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ORIGINAL ARTICLE

Recognising older people's individual resources and home-care-specific tasks in home care in Finland: A document analysis of care and service plans

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Abstract

Background and Rationale: Comprehensive care and service planning in home care is tailored to older people's individual needs and resources in order to support them living at home. However, little is known about how these individual resources and home-care-specific tasks are recognised in older people's care and service plans.

Aims: To describe the content of care and service plans in older people's home care with special attention to their individual resources and home-care-specific tasks.

Design: This was a document-based cross-sectional study with mixed-methods analysis, carried out in Eastern Finland during Spring 2018.

Methods: A document analysis using the deductive Finnish Care Classification (FinCC), and an inductively developed framework of older people's care and service plans ($n = 71$). The data were analysed with descriptive statistical methods.

Results: Altogether, 1718 notes were relevant to the FinCC main categories: 707 (41%) focused on older people's needs and 1011 (59%) on nursing interventions. We identified 1104 notes based on the 26 inductively developed main categories: the majority ($n = 628$, 57%) focused on individual resources and the remainder ($n = 476$, 43%) on home-care-specific tasks. Increasing age resulted in fewer notes on safety and sensory functions. There were fewer notes on resources related to sleeping and wakefulness after longer care and service periods. An increased number of home visits resulted in more documentation on tasks related to pharmaceutical issues, including repeat prescriptions.

Discussion: Individual resources for older people were documented, to some extent, in their care and service plans. It is necessary to review these alongside home-care-specific tasks that support older people's independence and safety at home.

Conclusion: Individual resources need to be recognised in order to enable home-care professionals to provide tailored, high-quality home care services. Home-care-specific tasks should be supported by documentation with updated, sensitive home care classifications.

KEYWORDS

care and service plans, document analysis, documentation, home care, home-care-specific tasks, individual resources, older people

INTRODUCTION

The clients of home care are becoming older and weaker as regards their functional ability than in the past decades [1–3]. Multiple comorbidities and medical conditions affect their well-being and quality of life [3, 4]. Memory disorders [5, 6] and polypharmacy [7, 8] are common and affect an increasing number of older people in home care. Even though older people often have various care needs [1, 3] tailored home care services enable more dependent older people to live longer in their own homes [2, 3]. Older people also have individual resources that support and help them achieve their daily living despite possible disabilities [9–11]. Individual resources refer to older people's personal assets, knowledge and skills with regard to physical, psychological, cognitive and social health and abilities. Individual resources also comprise individual experiences of human dignity, a sense of coherence and life satisfaction as well as societal and economic support from available services and social connections. [9] The significance of the home environment with its characteristics can also be seen as a resource that supports the well-being of older people [9, 12].

In home care, recognising older people's resources is a functional and value-based starting point for care and service planning [13]. Recognition of individual resources is part of a holistic and individualised care [14, 15] that aims at preventing a decline in capacity, ensuring active years and supporting older people's ability to live at home [16–18]. Individualised and person-centred care [19, 20] refers to care that considers clinical situation of individuals and recognises their personal abilities, resources, life situations, everyday activities and decisional control [21]. It has been found to improve patient and professional outcomes and the quality and ethics of care [21–24]. Recognition of the characteristics of the care environment may also enhance the provision of individualised and person-centred care. However, these characteristics seem to be underutilised when planning support for older people [9, 12]; similarly, older people's individual resources are also underutilised in their care and service planning [25].

A timely care and service plan, documented by home-care professionals, provides a tool for the comprehensive home care of older people and should include their needs, goals, planned interventions and evaluation of expected outcomes [24, 26]. Care and service planning includes a comprehensive assessment of older people's health, well-being, life situation and individual care needs. In addition, it includes home-care-specific tasks [27], such direct tasks carried out by home-care professionals to assist or care for clients with hygiene or eating [28], or indirect tasks such as medication management services [29] and organising support services [30]. The care and service needs assessment can be guided by some assessment systems or instruments [13, 31, 32] and the nursing documentation can be structured by such general care classifications as the Clinical Care Classification (CCC) [33, 34]. National applications of CCC's such as the Finnish Care Classification (FinCC) [35, 36] are also used. These include the Finnish classification of nursing diagnoses (FiCND), the Finnish classification of nursing interventions (FiCNI), the Finnish classification of nursing outcomes (FiCNO), components and different amount of main and sub-categories, which are hierarchically used in structured nursing documentation (Table 1) [35]. In addition, classifications have mainly been used for institutional care [37, 38] and may not be utilised consistently in home care and service plan documentation [39].

The documentation of home care and service plans has been mostly focused on care interventions, physical needs and illnesses [23]; this has not allowed an adjustment that included the individual needs of older people [37] or their independent actions or personal resources [25]. Because of the lack of home-care-specific classifications for care and service planning, there is a need to investigate the content of individual resources and home-care-specific tasks in older peoples' care and service plans [23, 37, 38], and how home-care-specific classifications need to be developed in order to enable the well-being of older people at home.

Aim and research questions

The aim of this study was to describe the content of care and service plans in the home care of older people with special attention to the individual resources of older people and home-care-specific tasks.

The specific research questions were:

1. How are the needs of older people and nursing interventions documented in care and service plans according to FinCC main categories?
2. How are individual resources of older people and home-care-specific tasks documented in care and service plans?

TABLE 1 The deductive framework, definitions of the FinCC components ($N = 17$) and the number of the needs (FiCND) and nursing interventions (FiCNI)-based main categories [35]

Component	Content	Main categories FiCND (*n*)	Main categories FiCNI (*n*)
Activity	Physical activity, sleeping and wakefulness	4	7
Secretion	Digestion, urination, bleeding and other secretion factors	8	13
Coping	Ability of the individual or family to cope with the changes and challenges involved in health and social interactions	5	7
Fluid balance	Volume of body fluids	2	6
Health behaviour	Health promotion	3	3
Coordination of care	Coordination of multi-vocational care, examinations and care provided	5	7
Medication	How medication was used and taken	3	8
Nutrition	Ensuring sufficient nutrition and nutrients	5	6
Respiration	Lung function	4	4
Circulation	Circulation in various organs	3	6
Metabolism	Endocrinological and immunological systems	4	5
Safety	Safety risks that could lead to diseases and issues in the care environment	6	4
Daily activities	Independent initiatives and daily activities	3	4
Mental balance	Achieving a good mental balance	5	5
Sensory and neurological functions	Sensory and neurological functions	7	20
Skin integrity	Condition of the mucous membranes, cornea, skin and subcutaneous layers	6	10
Life cycle	Events during the client's life cycle	15	12
Main categories in total		88	127

3. How are the background characteristics of older people and their care and service plans associated with individual resources or home-care-specific tasks?

DESIGN

We conducted a document-based [40, 41] cross-sectional study [41, 42] with mixed-methods analysis [43] in home care in an urban region of Eastern Finland during Spring 2018 (Figure 1). We used a document analysis method with deductive [39, 41] and inductive strategies [41] to describe the content of the home care and service plans. The data were analysed by statistical methods [42, 44, 45].

METHODS

Research environment

The research environment was a Finnish government-funded, municipal older people's home care unit. In Finland, the aged population often refers to people over 63 years, as this is the minimum age for old age pension [46]; however, in the care and services provided to older people it can also be defined by different functional changes such as physical, psychological, cognitive and social changes that appear besides ageing [47]. Home care services comprise home health nursing [48] and home services which support older people in their daily activities such as cleaning, meals-on-wheels, care of clothing and housing [49]. Municipalities have a responsibility to organise home care services by local authority, in alliances with municipalities or in collaboration with private companies and the not-for-profit sector. Care and service planning for all older people in need of regular home care services is mandatory; it includes an assessment of functional ability, consideration of an older person's perspectives, and the planning should be carried out in collaboration with older people and their relatives [47].

In Finland in 2020, approximately 23% of the Finnish population (5.5 million) were aged 65 years or older [50]. In total, 55% of all older home care clients ($n = 208{,}000$) use the services regularly, over half of them (59%) had at least one home visit per day and 43% of all clients needed a considerable number of home care services

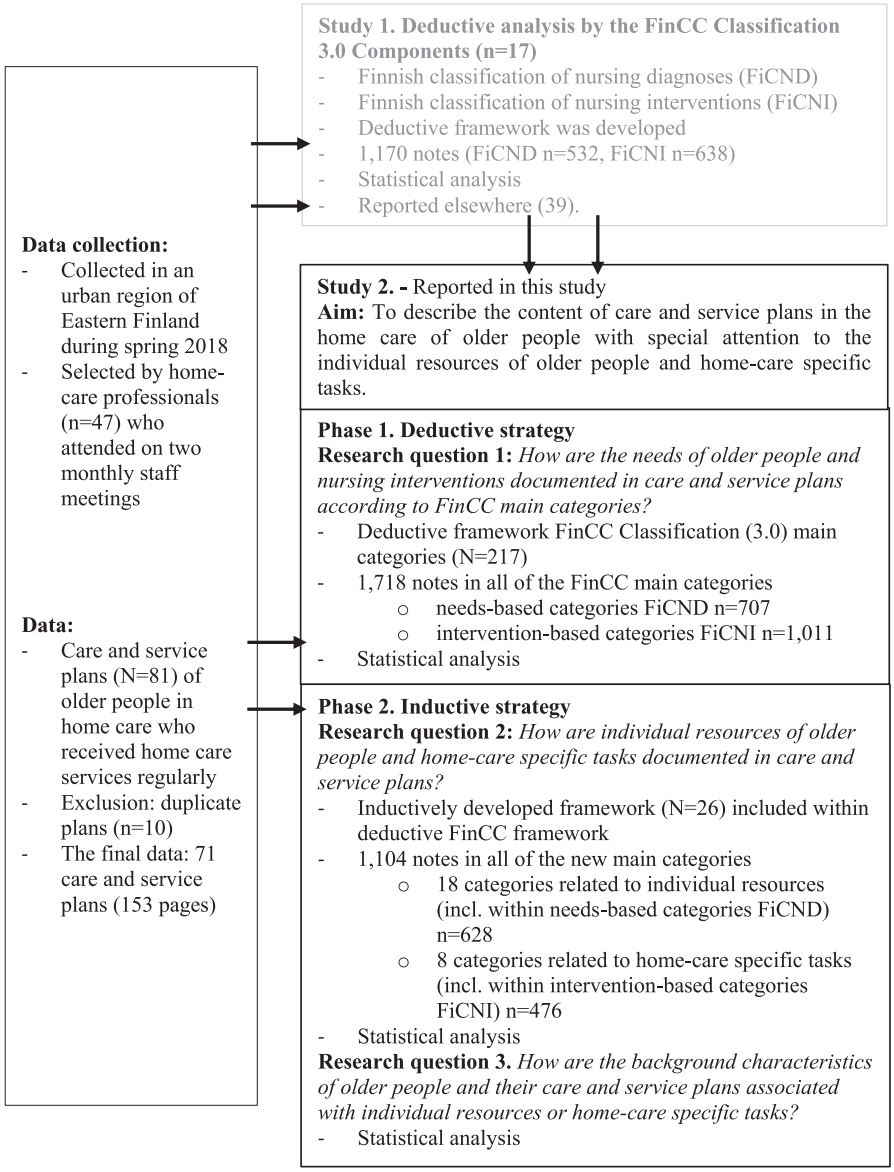

FIGURE 1 Study design

[1]. Home-care professionals, such as registered nurses and practical nurses, carry out home care services. In Finland in 2021, there were in total 17,000 professionals working in home care [1]; 74% were practical nurses (180 ECTS) from vocational colleges [51], and 12% were registered nurses (210 ECTS) or public health nurses (240 ECTS) graduates from a university of applied sciences [52]. The participating home care organisation had altogether 168 older clients who had been assessed as meeting the criteria for receiving regular home care services due to deteriorated functional ability and the need for care and services. All the clients except one were 63 years or older. The care staff ($N = 80$) included 65 practical nurses, seven registered nurses and eight service counsellors, and they all were responsible for carrying out the planning and documentation of older peoples' care and service plans.

Data collection and analysis

Data collection and data

After an ethical review was conducted by the Research Ethics Committee of the Northern Savo Hospital District (date 15.12.2015, Dnro 453/13.02.00/2015), and permission from the study organisation was granted, the researcher (RT) contacted the home care service manager and provided information about the study. The manager then informed the home-care professionals about the data collection. Subsequently, the researchers (RT, JP) attended to two monthly staff meetings to provide information and respond to questions about the study. The researchers advised the potential participants to select and anonymise one or two care and service plans. The inclusion criteria for the care and service plans were that they

should be for older people who received home care services regularly with a permanent care contact. The plans were in an electronic form and structured by titles related to physical, psychological and social aspects of care.

In total, 47 (59%) professionals were enrolled in the study. Most were employed as practical nurses ($n = 37$, 79%), and the remaining ($n = 7$, 15%) as registered nurses or service counsellors ($n = 3$, 6%). The mean of professional working experience was 12 years in the field of nursing and five years in their current positions. The professionals provided 71 care and service plans for this study. The length of the plans varied from one to three pages, producing a total of 153 A4 pages. According to several of the professionals, they selected the plans because they were good representations of primary nursing ($n = 37$, 45%) or they had client or service-related aspects ($n = 13$, 16%). Other professionals reported that they selected the plans randomly or because of a need to update or evaluate the quality of the plan.

Processing and analysis of the data

We analysed the data in two phases (Figure 1, Study 2). First, we carried out a deductive analysis using the main categories ($N = 215$) of the FinCC, version 3.0 which includes the Finnish classification of nursing diagnoses (FiCND, $n = 88$) and the Finnish classification of nursing interventions (FiCNI, $n = 127$) [35, 41] (Table 1).

In the second phase, we used the remaining data to develop an inductive framework within the FinCC main categories [40, 41]. The content focused on older people's individual resources and home-care-specific tasks, and we categorised them in relation to needs (FiCND) and interventions (FiCNI). As an example of inductively developed framework, we placed the older person's ability to do daily activities such as washing dishes, warming up their dinner in a microwave or taking care of hygiene independently as individual resources. We named it as a main category of *resources related to independent initiative and daily activities* and included within the needs-based main categories (FiCND, under the component of *Daily activities*) (Table 2). The contents of home-care-specific tasks were included within the intervention-based categories (FiCNI) in the deductive framework, which was developed in a previous study [39].

The structured analysis framework was made by using IBM Statistics for Windows (IBM Corp, NY, USA). The categories were treated as binary variables with a score of one or zero. We analysed the data by descriptive statistical methods, such as frequencies and percentages [42]. We used the statistical software package R and logistic regression to test the association between background characteristics (independent variables) and documentation of older people's individual resources or home-care-specific tasks (dependent variables). In all the models, the independent variables were the older peoples' age, gender, length of care and service period and number of home visits. Altogether we conducted 22 separate models with dependent variables. We excluded variables with a low number ($n < 5$) of notes or no notes to increase the reliability of the analysis. The excluded variables were *resources related to safety* (*Safety, FiCND*) *and independent initiative and daily activities* (*Daily activities FiCND*), *and tasks related to coordination of informal care provided by relatives* (*Coordination on care, FiCNI*) *and evaluation of home and surroundings' safety* (*Safety, FiCNI*). We reported odds ratios (OR) and confidence intervals (95%), and p values < 0.05 were defined as statistically significant. The odds were increased, when the value of OR was above 1 and decreased, when the OR value was below 1 [42].

RESULTS

Characteristics of older people and the care and service plans in home care

The data consisted of care and service plans for older people in home care ($n = 71$). Most of the individuals were female (69%) and on average 83 years old. They had received home care services for an average of two years and nine months and the number of home visits per week was approximately 19 (Table 3). The main reasons for starting a clientship in home care were monitoring of medication (35%) and assisting in everyday activities (34%).

Older people's needs and nursing interventions documented in care and service plans according to FinCC main categories

Based on the deductive findings, a total of 1718 notes were identified according to FinCC main categories ($N = 215$). Of these, 707 (41%) notes focused on older people's needs, and 1011 (59%) focused on nursing interventions (Table 4). The majority of the care needs (FiCND) were about *Daily activities* ($n = 107$, 15%), *Sensory and neurological functions* ($n = 106$, 15%) and *Coping* ($n = 90$, 13%). The nursing intervention (FiCNI) documentation was most often focused on *Coordination of care* ($n = 155$, 15%), *Medication* ($n = 139$, 14%), *Nutrition* ($n = 120$, 12%) and *Daily activities* ($n = 111$, 11%). There were no notes on *Life cycles* in either the needs or nursing interventions categories nor any on the older people's needs in relation to *Circulation* (Table 4, Figure 2).

TABLE 2 An example of categories in the inductively developed framework within the FinCC component, *Daily activities,* and the needs (FiCND) and interventions (FiCNI) for statistical analysis

	Component	Inductive category for statistical analysis	
FiCND	Daily activities (factors related to independent initiative)	Main categories in FinCC	Deficiency in self-care
			The need for information related to supporting independent initiative
			The need for the personal aids to support weakened functional ability
		Inductively developed category	Resources related to independent initiative and daily activities, for example, • no problems or needs related to daily activities or personal aids • having some independent initiative or resources related to dressing, changing clothes, taking care of hygiene, making dinner, eating etc.
FiCNI	Daily activities (factors related to independent initiative)	Main categories in FinCC	Supporting independent initiative
			Supplying the personal aids to support daily activities
			Guidance in the use of personal aids
			Guidance related to daily activities
		Inductively developed category	Tasks related to assistance in housekeeping chores, for example, • housekeeping chores such as changing the sheets, making the bed, washing the dishes, doing the laundry, getting or posting the mail, taking out the garbage, etc.

TABLE 3 The background characteristics of older people in home care, and the care and service plans ($N = 71$)

Background characteristics	(*n*) %/*N*	Min–max	Median (IQR)	Mean (SD)
Older people's gender ($n = 71$)				
Female	($n = 49$) 69			
Male	($n = 22$) 31			
Older people's age in years ($n = 71$)		53–98	85 (10)	83 (8.54)
The length of care and service period in months ($n = 59$)		4–166	25 (25.5)	33 (31.24)
The number of home visits per week ($n = 70$)		1–42	21 (14)	19 (10.04)

Individual resources of older people and home-care-specific tasks documented in care and service plans

Based on the inductive findings, there were, in total, 1104 notes, of which the majority ($n = 628$, 57%) focused on the older people's individual resources (under 18 new main categories), and the rest of the notes ($n = 476$, 43%) were focused on home-care-specific tasks (under eight new main categories) (Table 4, Figure 2).

Individual resources of older people

There were notes about older people's individual resources in relation to most ($n = 15$) of the components' of FinCC ($N = 17$), excluding *resources related to coordination of care* and *life cycle* (Table 4, Figure 2). The average number of notes on individual resources ($n = 628$) documented per a plan was 9.04 (SD 2.86, mode 10) and they ranged from two to 16 notes. In most of the plans ($n = 70$, 99%), the documentation of the older people's individual resources focused on *resources related to independent initiative and daily activities; with resources related to social functions* ($n = 64$, 90%), *communication* ($n = 58$, 82%) and *activity and physical activities* ($n = 58$, 82%) being documented almost as often (Table 4, Figure 2).

Home-care-specific tasks

There were notes about home-care-specific tasks in relation to five of the FinCC components ($N = 17$), these were *Coordination of care*, *Medication*, *Safety*, *Daily activities* and *Life cycle* (Table 4, Figure 2). The average number of notes on home-care-specific tasks ($n = 476$) documented per a plan was 6.61 (SD 1.19, mode 7) and they ranged from three to eight notes. In every plan ($n = 71$, 100%), there were *tasks related to the evaluation of home and surroundings' safety* documented. In most of the plans

($n = 69$, 97%), documentation of home-care-specific tasks focused on *tasks related to the coordination of informal care provided by relatives*. Very nearly as often was the documentation of *tasks related to pharmacy affairs and renewal of drug prescriptions* ($n = 65$, 92%), *assistance in housekeeping chores* ($n = 63$, 89%), *coordination of support services* ($n = 62$, 87%) and *coordination of social security benefits* ($n = 61$, 86%) (Table 4, Figure 2).

Association between background characteristics and individual resources or home-care-specific tasks

We found statistically significant association between four of the inductively developed categories and older peoples' age, the length of care and service period or the number of home visits. The higher the older person's age, the fewer the notes concerning *resources related to safety* (Safety FiCND) (OR = 0.909, $p = 0.026$) and *sensory functions* (Sensory and neurological functions FiCND) (OR = 0.882, $p = 0.020$). When the length of care and service period was extended, there were fewer notes concerning resources related to sleeping and wakefulness (OR = 0.976, $p = 0.035$). In addition, an increase in the number of home visits per week meant there was more documentation on *tasks related to pharmacy affairs and renewal of drug prescriptions* (Medication FiCNI) (OR = 1.167, $p = 0.037$) (only six plans did not have this note) (Table 5).

DISCUSSION

This study provided new knowledge about how home-care professionals recognise and document the multiple individual resources of older people in care and service planning. The documented resources referred mostly to older people's physical health and functional abilities. Home-care-specific tasks were documented in every plan; they referred to supporting older people's independence in their practical daily needs and to complex issues concerning safety in home care and services. Our study provided new content on individual resources and home-care-specific tasks for care and service planning and documentation. Based on our results, there is a need for the development of home care and service plan documentation and the necessity to update home-care sensitive categories and classifications. Both these are required to enable and guide the professionals in a comprehensive care and service planning, as well as the documentation of older people's individual resources and home-care-specific tasks to ensure individual and quality home care services.

Recognised and documented individual resources of older people

Based on our results, the documentation focused more on the interventions and daily tasks performed by the home-care professionals, instead of the older people's needs, which confirms the results of previous research [23, 39, 53]. However, our results showed that multiple older people's individual resources in several areas of life were recognised and documented by the professionals in the care and service plans. The documented resources emphasised the older people's health condition and functional ability with their psychological, cognitive and social abilities. The documentation was lacking other aspects of individual resources, such as personal experiences of life satisfaction, a sense of coherence or the significance of the home environment; these are aspects that have been introduced in previous research [9, 12]. Nevertheless, in our study, older people's higher age was related to fewer notes on *resources related to safety and sensory functions* and a longer care and service period related to fewer notes on concerning *resources related to sleeping and wakefulness*. In the future, more research is needed to obtain comprehensive knowledge of resources, for example, what is their meaning for older people and how do they change during the home care period. This knowledge is needed to support professionals identify resources and to document them comprehensively.

Based on our findings, the professionals did, to some extent, recognise older people's resources. This differs from the findings of previous studies where it was found that the professionals left these resources under-recognised [10] and often omitted them from the adjustment of care and service plans [37, 53]. According to our results, in most of the plans, the individual resources documented seemed to correspond to topics already recognised and documented as multiple care needs and nursing interventions. However, it is important to identify and document other resources not just those related to health and functional ability; these may have the potential to improve older people's motivation and offer supportive behaviours in their person-centred care [15]. Noteworthy is that older people's resources related to social functions and communication were often documented, even though in previous research older people's loneliness has been increasingly reported, and the loss of meaningful social connections is known to diminish their quality of life [54, 55]. Previous studies have criticised the fact that older people's perceived personal resources have not been optimally utilised in their home care [13], and there is a risk that older people's own potential might be lost [25]. Resource-orientation is vital in respect of promoting health, improving functional ability and supporting the independent living of older people

TABLE 4 A total of 2822 notes from the 71 older people's care and service plans categorised according to FinCC main categories and the inductively developed categories included in the FinCC (FiCND, FiCNI) components ($N = 17$)

Components ($N = 17$) and number of categories (n)	FiCND Total notes in categories n/N	FiCNI Total notes in categories n/N	CS plans ($N = 71$) with a note in new category (n) %/N
1. Activity			
FinCC categories (FiCND $n = 4$, FiCNI $n = 7$)	73	93	
New categories (FiCND $n = 2$)	104	0	
Resources related to			
activity and physical activities			(*n = 58*) *82*
sleeping and wakefulness			(*n = 46*) *65*
2. Secretion			
FinCC categories (FiCND $n = 8$, FiCNI $n = 13$)	41	64	
New categories (FiCND $n = 1$)	24	0	
Resources related to			
secretion			(*n = 24*) *34*
3. Coping			
FinCC categories (FiCND $n = 5$, FiCNI $n = 7$)	90	52	
New categories (FiCND $n = 3$)	146	0	
Resources related to			
cognitive functions			(*n = 24*) *34*
communication			(*n = 58*) *82*
social functions			(*n = 64*) *90*
4. Fluid balance			
FinCC categories (FiCND $n = 2$, FiCNI $n = 4$)	23	4	
New categories (FiCND $n = 1$)	4	0	
Resources related to			
fluid balance			(*n = 4*) *6*
5. Health behaviour			
FinCC categories (FiCND $n = 3$, FiCNI $n = 3$)	47	31	
New categories (FiCND $n = 1$)	43	0	
Resources related to			
health behaviour			(*n = 43*) *61*
6. Coordination of care			
FinCC categories (FiCND $n = 5$, FiCNI $n = 7$)	39	155	
New categories (FiCNI $n = 3$)	0	192	
Tasks related to			
coordination of support services			(*n = 62*) *87*
coordination of informal care provided by relatives			(*n = 69*) *97*
coordination of social security benefits			(*n = 61*) *86*

TABLE 4 (Continued)

Components ($N = 17$) and number of categories (n)	FiCND Total notes in categories n/N	FiCNI Total notes in categories n/N	CS plans ($N = 71$) with a note in new category (n) %/N
7. Medication			
FinCC categories (FiCND $n = 3$, FiCNI $n = 8$)	30	139	
New categories (FiCND $n = 1$) *Resources related to*	21	112	
implementation of medication			*(n = 21) 30*
New categories (FiCNI $n = 2$) *Tasks related to*			
coordination of medication administration responsibilities			*(n = 47) 66*
pharmacy affairs and renewal of drug prescriptions			*(n = 65) 92*
8. Nutrition			
FinCC categories (FiCND $n = 5$, FiCNI $n = 6$)	32	120	
New categories (FiCND $n = 1$) *Resources related to*	43	0	
nutrition			*(n = 43) 61*
9. Respiration			
FinCC categories (FiCND $n = 4$, FiCNI $n = 4$)	15	3	
New categories (FiCND $n = 1$) *Resources related to*			
respiration	8	0	*(n = 8) 11*
10. Circulation			
FinCC categories (FiCND $n = 3$, FiCNI $n = 6$)	0	49	
New categories ($n = 0$)	0	0	
11. Metabolic			
FinCC categories (FiCND $n = 4$, FiCNI $n = 5$)	4	19	
New categories (FiCND $n = 1$) *Resources related to*	26	0	
metabolic			*(n = 26) 37*
12. Safety			
FinCC categories (FiCND $n = 6$, FiCNI $n = 4$)	29	70	
New categories (FiCND $n = 1$) *Resources related to*	18	71	
safety			*(n = 18) 25*
New categories (FiCNI $n = 1$) *Tasks related to*			

(Continues)

TABLE 4 (Continued)

Components ($N = 17$) and number of categories (n)	FiCND Total notes in categories n/N	FiCNI Total notes in categories n/N	CS plans ($N = 71$) with a note in new category (n) %/N
evaluation of home and surroundings' safety			(*n = 71*) *100*
13. Daily activities			
FinCC categories (FiCND $n = 3$, FiCNI $n = 4$)	107	111	
New categories (FiCND $n = 1$) *Resources related to*	70	63	
independent initiative and daily activities			(*n = 70*) *99*
New categories (FiCNI $n = 1$) *Tasks related to*			
assistance in housekeeping chores			(*n = 63*) *89*
14. Mental balance			
FinCC categories (FiCND $n = 5$, FiCNI $n = 5$)	36	3	
New categories (FiCND $n = 1$) *Resources related to*	45	0	
mental balance			(*n = 45*) *63*
15. Sensory and neurological functions			
FinCC categories (FiCND $n = 7$, FiCNI $n = 20$)	106	13	
New categories (FiCND $n = 2$) *Resources related to*	62	0	
sensory functions			(*n = 51*) *72*
neurological functions			(*n = 11*) *16*
16. Skin integrity			
FinCC categories (FiCND $n = 6$, FiCNI $n = 10$)	35	87	
New categories (FiCND $n = 1$) *Resources related to*	21	0	
Skin integrity			(*n = 21*) *30*
17. Life cycle			
FinCC categories (FiCND $n = 15$, FiCNI $n = 12$)	0	0	
New categories (FiCNI $n = 1$) *Tasks related to Hearing the living will*	0	31	(*n = 31*) *44*

and also providing older people's care in an ethically and economically sustainable manner [56–58].

Home-care-specific tasks supporting independent and safe living of older people

Based on our results, home-care-specific tasks were documented in every care and service plan and they related to a comprehensive support of older people's practical daily life needs and to the complex issues of safety in home care. Most often these tasks focused on safety evaluations of the home and its surroundings, coordination of informal care provided by relatives, coordination of support services and assistance in housekeeping chores. Pharmacy affairs and renewal of drug prescriptions were also often documented, and with an increase in the number of home visits per week the greater the number of tasks documented. The results are in line with previous research that older people being offered home care

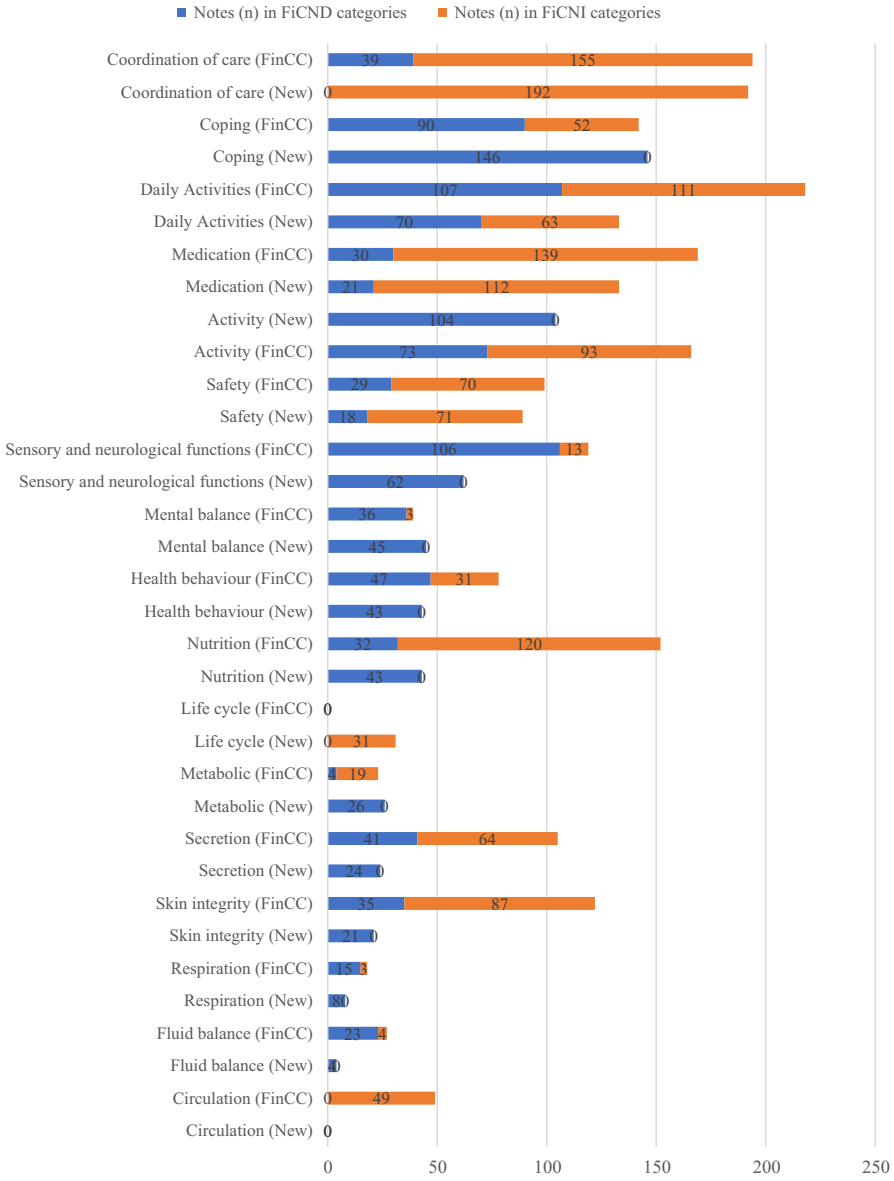

FIGURE 2 The total number of 2822 notes categorised in order of magnitude of the notes in the new inductively developed categories (FiCND, FiCNI) and compared to notes in the FinCC main categories (FiCND, FiCNI) of the 17 FinCC components.

need more personal and practical support that goes beyond their care needs, meets with their individual life situations and helps them to maintain their independence [59].

The documentation of home-care-related tasks highlighted the diverse safety issues necessary in home care. Based on our results, carefully documenting all the safety-related information and tasks about the home and its surroundings into the plans is important. The results confirm previous studies that highlight the need for supporting older people's safe living in their homes, where situations can vary widely [60]. Our results about the documented medication-related tasks in the plans seem vital in respect of safety, when it is known that medication errors in home care are often caused by insufficient exchange of information [61] and unclear communication concerning responsibilities between clients, relatives and professionals [8]. Clear communication and responsibilities are connected to the continuity of care as well. Based on our results, almost every plan included tasks related to the coordination of support services and informal care provided by relatives. In previous studies family members have also been reported to have a central role in older people's lives as regards their home care and service planning, deepening the professional's understanding of older people's individual life situations, resources and needs, and supporting older people's independent living [53, 62–64]. This emphasises the need for planning and documenting clearly all of the collaborators and their responsibilities in the plans to ensure continuity and safety and prevent misunderstandings in the care and services provided in older people's homes, where most of the collaborators are not "under the same roof".

TABLE 5 The association between older people's or home care service characteristics and older people's individual resources or home-care-specific tasks documented in care and service plans ($N = 71$)

Background characteristics (independent)	**New inductively developed categories (dependent)**								
FiCND	Resources related to sleeping and wakefulness (Activity)			Resources related to safety (Safety)			Resources related to sensory functions (Sensory and neurological functions)		
	OR	95%-CI	*p*-value	OR	95%-CI	*p*-value	OR	95%-CI	*p*-value
Intercept	28.818			498.264			33524.440		
Older people's gender, female vs. male	3.740	[0.940; 20.916]	0.085	0.145	[0.012; 0.864]	0.067	2.414	[0.521;14.920]	0.292
Older people's age in years	0.964	[0.882; 1.041]	0.338	0.909	[0.828; 0.984]	0.026	0.882	[0.783; 0.971]	0.020
The length of care and service period in months	0.976	[0.951; 0.996]	0.035	0.990	[0.949; 1.020]	0.573	1.032	[0.998; 1.084]	0.144
Number of home visits per week	1.046	[0.983; 1.124]	0.179	1.062	[0.990; 1.151]	0.112	1.015	[0.935; 1.105]	0.722
FiCNI	Tasks related to pharmacy affairs and renewal of drug prescriptions (Medication)								
	OR	95%-CI	*p*-value						
Intercept	10441.050								
Older people's gender, female vs. male	1.064	[0.111; 18.499]	0.959						
Older people's age in years	0.906	[0.745; 1.053]	0.253						
The length of care and service period in months	0.973	[0.928; 1.003]	0.162						
Number of home visits per week	1.167	[1.033; 1.398]	0.037						

Note: $p < 0.05$ highlighted in grey.

Need for updated categories for home care and service planning and its documentation

Our research provided new content related to older people's individual resources and home-care-specific tasks for home care and service planning and its documentation. These contents provide an insight into what should be considered when planning and documenting home care and service plans and updating of home-care-sensitive categories in addition to often institutionally focused documentation classifications and categories. It is noteworthy, there were almost as many notes drafted in the inductively developed main categories as there were notes in the current FinCC main categories, even if the documentation of the plans was not guided by any classification. This raises the question of whether the use of standardised and often needs-based classifications and their limitations lead to less comprehensive contents in care and service plans [23, 39], and lack of resource-related documentation and home-care sensitive categories [23] as recognised in previous research.

However, standardised and structured documentation has its benefits in guiding the exact and systematic documentation of the plans [65]. Structured data is proven to support the delivery of equal and high-quality care, data exchange and its reuse in interprofessional collaboration; this support strengthens the continuity and safety of care [35, 66, 67] which can easily be compromised in home care. However, this requires the structures and categories of the care and service plan documentation to be both general and detailed enough to meet with the individual aspects of older people and their living situations [38, 39, 52, 65]. Our results confirm the previous results that differential care contexts require context-specific terminologies, classifications [35, 38, 65] and structures that corresponds to concepts of home care in order to avoid scattered information and narrow views [38]. Our results highlighted the need for future research to develop home care and resource-sensitive categories and classifications, both of which may have the potential to guide professionals in the recognition of older people's individual resources and unifying the documentation of the home care and service planning process.

STRENGHTS AND LIMITATIONS

The strengths and limitations of this study concern sampling, data and analysis. The data collection method and results are vulnerable to bias because we chose to use a convenience sample in our study to obtain the representative document data from the plans of the cases that the home-care professionals handled [41]. Therefore, our findings cannot be generalised and do not represent the contents of all older people's home care and service plans. The inclusion and exclusion criteria did not set specific requirements for the health status of older people's or their comorbidities, nor did the criteria include the professionals' background education, degrees or documentation competencies; these factors might have affected the results [42]. However, we only included in the study home care and service plans that were made for older clients, whose functional ability had been assessed to have deteriorated and therefore met the criteria for accessing regular home care services. We have confidence in the representativeness of the data, as the information indicates that the sample of the care and service plans ($n = 71$) and the background characteristics such as the older people's age, number of home visits and variety of documented care and service needs seem to be diverse and versatile in describing the study population ($N = 168$) of older people in home care [1, 5, 6, 50].

Another limitation is that the documents were not originally meant to be used as research data, the contents were documented in a semi-structured way and they did not follow the FinCC classification, which was the chosen base for the structured analysis framework [41, 44, 68]. However, the contents of the plans responded well to the aim of this study [40, 41] and FinCC was considered as a reliable structure because it is based on evidence and many years of development work [34, 41]. In addition, the use of the document data and document analysis enabled an anonymous and objective way to gather information about sensitive situations and a group of older people in home care settings [40, 41]. A further strength was the close and regular collaboration between the research group members during all phases of the research. Additionally, the analysis was confirmed by all three researchers, and with the help of the statistician [42] and a STROBE checklist for cross-sectional studies was used for reporting the study [69]. Despite the limitations we have confidence in the results.

CONCLUSIONS

Based on our results, older people's individual resources and home-care-specific tasks were recognised and documented by home-care professionals in the home care and service plans. However, there is a need for more knowledge to update home-care-sensitive documentation of care and service planning to support individualised and person-centred home care. In this respect, our study provided new insights that highlight older people's individual resources and also the home-care-specific tasks that were

recognised in the documentation of the plans. Future research is needed about the overall nature of older people's individual resources and home-care-specific tasks and how these relate to our results to develop classifications and categories; these would then enable and guide the professionals in the comprehensive documentation of home care and service plans. In addition, the competency of home-care professionals to provide adequate documentation of home care and service plans needs to be investigated.

AUTHOR CONTRIBUTIONS

The authors ensure that they all agree and are accountable for all decisions concerning this study and its accuracy and integrity. They all confirm their final approval of the study for publishing. Jonna Puustinen, the first author and doctoral researcher: conception and design of the study, data collection, analysis and interpretation, drafting of manuscript. Mari Kangasniemi, the supervisor: conception and design of the study, data analysis and interpretation, critical revision for the important intellectual content of the manuscript. Miko Pasanen, the statistician: data analysis and interpretation, critical revision for the important intellectual content of the manuscript and statistical expertise. Riitta Turjamaa, the supervisor: conception and design of the study, data collection, analysis and interpretation, critical revision for the important intellectual content of the manuscript.

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CONFLICT OF INTEREST

All authors declare no conflicts of interest.

ETHICS STATEMENT

Throughout the study, we followed the ethical principles of the scientific process and the Declaration of Helsinki [70–72]. The attendance of the home-care professionals was voluntary, and we obtained informed consents from all of the participants in this study. Prior to the data collection, the ethical review was conducted by the Research Ethics Committee of the Northern Savo Hospital District (date 15.12.2015, Dnro 453/13.02.00/2015) and an appropriate permission was admitted by the study organisation.

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