a contemporary dialogue*. Thousands Oaks, Sage, CA.
- MOT Collins English Dictionary. 2000. Retrieved 9th September 2008 from www.kielikone.fi/turkuyo/netmot.exe.
- Muurinen S. 2003. Nursing care and the structure of the nursing staff in institutional respite care. *Acta Universitatis Tamperensis* 936. University of Tampere, Tampere.
- Muurinen S, Raatikainen R. 2005. The correspondence between older clients' needs and assistance in home care. *Gerontologia* 19, 13-22.
- Nezlek JB, Richardson DS, Green LR, Schatten-Jones EC. 2002. Psychological well-being and day to day social interaction among older adults. *Personal relationship* 9, 57-71.
- Nies H. 2006. Managing effective partnerships in older people's services. *Health & Social Care in the Community* 14, 391-399.
- Nikander P. 2003. Moniammatillinen yhteistyö sosiaali- ja terveydenhuollon haasteena. *Vuorovaikutuksellinen näkökulma. Sosiaalilääketieteellinen aikakauslehti* 40, 279-290.
- Nolan MR, Davies S, Brown J, Keady J. 2004. Beyond 'person-centred' care: a new vision for gerontological nursing. *International Journal of Older People Nursing* 13, 45-53.
- Nolan E, Hewison A. 2008. Teamwork in primary care mental health: a policy analysis. *Journal of Nursing Management* 16, 649-661.
- Nolan M, Nolan J. 1998. Nursing and rehabilitation: towards new horizons. *Reviews in Clinical Gerontology* 8, 319-329.
- Nummenmaa T, Konttinen R, Kuusinen J, Leskinen E. 1997. Tutkimusaineiston analyysi. WSOY, Porvoo.
- Nykänen S. 2007. "Kot" on paraspaikka" Kotona asumisen merkitys ikääntyvälle. *KaupunkiElvin osaraportti 2. Lapin yliopistopaino*. Rovaniemi.
- O'Rand AM. 2001. Stratification and the Life Course. The Forms of LifeCourse Capital and Their Interrelationships. In: Binstock RH, Linka GK. (eds.) *Handbook of Aging and the Social Sciences*. Academic Press. New York, 197-213.
- Oxford English Dictionary. 2007. Retrieved 9th September 2008 from www.ezproxy.utu.fi:2262/
- Paasivaara L. 2004. Kotihoito hoitotieteellisten opinäytetöiden perusteella. *Tutkiva hoitotyö* 2, 29-34.
- Paljärvi S, Rissanen S, Sinkkonen S. 2003. Kotihoidon sisältö ja laatu vanhusasiakkaiden, omaisten ja työntekijöiden arvioimana – Seurantatutkimus Kuopion kotihoidosta. *Gerontologia* 17, 85-97.
- Parkinson W. 2004. Multi-disciplinary person-centred care: has government policy helped or hindered? *Nursing Older People* 16, 14-17.
- Partanen I. 2002. Toimialaraportti 2002. Sosiaalipalvelut. Kauppa- ja teollisuusministeriö, TE-keskus.
- Paukkunen L, Turunen H, Tossavainen K, Taskinen H, Sinkkonen S. 2003. Interpersonalliset prosessit ja yhteistyöosaaminen sosiaali- ja terveydenhuollossa – ammatillisen koulutuksen merkitys. *Hoitotiede* 15, 74-88.
- Payne M. 2000. *Teamwork in Multi-professional Care*. Palgrave, London.
- Pelkonen M. 1994. Lapsiperheiden voimavarat ja niiden vahvistaminen hoitotyön keinoin. *Kuopion yliopiston julkaisuja E. Yhteiskuntatieteet* 18, Kuopio.
- Perälä M-L, Grönroos E, Sarvi A. 2006. Home care personnel's work and well-being. *STAKES. Reports* 8/2006. Helsinki.
- Peters M. 2000. Does constructivist epistemology have a place in nursing education? *Journal of Advanced Nursing* 39, 166-170.
- Phelan EA, Anderson LA, LaCroix AZ, Larson EB. 2004. Older adults' views of "successful aging" -how do

- they compare with researchers' definitions? *Journal of American Geriatric Society* 52, 211-216.
- Pietilä A-M, Tervo A. 1998. Elderly Finnish people's experience with coping at home. *International Journal of Nursing Practice* 4, 19-24.
- Pitkälä K, Routasalo P, Blomqvist L. 2004a. Ikääntyneiden yksinäisyys. Taide- ja virikeryhmät psykososiaalisena kuntoutuksena. Geriatrisen kuntoutuksen tutkimus- ja kehittämishanke, tutkimusraportti 5, Vanhustyön keskusliitto, Gummerus Kirjapaino Oy, Saarijärvi.
- Pitkälä K, Laakkonen ML, Strandberg T, Tilvis R. 2004b. Positive life orientation as a predictor of 10-year outcome in an aged population. *Journal of Clinical Epidemiology* 57, 409-414.
- Pitkälä K, Valvanne J, Kulp S, Strandberg TE, Tilvis RS. 2001. Secular trends in self-reported functioning, need for assistance and attitudes towards life: 10 years differences of three older cohorts. *Journal of American Geriatrics Society* 49, 596-600.
- Plochg T, Klazinga NS. 2002. Community-based integrated care: myth or must? *International Journal of Quality Health Care* 14, 91-101.
- Polit DF, Beck CT. 2004. *Nursing research: Principles and Methods*, 7th edn. Lippincott Williams & Wilkins, Philadelphia.
- Poskiparta M, Liimatainen L, Kettunen T, Karhila P. 2001. From nurse-centered health counselling to empowermental health counseling. *Patient Education and Counseling* 45, 69-79.
- Poulton BC, West MA. 1999. The determinants of effectiveness in primary health care teams. *Journal of Interprofessional Care* 13, 7-18.
- Ravanipour M, Salehi S, Taleghani F, Ali Abedi H, Schuurmans MJ, Jong A. 2008. Sense of power among older people in Iran. *Educational Gerontology* 34, 923-938.
- Reech R, Russell W, Little R, Sherlow-Jones S. 2004. An evaluation of a multidisciplinary team for intermediate care at home. *International Journal of Integrated Care* 4, 1-10.
- Reed J, Pearson P, Douglas B, Swinburne S, Wilding H. 2002. Going home from hospital – an appreciative inquiry study. *Health and Social Care in the Community* 10, 36-45.
- Reichstadt J, Depp CA, Palinkas LA, Folsom DP, Jeste DV. 2007. Building Blocks of Successful Aging: A Focus Group Study of Older Adults' Perceived Contributors to Successful Aging. *American Journal of Geriatric Psychiatry* 15, 194-201.
- Reilly S, Challis D, Burns A, Hughes J. 2003. Does integration really make a difference?: a comparison of old age psychiatry services in England and Northern Ireland. *International Journal of Geriatric Psychiatry* 18, 887-893.
- Rissanen L. 1999. Ability of elderly people to cope at home. Health, functional capacity and subjective need for social and health care services among people aged over 65. *Acta Universitatis Ouluensis Medica* D 560. University of Oulu, Oulu.
- Rissanen S, Laitinen-Junkkari P, Hirvonen R, Sinkkonen S. 1999. Vanhusten kotihoidon laatu Kuopiossa 1994 ja 1997 – arviointitutkimus kotipalvelun ja kotisairaanhoidon yhdistämisen vaikutuksesta kotihoidon laatuun vanhusasiakkaiden, omaisten ja työntekijöiden arvioimana. *Gerontologia* 13, 71-81.
- Ritzel DO, Beasley D, Flynn J, Liefer M. 2001. Injuries to elderly women in the home environment: a research review. *The International Electronic Journal of Health Education* 4, 64-66.
- Rogers A. 1997. Vulnerability, health and health care. *Journal of Advanced Nursing* 26, 65-72.
- Roine K, Tarkka M-T, Kaukonen M. 2000. Säännöllistä sosiaali- ja terveydenhuollon palveluita käyttämättömien yli 75-vuotiaiden vanhusten kotona selviytyminen. *Hoitotiede* 12, 312-321.
- Rolfé G. 2006. Technical rationality and the theory practice gap. *Nursing Science Quality* 19, 39-43.
- Roschelle J, Teasley SD. 1995. The construction of shared knowledge in collaborative problem solving. In: O'Malley CE. (eds.) *Computer-supported collaborative learning*. Springer-Verlag, Berlin, 69-197.
- Routasalo P, Arve S, Lauri S. 2004a. Geriatric rehabilitation nursing: Developing a model. *International Journal of Nursing Practice* 10, 207-215.
- Routasalo P, Pitkälä K. 2004. Taideryhmäläisten kokemuksia haastattelujen perusteella. Teoksessa: Pitkälä K, Routasalo P, Blomqvist L. (toim.) *Ikääntyneiden yksinäisyys. Taide- ja virikeryhmät psykososiaalisena kuntoutuksena. Geriatrisen kuntoutuksen tutkimus- ja kehittämishanke, tutkimusraportti 5*, Vanhustyön keskusliitto, Gummerus Kirjapaino Oy, Saarijärvi, 103-112.
- Routasalo P, Pitkälä K, Savikko N, Tilvis R. 2003. Ikääntyneiden yksinäisyys: kyselytutkimuksen tuloksia. Geriatrisen kuntoutuksen tutkimus- ja kehittämishanke, tutkimusraportti 3, Vanhustyön keskusliitto, Gummerus Kirjapaino Oy, Saarijärvi.
- Routasalo P, Savikko N, Tilvis RS, Strandberg TE, Pitkälä K. 2006. Social Contacts and Their Relationship to Loneliness among Aged People – A Population- Based Study. *Gerontology* 52, 181-187.
- Routasalo P, Tilvis RS, Kautiainen H, Pitkälä KH. 2009. Effects of psychological group rehabilitation on social functioning, loneliness and well-being of lonely, older people: randomized controlled trial. *Journal of Advanced Nursing* 65, 297-305.
- Routasalo P, Wagner L, Virtanen H. 2004b. Registered nurses' perceptions of geriatric rehabilitation nursing in three Scandinavian countries. *Scandinavian Journal of Caring Sciences* 18, 220-228.
- Rummery K, Coleman A. 2003. Primary health and social care services in the UK: progress towards partnership? *Social Science & Medicine* 56, 1773-1782.
- Ruoppila I. 2002. Psykkisen toimintakyvyn tukeminen. Teoksessa: Heikkinen E, Marin M. (toim.) *Vanhuden voimavarat. Kustannusosakeyhtiö Tammi, Helsinki*, 119-150.
- Ryan AA, McCann S, McKenna H. 2008. Impact of community care in enabling older people with complex needs to remain at home. *International Journal of Older People Nursing* 4, 22-32.
- Saarenheimo M. 2004. Psykkisen vanhenemisen nykytila. *Gerontologia* 18, 63.
- Saaren-Seppälä T. 2004. Inter-Organizational Medical Care: a study about new practices and relationships between GP, hospital and childrens' parents. *Acta Universitatis Tampereensis* 1052, University of Tampere, Tampere.
- Saevareid HI, Thygesen E, Nygaard HA, Lindstrom TC. 2007. Does sense of coherence affect the relationship

- between self-rated health and health status in a sample of community-dwelling frail elderly people? *Aging and Mental Health* 11, 658-667.
- Salmelainen U. 2008. Information exchange and knowledge construction in rehabilitation. Multiprofessional networking in institutional geriatric rehabilitation. *Sosiaali- ja terveysturvan tutkimuksia* 98. Kelan tutkimusosasto, Helsinki.
- Salin S. 2008. Lyhytaikaisen laitoshoidon reaalityö vanhuksen kotihoitoon osana. *Acta Universitatis Tampereensis*, 1346. University of Tampere, Tampere.
- Salonen P, Haverinen R. 2003. Providing integrated health and social care for older persons in Finland. Available at <http://www.imsersomayores.csic.es/documentos/documentos/procare-providingfinlandia-01.pdf> (assessed on 6 March 2009)
- Sandelowski M. 2000. Focus of Research Methods. Whatever Happened to Qualitative Description? *Research in Nursing & Health* 23, 334-340.
- San-Martin-Rodriguez L, Beaulieu M, D'Amour D, Ferrada-Videla M. 2005. The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care* 1, 132-147.
- Santana S, Dias A, Souza E, Rocha N. 2007. The Domiciliary Support Service in Portugal and the change of paradigm in care provision. *International Journal of Integrated Care* 15, 1-8.
- Savikko N. 2008. Loneliness of older people and elements of an intervention for its alleviation. Doctoral dissertation. *Annales Universitatis Turkuensis, Series Medica-Odontologia D 808*. University of Turku, Turku.
- Scholes J, Vaughan B. 2002. Cross-boundary working: implications for the multi-professional team. *Journal of Clinical Nursing* 11, 399-408.
- Schmitt MH. 2001. Collaboration improves the quality of care: methodological challenges and evidence from US health care research. *Journal of Interprofessional Care* 15, 47-66.
- Seidman IE. 1998. *Interviewing as Qualitative Research: a Guide for Researchers in Education and the Social Sciences*. 2nd ed. Teachers College Press, New York.
- Shilling O, Wahl HW. 2002. Family networks and life satisfaction of older adults in rural and urban regions. *Kolner Zeitschrift für Soziologie und Sozialpsychologie* 54, 304-317.
- Sims RV, Ahmed A, Sawyer P, Allman RM. 2007. Self-Reported Health and Driving Cessation in Community-Dwelling Older Drivers. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences* 62, 789-793.
- Siitonen J. 1999. Voimaantumisteorian perusteiden hahmottelua. *Acta Universitatis Ouluensis, Series E. Scientia Retum Socialium*. Oulun yliopisto, Oulu.
- Sommers L, Marton K, Barbaccia J, Randolph J. 2000. Physician, Nurse and Social Worker Collaboration in Primary Care for Chronically Ill Seniors. *Archives of Internal Medicine* 160, 1825-1833.
- Sparks M, Zehr D, Painter B. 2004. Predictors of life satisfaction. Perceptions of Older Community-Dwelling Adults. *Journal of Gerontological Nursing* 47-53.
- STAKES. 2008. Kotihoidon laskenta (A count of clients having regularly home care services). *Tilastotiedote* 22/2008, 25.6.2008 Suomen virallinen tilasto, Sosiaaliturva 2008.
- STAKES. 2007a. Care and services for older people. Finnish Official Statistics, Social Protection. Yliopistopaino, Helsinki.
- STAKES. 2007b. Dementia-asiakkaat sosiaali- ja terveystalvelujen piirissä 2001, 2003 ja 2005. *Tilastotiedote* 20/2007, Helsinki.
- Statistic Finland. 2007. Population projection 2007 – 2040. Available at http://www.stat.fi/til/vaenn/2007/vaenn_2007_2007-05-31_tie_001_en.html (accessed 25 February 2009)
- Stenzelius K, Westergren A, Thorneman G, Hallberg IR. 2005. Patterns of health complaints among people 75+ in relation to quality of life and need of help. *Archives of Gerontology and Geriatrics* 40, 85–102.
- Steward A, Petch A, Curtice L. 2003. Moving towards integrated working in health and social care in Scotland: from maze to matrix. *Journal of Interprofessional care* 17, 335-350.
- STM ja Suomen Kuntaliitto. 2008. Ikäihmisten palveluiden laatusuositus. Sosiaali- ja terveystalvelministeriön julkaisuja 3. Yliopistopaino Oy, Helsinki. Available at <http://www.stm.fi/Resource.phx/julkt/Julkaisu-2008-short.htm> (accessed 25 February 2009)
- Strauss A, Corbin J. 1998. *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, Sage Publications, CA.
- Stuck AE, Egger M, Hammer A, Minder CE, Beck JC. 2002. Home visits to prevent nursing home admission and functional decline in elderly people: systematic review and meta-regression analysis. *JAMA* 287, 1022-1028.
- Takkinen S, Suutama T. 1999. Elämän tarkoituksellisuus iäkkäiden ihmisten kokemana kahdeksan vuoden seuraututkimuksessa. Teoksessa: Suutama T, Ruoppila I, Laukkanen P. (toim.) Iäkkäiden henkilöiden toimintakyvyn muutokset. Havainnot ja Ikivihreät-projektin 8-vuotisesta seuraututkimuksesta. Kela, Sosiaali- ja terveystalvel tutkimuksia 42, Helsinki, 77-98.
- Taylor SJ, Bogdan R. 1998. *Introduction to Qualitative Research Methods: A Guidebook and Resource*. 3rd ed. John Wiley & Sons Inc, New York.
- Tedre S. 1999. Vanhusten kotitalvelu huolenpitoverkoston solmukohtana. Teoksessa: Metteri A. (toim.) Moniammatillisuus ja sosiaalityö. Sosiaalityön vuosikirja. Edita. Helsinki, 104-111.
- Tenkanen R. 2003. The development of cooperation in home care and its implications for quality of life among elderly clients. *Acta Universitatis Lapponensis*. 62. University of Lapland, Rovaniemi.
- Tepponen M. 2009. Kotihoidon integrointi ja laatu. Kuopion yliopiston julkaisuja E. Yhteiskuntatieteet 171. University of Kuopio, Kuopio.
- Tepponen P. 2003. The Implementation of Services for the Customers of Home Care, of the Age of over 75 Years in the Metropolitan Area An Analysis in the Cities of Espoo, Helsinki and Vantaa. University of Helsinki, Helsinki.
- The Primary Health Care Act (66/1972) *Kansanterveyslaki* 28.1.1972/66. Available at www.finlex.fi (accessed 25 February 2009)
- The Primary Health Care Temporary Removal Act 1429/2004 *Laki kansanterveyslain väliaikaisesta muuttamisesta* 31.12.2004/1429. Available at www.finlex.fi (accessed 25 February 2009)

- The Social Welfare Act (710/1982) Sosiaalihuoltolaki 17.9.1982/710. Available at www.finlex.fi (accessed 25 February 2009)
- The Social Welfare Temporary Removal Act 1428/2004 Laki sosiaalihuoltolain väliaikaisesta muuttamisesta 31.12.2004/1428. Available at www.finlex.fi (accessed 25 February 2009)
- The Act on the Status and Rights of Social Welfare Clients (812/2000) Laki sosiaalihuollon asiakkaan asemasta ja oikeuksista 22.8.2000/812. Available at www.finlex.fi (accessed 25 February 2009)
- The Government Programme of Prime Minister Matti Vanhanen's second cabinet. 19.4.2007. Available at <http://www.valtioneuvosto.fi/hallitus/hallitusohjelma/fi.jsp> (accessed 25 February 2009)
- Themessl-Huber M, Hubbard G, Munro P. 2007. Frail older people's experiences and use of health and social care services. *Journal of Nursing Management* 15, 222-229.
- Thomé B, Dykes A-K, Hallberg IR. 2003. Home care with regard to definition, care recipients, content and outcome: systematic literature review. *Journal of Clinical Nursing* 12, 860-872.
- Thursz D, Nusberg C, Prather J. 1995. *Empowering Older People: An International Approach*. Greenwood Publishing Group, Canada.
- Tijhuis M, De Jong-Gierveld J, Feskens E, Kromhout D. 1999. Changes in and factors related to loneliness in older men. The Zutphen Elderly Study. *Age and Ageing* 28, 491-495.
- Tilvis RS, Pitkälä K, Jolkkonen J, Strandberg T. 2000. Feeling of loneliness and 10-year cognitive decline in the aged population. *Lancet* 356, 77-78.
- Toljamo M, Perälä M-L, Hammar T. 2008. The impact of the integrated services to home care personnel's job, job satisfaction and quality of services: an intervention study. *International Journal of Integrated Care* 8.
- Tornstam L. 1982. Teorier och forskningsansatser. In: Tornstam L, Öden B, Svanborg A. (eds.). *Äldre i samhället förr, nu och i framtiden*. Liber Förlag, Stockholm.
- Vaarama M. 2006. Kotihoidon laatu ja tuloksellisuus Espoossa. Espoon vanhuspalvelujen tuloksellisuusprojekti. Loppuraportti ja suositukset. Espoon kaupunki ja Stakes: Sosiaali- ja terveystoimen julkaisuja 7/2006.
- Vaarama M, Pieper R. 2006. *Managing Integrated Care for Older Persons. European Perspectives and Good Practices*. STAKES & EHMA. Gummerus Printing, Vaajakoski, Finland.
- Valta A. 2008. *Iäkkäiden päivittäinen suoriutuminen kotona*. Teoreettinen malli iäkkäiden kotona asuvien päivittäisestä suoriutumisesta kotisairaanhoidajien ja iäkkäiden näkökulmasta. Acta Universitatis Tamperensis; 1368, University of Tampere, Tampere.
- Valvanne J. 2006. Integrating social and health care in practice – A Finnish project. In: Vaarama M, Pieper R. (eds.) *Managing Integrated Care for Older Persons. European Perspectives and Good Practices*. Gummerus Printing, Finland, 200-219.
- Voutilainen P. 2004. Hoitotyön laatu ikääntyneiden pitkäaikaisessa laitoshoidossa. Stakes tutkimuksia 142.
- Voutilainen P, Kauppinen S, Heinola R, Finne-Soveri H, Sinervo T, Kattainen E, Topo P, Andesson S. 2007. Ikääntyneiden palvelut. Teoksessa: Heikkilä M, Lahti T. (toim.) *Sosiaali- ja terveydenhuollon palvelukatsaus 2007*. Stakes, Yliopistopaino, Helsinki, 154-190.
- Voutilainen P, Vaarama M-L. 2005. Toimintakyky mittareiden käyttö ikääntyneiden palvelutarpeen arvioinnissa. Stakes, raportteja 7. Helsinki.
- Walker A. 2006. Extending quality of life: Policy prescriptions from the Growing Older Program. *Journal of Social Policy* 35, 437-454.
- Walsh ME, Brabeck MM, Howard KA. 1999. Interprofessional Collaboration in Children's Services: Toward a Theoretical Framework. *Children's Services: Social Policy, Research & Practice* 2, 183-208.
- Webster J. 2002. Teamwork: understanding multi-professional working. *Nursing Older People* 14, 14-19.
- Weiss RS, Bass SA. 2002. *Challenges of the Third Age: Meaning and Purpose in Later Life*. Oxford University Press, Oxford.
- White H, McConnell E, Clipp E, Bynum L. 1999. Surfing the net in later life: A review of the literature and pilot study of computer use and quality of life. *Journal of Applied Gerontology* 18, 358-378.
- WHO. 2006. *The World Health Report 2006 – Working together for health*. World Health Organisation, Geneva.
- WHO. 2004. *International Classification of Functioning, Disability and Health*. Available at www.who.int/classifications/icf/site/icftemplate.cfm?mytitle=Literature%20review%20on%20environmental%20factors&myurl=litreview.html (accessed on 25 February 2009)
- WHO. 2002. *Active Ageing: A Policy Framework*. Available at www.euro.who.int/document/healthagepolframe.pdf (accessed on 25 February 2009)
- WHO. 1980. *International classification of Impairments, Disabilities, and Handicaps. A manual of classification relating to the consequences of disease*. Geneva, 1-43.
- Wilson V, Pirrie A. 2000. *Multidisciplinary Teamworking. Beyond the Barriers? A Review of the Issues*. SCRE Research Report No 96. University of Glasgow.
- Windle G, Woods RT. 2004. Variations in subjective wellbeing: the mediating role of a psychological resource. *Ageing and Society* 24, 583-602.
- World Medical Association Declaration of Helsinki. 2000. *Ethical principles for medical research involving human subjects*. Geneva.
- Železnik D. 2007. Self-care of the homedwelling elderly people living in slovenia. Acta Universitatis Ouluensis D Medica 954, University of Oulu, Oulu.
- Xyrichis A, Lowton K. 2008. What fosters or prevents interprofessional teamworking in primary and community care? A literature review. *International Journal of Nursing Studies* 45, 140-153.

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Turku, September 2009

Sini Eloranta

APPENDICES

Appendix 1. Studies on resources of home-dwelling older people

Author, year, country	Purpose	Sample	Method	Main findings
Backman 2001, Finland	To describe and understand the self-care of home-dwelling elderly and to produce a model of the phenomenon.	40 older people (75+)	Interview	Four types of self-care were constructed. The best functional ability is connected with an individual self-care behavioural style and survivors. In addition, these people have internal and external resources for self-care. They have a positive attitude and workable social networks.
Bryant et al. 2001, USA	To understand what constitutes older people's health and what contributes to it.	22 older people (60+)	Interview	For older people health meant going and doing something meaningful which required four components: something worthwhile to do, balance between abilities and challenges, appropriate external resources (social contacts with family, friends and health care providers) and personal attitudinal characteristics (e.g. positive attitude).
Burr & Mutchler 2007, USA	To evaluate an expanded version of the resource model of living arrangements among older persons.	2305 older people (60+)	Survey	The individual-level resource variables show those with a greater economic resources, more children, and better functional status are better able to maintain independence and are less likely to live in a nursing home.
Dean et al. 2008, UK	To explore how different types of resources and the goal relevance of these resources affect older people's satisfaction with food-related life.	3291 older people (65+)	Survey	Social resources such as support from family and friends added to the individuals' satisfaction with food-related life.
Elo S. 2006, Finland	To construct a theory of an environment supporting the well-being of the home-dwelling elderly from Northern Finland.	328 older people (65+)	Interview and survey	Physical, social and symbolic environments support older peoples' well-being. The attributes defining a physical environment supporting well-being are a northern environment, an environment ensuring safety and a pleasant physical environment. A social environment supporting well-being is made up of the availability of assistance, contact with family members, friends supporting well-being and a pleasant living community. A symbolic environment supporting well-being comprises the idealistic attributes of well-being, spirituality, the normative attributes of well-being and history.
Forssén 2007, Sweden	To explore how elderly women used humour, beauty and cultural activities to maintain physical and mental well-being.	20 older women (age 63-83)	Interview	Personal health resources such as humour, beauty and cultural activities formed a greater part of older women's survival strategies.
Forssén & Carlstedt 2006, Sweden	To describe strategies developed by women to handle lack of time for themselves, and lack of freedom in private life.	20 older women (age 63-83)	Interview	The need for privacy ("a room of one's own") was a health promoting resource for older women.
Hokkanen et al. 2006, Finland	To produce descriptive concepts of the resources of the home-dwelling elderly according to the previous research literature.	20 articles	Review	The categories describing resources were psychological, mental and physical well-being, social relationships, services and co-operation partnership, meaningful activities, environment and financial circumstances.
Johannesen et al. 2004, Denmark	To investigate whether social relations, continuity, self-determination, and use of own resources are associated with everyday life satisfaction among older people with physical disabilities.	187 older people (85 years)	Survey	Older people more frequently express satisfaction with their daily lives when they have friends and feel able to manage their own lives.

Author, year, country	Purpose	Sample	Method	Main findings
Knipscheer et al. 2000, Netherlands	To examine the environmental and personal resources (psychosocial) and determinants of depression in older adults.	2981 older people (55 to 85 years)	Survey	Being able and feeling able to influence one's environment increases proactive behaviour and decreases depressive symptomatology in older adults with lower functional status.
Koskinen et al. 2007, Finland	To study what kind of resources older people have and the meanings given to these strengths in different spheres of life.	140 older people, (60 to 79 years)	Interview	The older people's resources consisted of collective, socio-cultural, social and personal resources. Older people also have lost of resources.
Koskinen & Ylikulppi 2000, Finland	To study home-dwelling older peoples' life.	110 older people (65+)	Interview	For older people, the social networks, especially family and village community and relation of nature were important resources.
Kulla et al. 2006, Finland	To explore the health resources and health strategies among home-dwelling Swedish-speaking Finns.	22 older people (75+)	Interview	The main health resources of older people were related to social and other activities as well as to personality.
Loft et al. 2003, Canada	To gain an enhanced understanding of empowerment within in-home care relationships after hospital discharge of elderly patients who had undergone total hip or total knee replacement.	9 older people (66 to 89 years)	Interview	Older people showed a strong desire to maintain their independent lifestyles as quickly as possible after discharge from hospital. In addition, collaboration between care providers were experienced as a resource.
Malterud et al. 2001, Denmark & Norway	To explore gender and coping in primary health care patients, expressed as self-assessed health resource in men and women.	76 people (19 to 85 years)	Interview	In men, personal resources were part of a proud identity, while women reported that they were able to manage because they had to. This positive attitude is related to the feeling of trust in the people's own capacity. In addition, social relations were described as resources.
Pietilä & Tervo 1998, Finland	To describe elderly Finnish people coping at home.	20 older people (75+)	Interview	The factors that promoted coping at home were maintenance of health, the experience of well-being and security. Older people's coping at home consisted of social contacts (family, public health services, and neighbours) and previous life experiences.
Ravanipour et al. 2008, Iran	To search for factors influencing the sense of power, which exist in elders' interactions in their environment.	26 older people (60+)	Interviews	These factors were awareness of personal changes, coping, role taking, perceived satisfaction, independence, and being in control. Self-management was at the core of all these factors.
Reichstadt et al. 2007, USA	To solicit the opinions of older adults about factors related to successful aging.	72 older people (60 to 99 years)	Focus groups interviews	Four major themes emerged: attitude/adaptation (positive attitude, realistic perspective, the ability to adapt to change), security/stability (living environment, social support/financial resource), health/wellness and engagement/stimulation (learning, feeling a sense of purpose in life, being useful to others and to society). Older adults place greater emphasis on psychosocial factors as being key to successful aging.
Rissanen 1999, Finland	To describe self-evaluated health, functional capacity and subjective need for and use of social and health care services among people living in Finland.	157 older people (65+)	Survey	The major resources for women were religion, family and a positive outlook. Men derived strength from their responsibilities, expectations of a better future and religion.
Roine et al. 2000, Finland	To discover the characteristics of older people living at home without the help of home care services.	198 older people (75+)	Interview	Resources of older people were a positive attitude to life, religion, feeling well and strong family values.
Routasalo & Pitkälä 2004, Finland	To describe how home-dwelling older people experience taking part in art groups.	12 older people (75+)	Interview	The older people experienced art as music, poetry, movies, theatre, dance, literature, wildlife, photography, visual arts, good feelings and this gave them strength.

Author, year, country	Purpose	Sample	Method	Main findings
Saevareid et al. 2007, Norway	To examine the association between self-rated health and physical, functional, social and mental health measures in community dwelling elderly people needing nursing care. Of special interest was how coping resources influenced this relationship.	242 older people, (mean age 84.6)	Interview and survey	Coping resources (e.g. sense of coherence) associated with self-rated health directly and indirectly through subjective perceived health but only in men.
Sparks et al. 2004, USA	To investigate variables that predicts life satisfaction in elderly individuals.	70 older people (69 to 91 years)	Survey	Social interaction and perceived control were predictors of life satisfaction.
Takkinen & Suutama 1999, Finland	To describe the changes in degree and content of meaning in life, the source of strength of life, a new activity giving meaning in life, changes in zest for life and the meaning of death.	598 older people (born 1904-1923)	Interview	Most participants found their life meaningful. The most common source for meaning in life was human relationships. The most important source of strength of life was religion. In the younger age group (born in 1917-23), reference was also made to psychological well-being.
Valta 2008, Finland	To built a theoretical model for the daily performance of home dwelling elderly over 75 years old.	204 home nurses 20 elderly	Interview and survey	The elderly persons' own experiences of 'good feeling' consisted of the elements of own activity and doing, joy and happiness and taking care of oneself. Getting assistance from family and providers were important.
Windle & Woods 2004, UK	To examine the role of psychological resources and its mediating effect on subjective wellbeing.	423 older people (mean age 78)	Interview and survey	Psychological resources such as a sense of mastery, and competence in managing the environment underlie the processes of adaptation to the changing situations that can accompany increasing age and which help to prevent a negative outcome.

Appendix 2. Studies on social and health care collaboration in primary and community care

Author, year, country	Purpose	Sample	Method	Main findings
Allan et al. 2005, England	To evaluate a project (Beechtree Health Practice) to develop an interprofessional learning culture within a primary care setting.	46 primary care staff	Interviews and focus groups	Interprofessional learning culture requires responsibility for one's own learning as individuals as well as learning as teams of work colleagues if learning is to be successful. There were not only different but conflicting views that take time to resolve in order that progress towards shared goals can be achieved.
Andersson et al. 2004, Finland	To assess the flexibility of integrated home care as perceived by older clients, social and health care staff and managers.	Two municipalities: 22 older people, 17 social and health care professionals and managers.	Interview of older clients and focus-group interview for staff	Integrated home care improved communication and the job satisfaction of staff. The clients' knowledge about what the staff had overall responsibility for in their care increased a little. Care delivery was expert-oriented and the clients' care and service plan use was inadequate.
Beech et al. 2004, England	To evaluate a multidisciplinary Rapid Response Team (RRT) service that aimed to provide a home based alternative to care previously provided in an acute hospital.	231 older clients 11 staff	Quantitative and qualitative methods	Older clients and carers had positive attitudes to the new service, but some expressed concerns about their ability to influence the choice of care option (24.1% of clients and 25.0% of carers), whilst 22.7% of carers were concerned about the quality of information about care.
Bélangier & Rodriguez 2008, Canada	Qualitative research synthesis review papers on multi-disciplinary primary care teams.	19 qualitative studies	Review	Strategies for organizational change toward collaborative practice: time and resources; locally adapted and flexible organizational structure, clear goals and communication effectively and sharing power involving all health professionals. Dimensions of team interaction and work relations: trust and respect, maintaining the central role of the general practitioner, redefining professional identities and promoting a team-based organisational identity.
Bernabei et al. 1998, Italy	To evaluate the impact of integrated social and health care among older people living at home.	200 older people	Randomised study with 1 year follow-up	In a comparison to fragmented model of community care the integrated care approach reduced admission to institutions and functional decline in older people living at home and also reduced costs.
Brown et al. 2003, England	To explore whether an integrated service is more effective than a traditional non-integrated method of service delivery.	393 older people	Non-randomised comparative design Follow-up time over 18 months. Survey and semi-structured interview	There were no discernible differences between the integrated care and a traditional care group on the following outcome measures: previous contact with social services, visits made by a district nurse, functional ability and mental functioning. The speed of response from referral to assessment was quicker in the integrated teams. In the integrated teams, the initial stages of the process of seeking help and being assessed for a service may have improved through better communication, understanding and exchange of information among different professional groups.
Büscher 2007, Finland	To investigate how family caregivers and nurses consider their mutual relationship and to develop a substantive theory on the relationship between formal and informal care.	88 family caregivers, nurses and nurse managers	Interviews	The perspectives of family caregivers and nurses on their relationship differ considerably, but both are engaged in a process of negotiating helpful action. The main aspect was trust between family caregivers and nurses.
Cameron et al. 2007, England	To explore joint working between health, social and housing.	The six pilot studies from the statutory independent and voluntary sectors. Professional stakeholder groups and agencies and people who used services.	Semi-structured interviews	There is a need to shave an understanding of the purpose of joint working, the history of joint working and clear and efficient governance arrangements. Integrating services to support people with complex needs works best when the service is determined by the characteristics of those who use the service rather than pre-existing organisational structures.

Author, year, country	Purpose	Sample	Method	Main findings
Cheung & Ngan 2005, China	To study the effect of multidisciplinary home care services on older users' functional ability.	49 older people	Survey and interviews 2 years follow-up study	Older users maintained better functional ability with a longer time of using a home care service. Multidisciplinary services under case management underpin an effective home care program.
Cook et al. 2001, England	To draw from findings of two evaluations of team working arrangement to illustrate the impact of team development on decision making.	24 professionals 2 health and social care teams	Action research using focus groups and interviews	The shared geographical location, the team's autonomy, the shared goals, an understanding of each professional's role and positive interpersonal relations (e.g. trust) facilitated an increase in the speed and quality of decision making, and increase innovation and provided a client-centred quality service.
Davey et al. 2005, England	To compare two models of joint working service and examine the relative impact of personal characteristics, service use and co-location on the likelihood of older people remaining in the community.	79 older people Compared two models (5 social work teams moved into health centres with the primary care professionals vs. traditional structure)	Interview Follow-up six months	The co-location of health and social care staff alters the extent of direct face to face communication, but does not alter the overall style of communication, nor its direction between social care and community nurses. 82% of the total 86 contacts with nurses were initiated by social care workers, whereas nurses had initiated 14% of contacts.
Enderby 2002, England	To identify the different models of community rehabilitation and to investigate approaches to collaboration in teams working with disabled older adults.	152 community rehabilitation teams	Survey	Members of teams were unclear about the management structure of the team or of them as individual members. Different views of the main purpose of the team were not unusual. The biggest threat to teams being effective was lack of attention to the principles of team working.
Freeman et al. 2000, England	To explore the factors that inhibited or supported collaborative practice.	Six clinical teams (diabetes, primary health care, medical ward, neuro-rehabilitation unit, child development assessment and community mental health teams)	Six case studies	Three main categories emerged: shared vision, communication and role understanding and valuing.
Hammar 2008, Finland	To describe older home care clients need for help and to assess the effectiveness and cost-effectiveness of the PALKO model (Integrated Services in the Practice of Discharge and Home Care).	22 municipalities randomised to the intervention and to the controls 770 older clients 668 relatives	Interviews for the clients and survey for the professionals Health statistics database "SOTKA"	The clients' own views and the workers' views differed considerably in the amount of help and assistance needed to cope with activities of daily living. Implementing the PALKO model had no effect on the clients' functional ability, health or mortality. By developing home care practices according to the PALKO model, municipalities will be able to offer older people services more efficiently.
Hek et al. 2004, England	To describe the evaluation of the 1-year pilot project the aim of which was to assist older people to remain in their own homes through joint working between health and social care.	5 older clients 29 (generic workers = something between the existing community health care assistant and the existing community support worker, district nurse, community support workers)	Semi-structured interviews of the clients and diary + focus group interviews with the professionals - at the beginning of the new service and again at the end (1-year)	The clients were satisfied with the care they received, particularly the emotional aspects of care. The generic worker role fulfilled an important function for older people at home in the community. A high proportion of the generic workers' time was spent listening and responding to their client's mental health needs and providing comfort and emotional support. Having been trained by local health professionals, the generic workers felt valued and respected, better able to communicate with their health colleagues and, therefore, able to provide holistic care to their clients.

Author, year, country	Purpose	Sample	Method	Main findings
Hills et al. 2007, Canada	To explore the challenges of putting the multidisciplinary practice (MDP) approaches into practice.	1 community	Community-based participatory action research project	Multidisciplinary team approaches to care were difficult to achieve. The successful implementation of an MDP approach to primary health care requires moving away from physician-driven care. This can only be achieved once there is a change in the underlying structures, values, power relations and roles defined by the health care system and the community at large, where physicians are traditionally ranked above other care providers.
Hubbard & Themessl-Huber 2005, Scotland	To report health and social care professionals' perceptions on joint working for the care of older people.	34 primary health care and social care professionals	Interview	Professionals emphasised that joint working requires a fundamental change in thinking and a scrutiny of professional roles and identities and is influenced by the given geographical and organisational infrastructure.
Huxley et al. 2008, Wales	To examine the relationship between assessments and eligibility decisions made by health and social care staff in multidisciplinary community teams.	413 care coordinators from 71 teams	Survey	The need for training for health professionals in order to make decisions about social assessment and eligibility determination. Social care, in the partnership context, was marginalised within health care.
King & Ross 2003, England	To explore the ways social and health care professionals construe their identity and relationship within the changing context of collaborative projects.	70 social workers and district nurses	Focus groups and in-depth individual interviews	A number of areas associated with professional identity and the development of roles in response to changing situations were identified as pertinent including role ambiguity, role erosion and extension.
Koponen 2003, Finland	To develop a substantive theory of coping skills for elderly clients and their cooperation with their family members and formal caregivers promoting coping skills during the client's transition between home and hospital.	24 older people 14 family members 54 formal caregivers in home care and hospitals during the clients' transition between home and hospital.	Interviews	The intensity of multi-professional collaboration was problematic, when the clients' health situation changed. Intense collaboration between care providers is needed, especially in situations, where there is repeated transition between home and hospital.
Lim 2008, Korea	To test a hypothesized collaboration model in home care.	40 nurse teams 40 social worker teams	Survey	Four constructs: team member, context, collaboration process and degree of collaboration influence collaboration.
Mahmood-Yousuf et al. 2008, England	To investigate the inter-professional relationship and communication and to compare GPs' (general practice) and nurses' experiences.	38 GPs and district nurses	Interviews	Multidisciplinary team meetings enabled communication for sharing knowledge, discussing management problems and keeping colleagues informed. However, arranging and maintaining such meetings was often problematic. The best functioning teams used a mixture of formal and informal meetings with a relatively non-hierarchical working style.
Mitton et al. 2007, England	To improve both access to and quality of primary health care services through the development, implementation and evaluation of a collaborative partnership between home care nurses and a family physician practice.	37 older people 1 physician and 2 nurses	Interviews and survey	Older people made improvements in activities of daily living and cognitive status. Older people reported improvements in psychological well-being, knowledge of disease processes and confidence to manage health issues. Peoples' use of acute health care services decreased, showing a 51% reduction in the number of days in hospital, a 32% reduction in emergency department visits and a 25% reduction in hospital admissions. Total service cost decreased by 40%.
Muurinen & Raatikainen 2005, Finland	To study older clients' health needs and level of required assistance in home care.	97 older people 38 social and health care professionals	Interviews for clients and survey for professionals	Poor collaboration between the clients, their relatives and staff, the flow of information and clients' participation of their own care was problematic in home care.

Author, year, country	Purpose	Sample	Method	Main findings
Paijärvi et al. 2003, Finland	To describe and assess home care quality and changes in 1994, 1997 and 2000.	66-84 older clients 73-75 relatives 68-87 social and health care professionals	Follow-up study Interviews for clients and survey for relatives and professionals	Integration of home help and home health care services did not increase quality of care. However, the continuity of care can be improved with collaboration. The clients receiving care in homes have more disabilities and complex health needs than was previously the case.
Perälä et al. 2006, Finland	To describe home care personnel and their work in the home-help service, home nursing and unified home help and home nursing services.	1183 home care personnel	Survey	The flow of information and quality of care are improved in unified home care units. Those staff who worked in unified integrated home care units believed that they could not influence their work as well as those staff who worked in separate units.
Poulton & West 1999, UK, England	To examine the influence of team composition and processes upon team effectiveness.	528 members of 68 primary health care teams	Survey	Team processes (objectives, participation, quality emphasis and support for innovation) accounted for 23% of the variation between teams in their effectiveness. In particular, clarity of and commitment to team objectives was key in predicting the overall effectiveness of the primary health care team.
Reilly et al. 2003, England	To test whether jointly administrated social and health services are more likely to promote collaborative and multi-disciplinary working and to explore what factors contribute to more integrated practices.	331 psychiatrists in integrated health and social services	Survey	Integrated structures do not automatically lead to integrated practices. Three types of factors were found to be associated with greater integration of health and social care: presence of specialist services, presence of outreach activities and shared team policies and procedures by which the whole team worked.
Rummary & Coleman 2003, England	To study partnership working between primary care groups and trusts (PCG/Ts) and social services departments.	15% of English PCG/ Ts key stakeholders (survey) Stakeholders at PCG/ Ts board level, national health service (NHS) and social services department (SSD) (interviews)	3-year longitudinal study Survey and semi-structured interviews	Shared values and visions in partnership working are important. Acknowledgement of the need for partnership working and the commitment necessary to sustain it. Interprofessional differences between health and social care workers also need to be acknowledged. If trust and enthusiasm for partnership working are to be maintained, then one side will not be able to be completely take the process over, it has to be a joint activity, in which both sides benefit.
Salmelainen 2008, Finland	To study the exchange, construction and adequacy of information and knowledge between the members of the multi-professional expert network within a geriatric rehabilitation intervention.	58 key workers 7 multi-professional teams	Interview and survey	Written documents served well for the purpose of transferring information about an individual rehabilitee's illness and physical capabilities, but they only contained sparse information about the elderly person's social functioning or any situational factors, such as living environment, life situation, ability to cope at home, or need of assistance. Multi-professional forums enabled the expert involved in the intervention to exchange information and construct shared knowledge concerning the rehabilitees.
Salin 2008, Finland	To develop a real model of short-term institutional respite care as part of home care for the elderly, as described by nurses and informal carers.	17 informal carers 22 nursing staff	Semi-structural interviews	There was an absence of a shared view on the client's need for care and home aids between informal carers and nurses.

Author, year, country	Purpose	Sample	Method	Main findings
Santana et al. 2007, Portugal	To describe the home support services (SAD) provided by social and health professionals and understand if this service is the first step in a change towards integrated care.	75 institutions	Survey	SAD seems to have been promoting a formal collaboration between several entities in the social and health systems. The information shared between these institutions has increased, but where cooperation in care service provision is concerned this seldom surpasses the social care because health care is still difficult to integrate.
Scholes & Vaughan 2002, England	To explore cross-boundary working and the impact it has on the manner in which multi-professional teams function.	A series of case studies on post holders, patients and stakeholders	Observation, interviews and reflection	Three types of new role development were identified: complementary roles, substitution roles and niche developments. They found factors that enhanced (e.g. good communications skills, clear focus, responsibilities, mutual respect, hard-work) or inhibited (e.g. unclear role, philosophical disagreement) effective working relations.
Stewart et al. 2003, Scotland	To present a detailed matrix of drivers and barriers to integrated social and health care working.	A number of case studies. Review provided details of 422 initiatives with elements of joint working from around Scotland.	Review	Drivers and barriers in three key areas are highlighted: national policy frameworks, the local planning context and operational factors such as relations between partners, organisational culture, change management, enabling staff, professional behavioural, attitudes and outcomes (e.g. user focused).
Sommers et al. 2000, USA	To examine the impact of an interdisciplinary, collaborative practice intervention involving a primary care physician, a nurse and a social worker for community-dwelling seniors with chronic illnesses.	543 patients in 18 private office practices of primary care physicians were conducted.	Controlled cohort study. The intervention group received care from their primary care physician working with a nurse and a social worker, while the control group received care as usual from their primary care physician.	The hospitalization rate of the control group increased from 0.34 to 0.52, while the rate in the intervention group stayed at baseline. The proportion of intervention patients with readmissions decreased from 6% to 4%, while the rate in the control group increased from 4% to 9%. In the intervention group, mean office visits to all physicians fell by 1.5 visits compared with a 0.5-visit increase for the control group. The patients in the intervention group reported an increase in social activities compared with the control group's decrease.
Tenkanen 2003, Finland	To analyze and assess the development of forms of cooperation among home care staff and the implications of these procedures for quality of life among older clients.	Case study 1 home care district	Interviews with older people, individual home care process and related documents and research memoranda	For older clients, home is a place where they can still have a positive experience of themselves despite the fact that their vitality is on the decline. The provision of care and assistance to the clients in their daily activities is quite successful, but too little attention is paid to their physical activity and social support. The environment in which the elderly live and their social relations are central elements of their quality of life. Clients participate in decision-making when the content of care is planned and improvements in the daily routine are worked out, yet it is difficult for them to retain autonomy. The time pressures under which the staff must work reduce the psychological and social support that clients receive in conjunction with home care.
Themessl-Huber et al. 2007, England	To study older people's experiences of community-based health and social care services.	18 older people	Semi-structured interviews	Older people appreciated the support they received from services, but services are not responsive to the older peoples' main concerns: meeting individual needs, maximising independence and helping to live fulfilled lives. Older people wanted services to be more flexible.

Author, year, country	Purpose	Sample	Method	Main findings
Toijamo et al. 2008, Finland	To examine the impact of integrated services on home care personnel's job, job satisfaction and the quality of services.	11 municipalities (randomised to the intervention and the controls) Home care personnel Spring 2001 (n=1183) and in autumn 2003 after the intervention (n=1291). documents 56 nursing managers 130 older clients 126 relatives 127 professionals	Survey This work forms part of a larger Finnish project entitled PALKO (Integrated Services in the Practice of Discharge and Home Care).	There were favourable changes in the quality of services and the home care personnel's job control in the intervention group compared to the control group. However, outcome measures and possible effects of socially complex interventions need to be discussed more.
Tepponen 2009, Finland	To investigate the impact of integrated social and health care services on the quality of care and to develop a theory on home care.	1 city in Finland 281 older clients	Interviews, survey	The integration of social and health care for older people is rationalized care delivery and increased the quality of care.
Vaarama 2006, Finland	To implement a theoretical model of care-related Quality of Life in home care practice and to study the efficiency management systems for older clients, and whether care contributes to the quality of life in old age.	1 city in Finland 281 older clients	Interviews, survey, observations, diary, data systems	Positive attitude for aging and satisfaction of home care delivery increased clients' quality of life. Home care professionals may support clients to adapt to aging, if the care delivery is client-oriented, respects his/her autonomy and is professionally skilled. In addition, it is important that professionals are nice, have empathy with the clients and take care of their hygiene and home cleanliness.
Valvanne 2006, Finland	To increase the effectiveness and quality of home care and evaluate integrated organisational models of home care.	1 city in Finland	Five-year development project	The integration of social and health care for older persons is a timely and challenging process, but at its best is a great learning experience for all participants. The vision for integration should be formulated and accepted by both sectors. Resources, open discussions, commitment and common multidisciplinary training for personnel are necessary.
Xyrichis & Lowton 2008, England	To explore the factors that inhibit or facilitate interprofessional teamworking in primary and community care settings	43 articles	A literature review	Two main factors, team structure (team premises, team size, composition, organisational support) and team processes (clear goals, regular team meetings, audit) have an impact on interprofessional teamworking.

Appendix 3. Cover letters to interviews

Turun yliopisto, Hoitotieteen laitos
 Tutkimuksen nimi: *Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa*

Turun yliopisto, Hoitotieteen laitos
 Tutkimuksen nimi:
Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa

Arvoisa kotihoitoyhteistyökumppani

Teen väitöskirjatutkimusta Turun yliopiston lääketieteellisen tiedekunnan hoitotieteen laitoksella ikäihmisen toimintakyvyn edistämisestä moniammatillisena yhteistyönä. Tutkimuksen ensimmäisessä vaiheessa haluan saada haastattelututkimuksella tietoa ikäihmisiltä toimintakyvyn edistämisestä moniammatillisena yhteistyönä.

Tarvitsen apuunne löytääkseni haastateltavakseni kotihoitoyhteistyökumppanit. Oheessa on tutkimustiedote ja tiedote tutkimukseen osallistumisesta suostumukseksi. Pyydän teitä toimittamaan ne kaikille sellaisille kotihoitoyhteistyökumppaneille, jotka ovat:

- yli 75-vuotiaita
- kunnunkoivututkimuksia ja
- saavat sekä kotipalvelun että kotisairaanhoidon palveluita

Pyydän teitä samalla kertomaan lyhyesti tutkimuksestani. Asiakkaan itse ratkaistavaksi jää suostuuko hän haastateltavaksi. Jos hän suostuu, hänen tulisi palauttaa oheinen tiedote ”Osallistuminen haastattelututkimukseen” allekirjoituksellaan ja puhelinnumerollaan varustettuna takaisin kotipalvelun henkilökunnalle mukana olevassa kirjeessä. Tutkija noutaa palautuneet kirjekuoret erikseen sovittuna päivänä kotipalvelun toimistolta.

Annan mielelläni lisätietoja tutkimuksesta ja sen toteuttamisesta puhelinnumerosta XXX niin teille kuin asiakkaillekin.

Yhteistyöstä kiittäen

Sini Eloranta
 SH, TtM, TtT-opiskelija

Arvoisa kotihoitoyhteistyökumppani

Teen väitöskirjatutkimusta Turun yliopiston lääketieteellisen tiedekunnan hoitotieteen laitoksella kotihoitoyhteistyökumppanien toimintakyvyn edistämisestä. Tutkimuksen tavoitteena on arvioida kotihoitoyhteistyökumppanien toimintakyvyn edistämisestä moniammatillisena yhteistyönä ja arvioinnin pohjalta laatia toimintaa ohjaavat suositukset. Tutkimukselle on saatu asianmukaiset tutkimusluvut ja siitä kerrotaan tarkemmin oheisessa tiedotteessa ”Osallistuminen haastattelututkimukseen”.

Eisin haastateltavakseni yli 75-vuotiaita kotihoitoyhteistyökumppaneita. Ystävällisesti toivon Teidän osallistuvan tutkimukseeni suostumalla haastateltavakseni, sillä uskon saavani Teiltä arvokasta tietoa kotihoitoyhteistyökumppanien kehittämiseen. Suoritan haastattelun Teidän omassa kodissanne ja haastattelu kestää noin tunnin. Haastatteluun osallistuminen on luonnollisesti Teille vapaaehtoista. Haastattelun vastaukset käsittelemme luottamuksellisesti, eikä Teidän henkilötietojamme tule esiin missään vaiheessa.

Jos suostutte haastateltavakseni, palauttakaahan oheinen tiedote ”Osallistuminen haastattelututkimukseen” allekirjoitettuna ja puhelinnumerollanne varustettuna mukana olevassa kirjeessä kotipalvelun henkilökunnalle. Otan Teihin sen perusteella yhteyttä puhelimitse ja sovin kanssanne Teille sopivan haastatteluaikojen. Vastaa mielelläni tutkimusta koskeviin kysymyksiin puhelinnumerosta XXX.

Mielenkiinnosta ja yhteistyöstä kiittäen

Sini Eloranta
 Sairaanhoidtaja, terveystieteiden maisteri, terveystieteiden tohtori-opiskelija

Pirkko Routasalo (tutkimuksen ohjaaja)
 Dosentti, terveydenhuollon tohtori (puh: XXX)

OSALLISTUMINEN HAASTATTELU-**TUTKIMUKSEEN**

Tutkimuksen nimi

Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa
Tutkimuksen tekijä, Sini Eloranta, sairaanhoitaja, terveys-tieteiden maisteri

Tutkimuksen tarkoitus

Väitöskirjatutkimuksen tavoitteena on tuottaa uutta tietoa kotihoitossa olevan ikäihmisen toimintakyvyn edistämisestä moniammatillisena yhteistyönä. Tutkimuksen tarkoituksena on arvioida ikäihmisten näkemyksiä toimintakyvyn edistämisestä moniammatillisena yhteistyönä sekä arvioinnin pohjalta laatia toimintaa ohjaavat suositukset.

Tutkimuksen toteutus

Tutkija haastattelee tutkimukseen osallistuvaa asiakasta hänen omassa kodissaan. Mahdollisesti voidaan haastattelun jälkeen sopia uudesta haastattelusta täsmennyksiä varten. Haastattelutilanteessa asiakas ja tutkija ovat kahden kesken ja haastattelut nauhoitetaan. Haastattelu kestää noin tunnin. Haastattelu on luottamuksellinen; haastattelunauhut säilytetään lukollisessa kaapissa eikä niitä käsittele muut kuin tutkija. Tutkimuksen valmistuttua tutkija hävittää haastattelunauhut. Tutkimusraportti sisältää esimerkkejä haastattelusta, mutta asiakkaiden henkilöllisyys ei esiin, sillä esimerkiksi käytetään peitenimiä. Haastattelu perustuu vapaaehtoisuuteen ja asiakas voi keskeyttää osallistumisensa tutkimukseen milloin tahansa, jos niin haluaa.

Suosittamus

Minä _____ (nimi) olen tutustunut tutkimuksen **Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa** -tutkimustiedotteeseen ja osallistun vapaaehtoisesti tähän tutkimukseen. Olen tietoinen siitä, että voin milloin tahansa keskeyttää osallistumiseni ja ettei minua voida tunnustaa tutkimusraportista.

Asiakkaan allekirjoitus _____

Turun yliopisto, Hoitotieteen laitos

Tutkimuksen nimi:

Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa

Arvoisa kotihoitoyhteistyön työntekijä

Kohteliaimmin pyydän Sinua osallistumaan tutkimukseen, jossa pyritään selvittämään kotihoitoyhteistyön näkemyksiä ikäihmisten (yli 75-vuotiaiden) toimintakyvyn edistämisestä moniammatillisena yhteistyönä.

Tutkimus toteutetaan ryhmähaastatteluna. Ryhmä koostuu kotihoitoyhteistyön työntekijöistä (kotipalvelun työntekijä, kotisaaraanhoidaja ja lääkäri). Haastattelu suoritetaan työpaikallanne ja se kestää noin tunnin.

Tiedän, että Sinulla olisi arvokasta tietoa kotihoitoyhteistyön kehittämiseen ja toivon Sinun osallistuvan tutkimukseen suostumalla haastatteluvaksi. Haastatteluun osallistuminen on luonnollisesti vapaaehtoista. Haastattelun vastaukset käsitellään luottamuksellisesti, eikä Sinun henkilötietosi tule esiin missään vaiheessa. Haastattelu liittyy tutkimukseen, jonka tulokset esitetään väitöskirjana. Tutkimukselle on saatu asianmukaiset tutkimusluvut.

Oleystävällinen ja palautta oheinen tiedote ”Osallistuminen ryhmähaastattelu-**tutkimukseen**” allekirjoitettuna, puhelinnumerolla varustettuna mukana olevalla kirjekuorella tutkijalle. Olan Sinuun sen perusteella yhteyttä puhelimitse ja sovin kanssasi Sinulle sopivan haastatteluaajan. Vastaaan mielelläni tutkimusta koskeviin kysymyksiin puhelinnumerosta XXXX.

Mielenkiinnosta ja yhteistyöstä kiittäen

Sini Eloranta, SH, TtM, TtF-opiskelija

Pirkko Routasalo (tutkimuksen ohjaaja)

Dosentti, THT (puh: XXX)

Appendix 4. Questionnaire

Turun yliopisto, Hoitotieteen laitos

Tutkimuksen nimi:

Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa

Arvoisa tutkimukseen osallistuja

Kohteliaimmin pyydän Teitä osallistumaan tutkimukseen, joka käsittelee **Ikäihmisen voimavarojen tukemista moniammatillisessa kotihoitossa**. Osallistuminen merkitsee vastaamista oheiseen kyselylomakkeeseen. Vastaaminen kyselyyn on Teille täysin vapaaehtoista, mutta jokaisen vastaajan näkymys on tutkimuksen onnistumisen kannalta erittäin tärkeä. Kysymyksillä kartoitetaan Teidän kokemuksianne ja mielipiteitänne.

Ikäihmisen kotihoitoon osallistuu monipuolinen auttajaverkosto, sillä asiakkaat tarvitsevat usein hoitoa ja palvelu monelta eri taholta. Eri ammattiryhmien moniammatillisen yhteistyön lähtökohdana on asiakas ja toiminnassa pyritään huomioimaan asiakkaan kokonaisuus. Tämän lomakkeen tarkoituksena on saada tietoa siitä, miten Te näette moniammatillisen työryhmän, kotipalvelun ja kotisairaanhoidon ammattihenkilöiden toimivan yhteistyössä auttaessaan Teitä.

Vastauslomakkeeseen ei tule nimeänne eikä henkilöilyytenne tule missään vaiheessa esille. Edetkää vastaamalla jokaiseen kysymykseen valitsemalla mielipidettänne parhaiten vastaava vaihtoehto tai kirjoittamalla vastauksenne sille varattuun tilaan. Kysymykseen ei ole olemassa oikeita tai vääriä vastauksia, vaan vastatkaa kysymykseen juuri niin kuin olette asian omalla kohdallanne kokeneet.

Täytetyn lomakkeen voitte laittaa ohessa jo valmiiksi maksetussa palautuskirjekuoressa postilaatikkoon.

Tälle kyselylle on saatu asiamukaiset tutkimusluvut, ja se liittyy tutkimukseen, jonka tulokset esitellään väitöskirjana. Tutkimuksen ohjaajana toimii professori, THT Pirkko Routasalo Turun/Tarton yliopiston hoitotieteen laitoselta (puh. XXX).

Vastaaan mielelläni mahdollisiin kysymyksiinne (puh. XXX).

Vastauksistanne etukäteen kiittäen

Sini Eloranta, sh, TtM, terveys- ja hoitotieteiden tohtoriopiskelija
TURUN YLIOPISTO, Hoitotieteen tutkijakoulu

OSALLISTUMINEN RYHMÄHAASTATTELUTUTKIMUKSEEN

Tutkimuksen nimi

Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa

Tutkimuksen tekijä

Sini Eloranta, sairaanhoitaja, terveys- ja hoitotieteiden maisteri, jatko-opiskelija, TY, hoitotieteen laitos

Tutkimuksen tarkoitus

Arvioida kotihoitoiden työntekijöiden näkemyksiä ikäihmisen toimintakyvyn edistämisestä moniammatillisena yhteistyönä.

Tutkimuksen toteutus

Tutkijat haastattelevat tutkimukseen osallistuvia kotihoitoiden työntekijöitä heidän työpaikallaan. Haastattelut toteutetaan ryhmähaastatteluna ja ne kestävät noin tunnin.

Haastattelut nauhoitetaan. Haastattelu on luottamuksellinen. Tutkimusraportti sisältää esimerkkejä haastatteluilta, mutta haastateltavien henkilöilyyksi ei tule siinä esin.

Suosittamus

Minä _____ (nimi) olen tutustunut tutkimuksen

Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa -tutkimus-

tiedotteeseen ja osallistun vapaaehtoisesti tähän ryhmähaastatteluun. Olen tietoinen siitä, että voin milloin tahansa keskeyttää osallistumiseni ja ettei minua voida tunnustaa tutkimusraportista.

Allekirjoitus _____

Ammattinimike _____

Toimipaikka / alue, jolla työskentelet _____

Turun yliopisto, Hoitotieteen laitos
 Tutkimuksen nimi:

Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoidossa

Kysely asiakkaille

Vastaajan taustatiedot:

1. Mikä on sukupuolenne?

1. Nainen
2. Mies

2. Ikänne _____ vuotta

3. Mikä on koulutuksenne?

1. Kansakoulu tai vähemmän
2. Ammattikoulu
3. Keskkoulu
4. Lukio
5. Opistoasteen ammattikoulutus
6. Korkeakoulu

4. Miten asutte?

1. Yksin
2. Puolison kanssa
3. Lapsen tai lapsen perheessä
4. Sisaruksen kanssa
5. Jonkun muun tai muiden kanssa

5. Millaisena pidätte terveydentilaanne tällä hetkellä?

1. Pidän itseäni terveenä
2. Pidän itseäni melko terveenä
3. Pidän itseäni sairaana
4. Pidän itseäni hyvin sairaana

6. Käyttekö päivittäin ulkona?

1. Kyllä
2. Ei

7. Pystytekö kävelemään yhtäjaksoisesti vähintään 0,5 km?

1. Kyllä
2. Ei

8. Tarvitsetko päivittäin toisen apua?

1. Kyllä
2. Ei

Seuraavaksi kysyn kokemuksianne ammattihenkilöiden ja Tiedän välisestä yhteistyöstä. Ammattihenkilöillä tarkoitetaan että kotisairaanhoidon ammattihenkilöitä.

	Täysin samaa mieltä	Jokseenkin samaa mieltä	En samaa mieltä	Jokseenkin eri mieltä	Täysin eri mieltä	Hyvin	Melko hyvin	Ei hyvin eikä huonosti	Melko huonosti	Huonosti	Ei tarpeen
9. Ammattihenkilöt tuntevat elämäntapani ja tottuukseni.	5	4	3	2	1	5	4	3	2	1	0
10. Ammattihenkilöt tietävät miten toivon itseäni autettavan.	5	4	3	2	1	5	4	3	2	1	0
11. Ammattihenkilöt tuntevat elämäni kiinnostuksen kohteet (esim. harrastukseni).	5	4	3	2	1	5	4	3	2	1	0
12. Ammattihenkilöt tietävät käsitykseni niistä henkilökohtaisista ominaisuuksista, joiden avulla selviydyn arjessani.	5	4	3	2	1	5	4	3	2	1	0
13. Ammattihenkilöt arvioivat suorittamistani päivittäisiä toimintoja suorittaessani (esim. ruoan valmistus, peseytyminen).	5	4	3	2	1	5	4	3	2	1	0
14. Ammattihenkilöt eivät tee puolestani päivittäisiä toimintoja, jos vielä itse pystyn suorittamaan niistä.	5	4	3	2	1	5	4	3	2	1	0
15. Minua hoitavat pääasiassa samat ammattihenkilöt, jotka olen oppinut tuntemaan.	5	4	3	2	1	5	4	3	2	1	0
16. Ammattihenkilöt työskentelevät yhdenmukaisesti hoitoani toteuttaessaan.	5	4	3	2	1	5	4	3	2	1	0
17. Ammattihenkilöt kunnioittavat aina toiveitani auttaessaan minua.	5	4	3	2	1	5	4	3	2	1	0
18. Koen yhteistyön ammattihenkilöiden kanssa luottamuskelliseksi.	5	4	3	2	1	5	4	3	2	1	0
19. Ammattihenkilöt keskustelevat riittävästi kanssani hoidon ja palvelun tarpeistani.	5	4	3	2	1	5	4	3	2	1	0
20. Ammattihenkilöt keskustelevat riittävästi läheisteni kanssa hoidon ja palvelun tarpeistani.	5	4	3	2	1	5	4	3	2	1	0
21. Ammattihenkilöt antavat minulle riittävästi tietoa hoitoa ja palveluitani koskevista asioista.	5	4	3	2	1	5	4	3	2	1	0
22. Tiedän aina milloin ammattihenkilöt tulevat luokseni kotikäynnille.	5	4	3	2	1	5	4	3	2	1	0
23. Tarvittaessa ammattihenkilöt ottavat puolestani yhteyttä toisiin ammattihenkilöihin.	5	4	3	2	1	5	4	3	2	1	0
24. Kaikki ammattihenkilöt ovat koko ajan selvillä voimistani ja palvelun tarpeistani.	5	4	3	2	1	5	4	3	2	1	0
25. Kaikki ammattihenkilöt saavat tiedon voimnin ja palvelutarpeeni muutoksista viiveettä.	5	4	3	2	1	5	4	3	2	1	0
26. Ammattihenkilöt huolehtivat, että läheiseni saavat tiedon vointini ja palvelutarpeeni muutoksista viiveettä.	5	4	3	2	1	5	4	3	2	1	0
27. Myönteisestä palautteesta silloin, kun onnistun itse suorittamaan päivittäisiä toimintoja	5	4	3	2	1	5	4	3	2	1	0
28. Itsenäiseen toimintaan ohjaamisesta	5	4	3	2	1	5	4	3	2	1	0
29. Kiinnittämällä huomiota enemmän vahvuuksini kuin rajoituksini	5	4	3	2	1	5	4	3	2	1	0
30. Kannustamisesta itse tekemään ne toiminnot, joista vielä selviydyin	5	4	3	2	1	5	4	3	2	1	0
31. Ravitsemuksesta	5	4	3	2	1	5	4	3	2	1	0
32. Henkilökohtaisesta hygieniastani	5	4	3	2	1	5	4	3	2	1	0
33. Vaatetuksistani	5	4	3	2	1	5	4	3	2	1	0
34. Nukkumisistani	5	4	3	2	1	5	4	3	2	1	0
35. Hampaiden ja suuni hoidosta	5	4	3	2	1	5	4	3	2	1	0
36. Ihoni hoidosta	5	4	3	2	1	5	4	3	2	1	0
37. Hiusteni hoidosta	5	4	3	2	1	5	4	3	2	1	0
38. Virtsaamisistani ja suoleni toiminnasta	5	4	3	2	1	5	4	3	2	1	0
39. Kuulostani	5	4	3	2	1	5	4	3	2	1	0
40. Näkökyvystäni	5	4	3	2	1	5	4	3	2	1	0
41. Liikkumisistani kodissa	5	4	3	2	1	5	4	3	2	1	0
42. Liikkumisistani ulkona	5	4	3	2	1	5	4	3	2	1	0
43. Apuvälineistäni	5	4	3	2	1	5	4	3	2	1	0
44. Asuntoni muurustöistä	5	4	3	2	1	5	4	3	2	1	0
45. Lääkehoidostani	5	4	3	2	1	5	4	3	2	1	0
46. Sairaukseistani ja sairauksien vaatimasta hoidosta	5	4	3	2	1	5	4	3	2	1	0
47. Kotitöistä	5	4	3	2	1	5	4	3	2	1	0
48. Mielialastani	5	4	3	2	1	5	4	3	2	1	0
49. Muististani	5	4	3	2	1	5	4	3	2	1	0
50. Turvallisuudestani	5	4	3	2	1	5	4	3	2	1	0
51. Vanhojen aikojen muistelemisestä	5	4	3	2	1	5	4	3	2	1	0
52. Väsymyksen tunteesta	5	4	3	2	1	5	4	3	2	1	0
53. Hengellisisä tarpeistani	5	4	3	2	1	5	4	3	2	1	0
54. Yksinäisyyden tunteesta	5	4	3	2	1	5	4	3	2	1	0
55. Mahdollisuudesta keskustella ammattihenkilöiden kanssa	5	4	3	2	1	5	4	3	2	1	0
56. Kodin ulkopuoliseen toimintaan kannustamisesta (esim. retket, kerhot)	5	4	3	2	1	5	4	3	2	1	0
57. Muiden ihmisten kanssa yhteydenpitoon kannustamisesta	5	4	3	2	1	5	4	3	2	1	0
58. Ikaisteni seuranaan kannustamisesta	5	4	3	2	1	5	4	3	2	1	0
59. Läheisten hoitoon osallistumisen tukemisestä	5	4	3	2	1	5	4	3	2	1	0
60. Harrastustoimintaan ohjaamisesta	5	4	3	2	1	5	4	3	2	1	0
61. Virkistysilaisuuksien järjestämisestä	5	4	3	2	1	5	4	3	2	1	0
62. Vapaaehtoistoiminnan hyödyntämisestä	5	4	3	2	1	5	4	3	2	1	0
63. Kuljetuspalveluista	5	4	3	2	1	5	4	3	2	1	0
64. Sosiaalitetuksista	5	4	3	2	1	5	4	3	2	1	0

Seuraavat kysymykset koskevat elämänsenne.

65. Oletteko tyytyväinen elämäänne?

1. Kyllä
2. Ei

66. Tunnetteko itsenne tarpeelliseksi?

1. Kyllä
2. Ei

67. Onko Teillä tulevaisuuden suunnitelmia?

1. Kyllä
2. Ei

68. Onko Teillä elämänhalua?

1. Kyllä
2. Ei

69. Oletteko masentunut?

1. Harvoin tai en koskaan
2. Toisinaan
3. Usein tai aina

70. Kärsittekö yksinäisyydestä?

1. Harvoin tai en koskaan
2. Toisinaan
3. Usein tai aina

Turun yliopisto, Hoitotieteen laitos

Tutkimuksen nimi:

Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa

Arvoisa tutkimukseen osallistuja

Kohteliaimmin pyydän Sinua osallistumaan tutkimukseen, joka käsittelee **Ikäihmisen voimavarojen tukemista moniammatillisessa kotihoitossa**. Osallistuminen merkitsee vastaamista oheiseen kyselylomakkeeseen. Vastaaminen kyselyyn on Sinulle täysin vapaaehtoista, mutta Sinun vastauksesi on erittäin tärkeä tutkimustuloksen saamiseksi. Kysymyksillä kartoitetaan Sinun kokemuksiasi ja mielipiteitäsi. Vastaamiseen kuluu aikaa noin 10 minuuttia.

Ikäihmisen kotihoitoon osallistuu monipuolinen auttajaverkosto, sillä asiakkaat tarvitsevat usein hoitoa ja palvelua monelta eri taholta. Eri ammattiryhmien moniammatillisen yhteistyön lähtökohdiana on asiakas ja toiminnaa pyritään huomioimaan asiakkaan kokonaisuus. Tämän lomakkeen tarkoituksena on saada tietoa siitä, miten Sinä arvioit moniammatillisen työryhmän: kotipalvelun ja kotisairaanhoidon ammattihenkilöiden yhteistyön tukevan ikäihmisen voimavaroja.

Vastauslomakkeeseen ei tule nimeäsi eikä henkilöllisyytesi tule missään vaiheessa esille. Etene vastaamalla jokaiseen kysymykseen valitsemalla mielipidettäsi parhaiten vastaava vaihtoehto tai kirjoittamalla vastauksesi sille varattuun tilaan. Kysymykseesi on ole olemassa oikeita tai vääriä vastauksia, vaan vastaa kysymykseesi juuri niin kuin olet asian omalla kohdallasi kokenut.

Vastatuasi kysymykseesi on hyvä ja palauta lomake oheisessa kirjekuoressa sisäpostissa tutkijalle.

Tälle kyselylle on saatu asianmukaiset tutkimusluvut, ja se liittyy tutkimukseen, jonka tulokset esitetään väitöskirjana. Tutkimuksen ohjaajana toimii professori, THT Pirrko Routasalo Turun/Tarton yliopiston hoitotieteen laitokselta (puh. XXX).

Vastaan mielelläni mahdollisiin kysymyksiisi (puh. XXX).

Vastauksistasi kiittäen

Sini Eloranta, sh, TtM, terveystieteiden tohtoriotiskelija
TURUN YLIOPISTO
Hoitotieteen tutkijakoulu

Turun yliopisto, Hoitotieteen laitos
 Tutkimuksen nimi:

Ikäihmisen toimintakyvyn edistäminen moniammatillisessa kotihoitossa

Kysely ammattihenkilöille

Vastaajan taustatiedot:

1. Mikä on sukupuolesi?
 1. nainen
 2. mies
 2. Ikäsi _____ vuotta
3. Mikä on ammatillinen koulutuksesi? (mainitse vain korkein ammatillinen koulutus)
 1. Ei ammatillista koulutusta
 2. Kodinhoitaja
 3. Sosiaalihoitaja
 4. Avopalveluhoitaja
 5. Apuhoitaja
 6. Perushoitaja
 7. Lähihoitaja
 8. Sairaanhoidtaja / terveydenhoitaja
 9. Erikoissairaanhoidtaja
 10. Lääkäri
 11. Erikoislääkäri
 12. Muu, mikä _____

4. Missä toimipaikassa työskentelet?

1. Sosiaalitoimi
2. Terveystoimi

5. Miten pitkä työkokemus Sinulla on vanhustenhoitosta?

1. <1 vuotta
2. 1-5 vuotta
3. 6-10 vuotta
4. >10 vuotta

Seuraavaksi kysyn kokemuksiasi ikäihmisten ja ammatihenkilöiden välistä yhteistyötä. Ammatihenkilöillä tarkoitetaan sekä kotipalvelun että kotisairaanhoidon ammatihenkilöitä.

	Täysin samaa mieltä	Jokseenkin samaa mieltä	En samaa mieltä	Jokseenkin eri mieltä	Täysin eri mieltä
6. Ammatihenkilöt tuntavat ikäihmisen elämäntavat ja tottumukset.	5	4	3	2	1
7. Ammatihenkilöt tietävät miten ikäihminen toivoo itseään autettavan.	5	4	3	2	1
8. Ammatihenkilöt tuntavat ikäihmisen elämän kiinnostuksen kohteet (esim. harrastukset).	5	4	3	2	1
9. Ammatihenkilöt tietävät ikäihmisen omat käsitykset niistä henkilökohtaisista ominaisuuksista, joiden avulla hän selviytyy arjestaan.	5	4	3	2	1
10. Ammatihenkilöt arvioivat ikäihmisen suoritustamista hänen suorittaessaan päivittäisiä toimintoja (esim. ruuan valmistus, peseytyminen).	5	4	3	2	1
11. Ammatihenkilöt eivät tee ikäihmisen puolesta päivittäisiä toimintoja, jos hän vielä pystyy itse suoriutumaan niistä.	5	4	3	2	1
12. Ikäihmistä hoitavat pääasiassa samat ammatihenkilöt, jotka hän on oppinut tuntemaan.	5	4	3	2	1
13. Ammatihenkilöt työskentelevät yhdenmukaisesti ikäihmisen hoitoa toteuttaessaan.	5	4	3	2	1
14. Ammatihenkilöt kunnioittavat aina ikäihmisen toiveita auttaessaan häntä.	5	4	3	2	1
15. Yhteistyö ikäihmisen ja ammatihenkilöiden välillä on luottamuksellista.	5	4	3	2	1
16. Ammatihenkilöt keskustelevat riittävästi ikäihmisen kanssa hoidon ja palvelun tarpeista.	5	4	3	2	1
17. Ammatihenkilöt keskustelevat riittävästi ikäihmisten läheisten kanssa hoidon ja palvelun tarpeista.	5	4	3	2	1
18. Ammatihenkilöt antavat ikäihmisille riittävästi tietoa hoitoa ja palvelua koskevista asioista.	5	4	3	2	1
19. Ikäihmiset tietävät aina milloin ammatihenkilöt tulevat kotikäynnille.	5	4	3	2	1
20. Tarvittaessa ammatihenkilöt ottavat ikäihmisen puolesta yhteyttä toisiin ammatihenkilöihin.	5	4	3	2	1
21. Kaikki ammatihenkilöt ovat koko ajan selvillä ikäihmisen voimista ja palvelun tarpeista.	5	4	3	2	1
22. Kaikki ammatihenkilöt saavat tiedon ikäihmisen voimien ja palvelutarpeen muutoksista viiveettä.	5	4	3	2	1
23. Ammatihenkilöt huolehtivat, että läheiset saavat tiedon ikäihmisen voimien ja palvelutarpeen muutoksista viiveettä.	5	4	3	2	1
24. Ammatihenkilöt ovat nimenneet jokaiselle asiakkaalle kokonaisuhoitosta vastaavan henkilön.	5	4	3	2	1
25. Ammatihenkilöt määrittelevät yhdessä asiakkaan yksilöllisten voimavarojen pohjalta toimintakykyä tukevia tavoitteita.	5	4	3	2	1
26. Ammatihenkilöt laativat yhdessä asiakkaan tavoitteita vastaavat toimintakykyä tukevat hoitokeinot.	5	4	3	2	1
27. Ammatihenkilöt pystyvät muodostamaan yhteisenä käsityksen asiakkaan toimintakyvyn tukemisen tavoitteista ja niiltä tukevista hoitokeinoista.	5	4	3	2	1
28. Ammatihenkilöt kirjaavat asiakkaan asiakirjoihin toimintakyvyn tukemisen tavoitteet ja hoitokeinot.	5	4	3	2	1

	Hyvin	Melko hyvin	Ei hyvin huonosti	Melko huonosti	Ei tarpeen
29. Ammatihenkilöt arvioivat yhdessä asiakkaan tavoitteiden saavuttamista ja keinojen sopivuutta säännöllisesti.	5	4	3	2	1
30. Ammatihenkilöt arvioivat yhdessä omaa työskentelyään asiakkaan toimintakyvyn tukemisessa.	5	4	3	2	1

Miten mielestäsi ammatihenkilöt huolehtivat ikäihmisen kotihoidossa seuraavista toiminnoista ja asioista?

	Hyvin	Melko hyvin	Ei hyvin huonosti	Melko huonosti	Ei tarpeen
31. Myönteisestä palausteesta silloin, kun ikäihminen omistuu itse suoriutumaan päivittäisistä toiminnoista	5	4	3	2	1
32. Itsenäiseen toimintaan ohjaamisesta	5	4	3	2	1
33. Kinnittämällä huomiota enemmän ikäihmisen vaikeuksiin kuin rajoituksiin	5	4	3	2	1
34. Kannustamisesta itse tekemään ne toiminnot, joista ikäihminen vielä selviytyy	5	4	3	2	1
35. Ravitsemuksesta	5	4	3	2	1
36. Henkilökohtaisesta hygieniasta	5	4	3	2	1
37. Vaateuksesta	5	4	3	2	1
38. Nukkumisesta	5	4	3	2	1
39. Hampaiden ja suun hoidosta	5	4	3	2	1
40. Ihon hoidosta	5	4	3	2	1
41. Hiusten hoidosta	5	4	3	2	1
42. Virtsastaamisesta ja suolen toiminnasta	5	4	3	2	1
43. Kuulosta	5	4	3	2	1
44. Näkökyvystä	5	4	3	2	1
45. Liikkumisesta kodissa	5	4	3	2	1
46. Liikkumisesta ulkona	5	4	3	2	1
47. Apuvälineistä	5	4	3	2	1
48. Asunnon muutostöistä	5	4	3	2	1
49. Lääkehoidosta	5	4	3	2	1
50. Sairaalkaissa ja sairausien vaatimasta hoidosta	5	4	3	2	1
51. Korttista	5	4	3	2	1
52. Mielialasta	5	4	3	2	1
53. Muistitoiminnoista	5	4	3	2	1
54. Turvallisuudesta	5	4	3	2	1
55. Vänhöljen alkojen muistelemisesta	5	4	3	2	1
56. Väsymyksen tunteesta	5	4	3	2	1
57. Hengellisiä tarpeita	5	4	3	2	1
58. Yksinäisyyden tunteesta	5	4	3	2	1
59. Mahdollisuudesta keskustella ammatihenkilöiden kanssa	5	4	3	2	1
60. Kodin ulkopuoliseen toimintaan kannustamisesta (esim. retket, kerhot)	5	4	3	2	1
61. Muiden ihmisten kanssa yhteydenpitoon kannustamisesta	5	4	3	2	1
62. Käisten seuran kannustamisesta	5	4	3	2	1
63. Läheisten hoitoon osallistumisen tukemisesta	5	4	3	2	1
64. Harrastustoimintaan ohjaamisesta	5	4	3	2	1
65. Virkistystilaisuuksien järjestämisestä	5	4	3	2	1
66. Vapaa-aikatoiminnan hyödyntämisestä	5	4	3	2	1
67. Kuljettajapalvelusta	5	4	3	2	1
68. Sosiaalietuuksista	5	4	3	2	1

Mitä mieltä olet seuraavista ikäihmisten elämänsennetin koskevista kysymyksistä?

Ajattele vastatessasi viimeksi hoitamaasi kotihoidon asiakasta.

74. Asiakas kärsii yksinäisyydestä?

1. Harvoin tai ei koskaan
2. Toisinaan
3. Usein tai aina
4. En osaa sanoa

69. Asiakas on tyytyväinen elämäänsä?

1. Kyllä
2. Ei

70. Asiakas tuntee itsensä tarpeelliseksi?

1. Kyllä
2. Ei
3. En osaa sanoa

71. Asiakkaalla on tulevaisuuden suunnitelmia?

1. Kyllä
2. Ei
3. En osaa sanoa

72. Asiakkaalla on elämänhalua?

1. Kyllä
2. Ei
3. En osaa sanoa

73. Asiakas on masentunut?

1. Harvoin tai ei koskaan
2. Toisinaan
3. Usein tai aina
4. En osaa sanoa