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Older People's Individual Resources and Reality in Home Care

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RIITTA TURJAMAA

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ABSTRACT

Most older people want to live meaningful lives in their own homes despite decreased abilities and, if needed, the aim of home care services is to enable them to live at home for as long as possible. That requires home care professionals to recognize clients' individual resources and take these into account while delivering daily care. However, little has been studied from the perspectives of older people and home care professionals regarding how care and services can be provided when being supported by professionals in daily care. In addition, there is a lack of research based on evaluating practice in older clients' daily care. Therefore, research based on supporting clients' resources in practice is needed. The aim of this study was to describe and evaluate the recognition and realization of older people's resources in daily home care services from clients' and home care professionals' perspectives.

This study consisted of four phases. The systematic literature review concerned international articles (n=17). The second phase included focus group interviews of home care professionals (n=32), and the third phase consisted of the analysis of older home care clients' (aged 75 years or over) care and service plans (n=437). The fourth phase included conducting video-based stimulated recall interviews of older home care clients (aged 75 years or over) (n=23) and practical nurses (n=14). The data of the systematic literature review and interviews were analysed by inductive content analysis and care and service plans by the method of document analysis.

According to results, older people were well-aware of their resources, as were home care professionals, and these were described multidimensionally by both. Resources consisted of the social relationships and elements of meaningful daily living, including ability to manage everyday activities, ability to function, available home care services as well as safety and functionality of the environment. However, the gap between awareness and practice in daily care was obvious. The experience of clients was that their resources had not been taken into account and were not supported, and professionals identified narrowly documented resources in care and service plans, insufficiently recognized and realized in daily care. According to older clients and professionals, the development of home care in future requires the recognition of individual resources, meaningful everyday lives, confidential and long-lasting relationships between clients and professionals and a safe environment at home.

In conclusion, current home care services are based on daily routine care and emphasize only clients' physical needs and ability to function. In order to be able to promote older home clients' living at home, the provided home care services need to be individually designed and must take into account clients' resources and their perspectives of meaningful and inspirational activities.

National Library of Medicine Classification: WY 115
Medical Subject Headings (MeSH): Home Care Services; Home Nursing; Aged; Family Relations; Interpersonal Relations; Activities of Daily Living; Professional-Patient Relations; Qualitative Research

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TIIVISTELMÄ:

Useimmat iäkkäät ihmiset haluavat elää mielekästä elämää omissa kodeissaan lisääntyvistä toimintakyvyn vajavuuksista huolimatta. Kotihoidon tavoitteena on mahdollistaa kotona asuminen huomioiden asiakkaiden yksilölliset voimavarat. Iäkkäiden asiakkaiden ja henkilökunnan näkemyksiä kotihoidon toteuttamisesta ja henkilökunnan tuesta päivittäisessä hoidossa on tutkittu vähän. Lisäksi tutkimus, joka kohdentuu voimavaralähtöisen työskentelyn toteutuksen arviointiin, on vähäistä. Tämän tutkimuksen tarkoituksena oli kuvata ja arvioida iäkkäiden kotihoidon asiakkaiden voimavarojen tunnistamista ja tukemista kotihoidossa asiakkaiden ja henkilökunnan näkökulmista.

Tutkimus koostuu neljästä osatutkimuksesta. Ensimmäisen osatutkimuksen aineistona olivat aikaisemmat iäkkäiden voimavaroja käsittelevät tieteelliset artikkelit (n=17). Toisen osatutkimuksen aineisto koostui tutkimukseen osallistuvan organisaation kotihoidon henkilökunnan (n=32) ryhmähaastatteluista. Kolmas osatutkimus kohdentui kotihoidon asiakkaiden palvelu- ja hoitosuunnitelmiin (n=437). Neljännessä osatutkimuksessa aineisto kerättiin videoimalla kotikäyntejä ja virikkeitä antavien haastatteluiden avulla kotihoidon hoitajilta (n=14) sekä heidän asiakkailtaan (n=23).

Sekä iäkkäät asiakkaat että kotihoidon henkilökunta pitivät sosiaalisia suhteita ja mielekkään arjen elementtejä kotona asuvien iäkkäiden ihmisten voimavaroina, johon liittyivät tärkeänä osana perhe- ja ystävyyssuhteet sekä luottamuksellinen suhde kotihoidon henkilöstön kanssa. Mielekkään arjen elementtejä luonnehtivat kokonaisvaltainen toimintakyky, mahdollisuus selviytyä päivittäisistä toiminnoista sekä positiivinen elämänasenne ja itseluottamus. Voimavaroja tukevia tekijöitä olivat kotihoidon palvelut sekä ympäristön turvallisuus ja toimivuus. Päivittäisessä hoitotyössä voimavarojen huomioiminen ja tukeminen oli melko vähäistä. Asiakkaan luona tapahtuvaa työskentelyä ilmensi kiireisyys ja asiakkaan puolesta tekeminen. Lisäksi työskentely keskittyi päivittäisten toimintojen ja lääkehoidon rutiininomaiseen suorittamiseen sekä välttämättömiin hoitotoimenpiteisiin. Myös hoito- ja palvelussuunnitelmissa oli nähtävissä sama suorituskeskeisyys eikä asiakkaan voimavaroja huomioitu.

Kotihoidossa on tunnistettavissa toimenpidekeskeisyyttä ja asiakkaan fyysisiin tarpeisiin vastaamista. Jotta voidaan edistää iäkkäiden asiakkaiden kotona asumista, tarvitaan yksilöllisesti suunniteltuja kotihoidon palveluita, joita toteutetaan voimavarojen tukemisen näkökulmasta. Voimavaralähtöisyyden toteuttaminen edellyttääkin iäkkäiden asiakkaiden sosiaalisten suhteiden ja mielekkään arjen elementtien huomioimista.

Luokitus: WY 115
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Kuopio, October 2014

Riitta Turjamaa

List of the original publications

This dissertation is based on the following original publications:

I Turjamaa R, Pietilä A-M and Hartikainen S. 2011. Kotona asuvien iäkkäiden ihmisten voimavarat ja niiden tukeminen – systemoitu kirjallisuuskatsaus. *Tutkiva hoitotyö* 4, 4-13.

II Turjamaa R, Hartikainen S and Pietilä A-M. 2013. The forgotten resources of older home care clients: Focus group study in Finland. *Nursing & Health Sciences* 15, 333-339.

III Turjamaa R, Hartikainen S, Kangasniemi M and Pietilä A-M. 2014. Is it time for a comprehensive approach in older home care clients' care planning in Finland? *Scandinavian Journal of Caring Sciences* doi: 10.1111/scs.12165.

IV Turjamaa R, Hartikainen S, Kangasniemi M and Pietilä A-M. 2014. Living longer at home: A qualitative study of older clients' and practical nurses' perceptions of home care. *Journal of Clinical Nursing* 23, 3206-3217.

Contents

1 Introduction

The majority of older people are healthy and living at home in a familiar environment (Hochhalter et al. 2011). Independent living at home can be enabled by using individual resources (Del-Pino-Casado et al. 2011, Janssen et al. 2012). Resources refer to an individual's subjective experience of the strategies that are needed to maintain one's well-being (Tornstam 1982, Koskinen 2004, Eloranta et al. 2008a). The resources of older people are multiple and varied, with functional, cognitive, psychological and social abilities (Hayashi et al. 2011, Salguero et al. 2011).

Ageing is often seen as carrying a growing risk of chronic disease as well as physical and physiological changes (Harrison et al. 2010). However, ageing is increasingly seen as a meaningful and healthy period of life focusing on older people's interaction with society (Hakonen 2008, Vuoti 2011). In addition, older people are seen as fully authorized members of society (Koskinen 2004, Tepponen 2009, Vuoti 2011).

Finland has one of the world's fastest growth rates of older people in the population (Statistics Finland 2013). Predictions show that the share of people aged 75 or over is expected to rise by 59 000 (10%) in 2020 and by 61 758 (15%) in 2040 (Statistics Finland 2013). Similarly, in Europe, the number of people aged 80 years or over is projected to almost triple from 21.8 million in 2008 to 61.4 million in 2060 (Eurostat 2010). As a result, the number of home care clients is expected to increase. Of older people aged 75 years or older, 53 703 (11.9%) are municipal home care clients (National institute for health and welfare 2013).

In Finland, social and health care services are under economic pressure due to the demographic change caused by the increasing number of older people. Institutional care is often more costly than home care (Hammar et al. 2008, National institute for health and welfare 2010, Burt et al. 2012). Therefore, growing attention has been given to changing the care of older people from institutional to home care (National institute for health and welfare 2010). In addition, there is also a legislative responsibility to supply home care services consisting of support for older clients at home (Social welfare act 710/1982, Act on supporting the functional capacity of the Ooder population and on social and health services for older persons 980/2012) by offering care based on clients' personal needs as well as resources (European Commission 2011, WHO & US national institute on aging 2011, WHO 2012b). According to previous studies, realizing care and services requires from an organizational level as well as home care professionals that older clients be recognized as individuals and that not only their needs but also resources be taken into account (Coleman et al. 2011, Hirao et al. 2012). Therefore, professionals have a crucial role in promoting clients' living at home (Verbeek et al. 2009, Rabiee & Glendinning 2011). This requires from home care professionals individual care planning, comprehensive daily care and continuing evaluation of each client's condition. This kind of care of clients emphasizes the confidential relationship and communication between home care professionals and clients and supports the maintenance of individuality (Bone et al. 2010, Goodman et al. 2013).

A confidential relationship between older clients and home care professionals refers to confidence (Coleman et al. 2011, Hirao et al. 2012) and autonomy (Lindblad et al. 2010, Zhang et al. 2011). A confidential relationship is based on reciprocal confidence where the home care professionals recognize and take into account older clients' autonomy and respect the way clients live in their own homes. Older clients' confidence in home care professionals increases when professionals focus on clients' perspectives and take their needs into account in care planning as well as in daily care (Coleman et al. 2011, Hirao et al. 2012). This kind of confidential relationship between client and professional is sensitive and based on an ethical perspective where the clients have their own equal worth and own

values. According to earlier studies, clients are sometimes seen as passive care recipients (Outhoorn et al. 2007), and thus, their perceptions are ignored (Hammar et al. 2009, Hayashi et al. 2011, Salguero et al. 2011). It can be a challenge for home care professionals to identify and take clients' resources into account (Hayashi et al. 2011, Salguero et al. 2011), and support them in daily care (Donahue et al. 2008, Raiche et al. 2012).

Autonomy refers to older people's rights of self-determination in the context of making decisions about their care and services (Lindblad et al. 2010, Zhang et al. 2011). In addition, autonomy is related to wholeness and dignity, and is a significant aspect of ethical conversation in home care services (Karlsson et al. 2009, Juthberg et al. 2010). According to the principle of autonomy, all home care clients have the right to influence their care in collaboration with home care professionals based on their subjective values (Act on the status and rights of patients 785/1992, Act on supporting the functional capacity of the older population and on social and health services for older persons (980/2012). For home care clients, being able to express their own opinions and having home care professionals show consideration are preconditions for achieving independence (Karlsson et al. 2009).

Most studies have provided descriptions of recognizing and supporting older clients' resources from the perspectives of home care professionals and older clients (Jopp et al. 2008, Verbeek et al. 2009, Eloranta et al. 2010). There is a lack of research based on evaluating practice in older clients' daily care. The knowledge that descriptions about clients' daily care based on taking into consideration clients' resources differ substantially from evaluated reality in daily care highlights the need to explore what older people's resources are and how these resources are recognized in daily care. Additionally, there is a need for more knowledge and understanding of older clients' daily care as a whole to develop home care that promotes clients' living at home. This makes it possible for home care professionals to take the best possible advantage of resources and to encourage clients to apply them in their everyday activities (Koskinen et al. 2007, Salguero et al. 2011). This knowledge is essential in order to develop home care that promotes clients' living at home. Therefore, the ultimate aim was to point out the multidimensional nature of the research phenomenon, resources, and also the elements of meaningful daily life based on older people's views.

2 Review of the literature

This review of the literature is based on previous studies, literature and other publications such as legislation and recommendations concerning older home care clients, their resources and home care services. Inyear 2009 the systematic literature review was first conducted as a part of study in the period between 2005 and 2009. The limitations were made about the publishing years, because the number of publications in this field has continued to increase in the 2000s. The exact phases of the literature search are shown in Article I and in summary on page 14. In year 2014 the literature review was updated concerning older people and older home care clients, their resources and home care services.

In year 2014, an electronic literature search was conducted of four international databases: Cinahl, Pubmed, PsycInfo and Cochrane Library. The English search phrases were: (resource* OR empower*) AND (aged OR elder* OR "old* people*") AND ("homecare" OR "home care" OR "home nursing" OR "home health service*" OR "home health care"), ("gerontol* nurs* OR "geriatric nurs*) AND ("home care" OR homecare OR "home health service" OR "home nursing"), (resource* OR empower*) AND (aged OR elder* OR old* people*"). "Resource" is an extensive term to use in a search because it can refer, for example, to economic resources or amount of employees as a resource and thus the search results become too wide. Therefore the terms "gerontol* nurs*" OR "geriatric nurs*" OR "home nursing" were used in the search. In addition, the term "empower", which is closely related to the term "resource", was used in the search. In addition, three national databases were used: Linda, Josku and Medic (Table 1). In Finnish databases, the used search phrases were: (voimavar* OR voimaantu*) AND (vanhu* OR iäkäs OR ikääntyv*). The search term "kotihoi*" was used in the preliminary search. However, this term was not included in the final search, because it was too exact when articles related to home living older people's resources were not identified.

The literature search was conducted in February 2014. The search was based on the following limitations: 1) peer-reviewed scientific article, published 2) between the years 2009 and 2014, 3) in Finnish, English or Swedish, and 4) available as full text. Inclusion criteria were as follows: 1) selected articles focused on older people's resources in the context of home care services, and 2) perspective of older people or home care professionals. A total of 504 articles were identified. The articles were selected in stages based on titles, abstracts and full text (Table 1). All types of articles including reviews, qualitative and quantitative studies and meta-analyses were included. Furthermore, duplicates were removed. As a result of electronic literature searches, eight articles were included in the theoretical background. After that, a manual search was conducted from the selected articles' bibliographies and the search was supplemented with two articles. A total of 10 articles were included in the theoretical background (Appendix 1). As a whole, altogether 27 articles based on a systematic literature review in the year 2009 and a literature search in the year 2014 were included in the description of older people's resources (Table 2, page 12).

Table 1. Selection of the literature searches by stages

Databases	**Amount**	**First selection: title** (search term/terms exist in the title)	**Second selection: abstract** (description of the phenomenon)	**Final selection: full text** (description of the phenomenon based on older people's or/and professionals' views)
Cinahl	198	13	9	5
PubMed	290	19	5	2
PsycInfo	13	2	1	1
Cochrane Library	0	0	0	0
Linda	0	0	0	0
Josku	0	0	0	0
Medic	1	0	0	0
Manual search	2	2	2	2
Total	**504**	**36**	**17**	**10**

2.1 UNDERSTANDING OF AGEING AND OLDER PEOPLE'S RESOURCES

Understanding of ageing has varied over different eras and definitions of older people concern chronological age as well as physical and social views of ageing (WHO 2012a). One of the most often used approaches to describe ageing is chronological age. Most developed countries have accepted the chronological age of 65 years as a definition of older people (World Health Organization 2012b). In Finland, in national statistics, the minimum age for older people is also 65 years (e.g. the National institute for health and welfare 2012, Statistics Finland 2013). In addition, several studies concerning older people have defined older people as 65 years or over (Borg et al. 2008, Jeune & Brøssum-Hansen 2008, Eloranta et al. 2010, Tan et al. 2013). However, this has been criticized because life expectancy is increasing in most countries and older people's ability to function has grown and they are often healthy without major functional limitations (Christensen et al. 2009, Salminen et al. 2012, Sherman et al. 2012). Thus, 75 years or more has been found to be more suitable, because 75-year-old people are more vulnerable than younger people. In particular, older people living alone have been described as having worse health and well-being than younger people (Sherman et al. 2012) and therefore the need for regular help starts to increase (Official Statistics of Finland 2013). One in three people aged 75 and every second person aged 85 needs help on a daily basis (Sarkeala et al. 2011).

2.1.1 Comprehensions of ageing

Three comprehensions of ageing have been presented, and characterized as biomedical (Joyce & Meika 2010), sociocultural (Hinterlong 2008) and holistic views (Allan & Johnson 2009). Concepts and perceptions of ageing and older people affect attitudes towards them (Koskinen 2004, Higgins et al. 2007, Gallagher et al. 2008). Comprehensions of ageing also have relevance for politics as well as organizing and delivering older people's social and health care services (McLafferty et al. 2004, Gallagher et al. 2006). Therefore, it is important to understand how older people are comprehended by society, as it is from these views and

attitudes that ageist behaviours and mistreatment of older people can arise (Drennan et al. 2009).

Definitions of older people have implications for society as well as health care services (Arnold-Cathalifaud et al. 2008, Allan & Johnson 2009). According to several earlier studies, ageing has been described with an illness-centred approach. Research focused on definitions of ageing has found the assumption that unfavourable attitudes are common (Arnold-Cathalifaud et al. 2008, Allan & Johnson 2009). Although there are several studies in which ageing has been observed through an illness-centred approach (Wachelke & Lins 2008, Arnold-Cathalifaud et al. 2008, Hall & Batey 2008, Allan & Johnson 2009, Musaiger & D'Souza 2009), a number of recent studies have reported overall respectful or at least neutral attitudes towards older people (Cuddy et al. 2005, Barrett & Cantwell 2007, Hall & Batey 2008).

Biomedical view of ageing

The biomedical view of ageing underlines the strong connection between ageing and illness as well as disabilities that have been explained via medicine (Thane 2003, Joyce & Meika 2010). The biomedical view is based on the physical definition of older people, which indicates physiological and physical changes (Harrison et al. 2010).

Physiological changes refer to the lifelong accumulation of a wide variety of molecular and cellular changes, which are mostly decreasing in nature (Kirkwood 2008). Physiological changes have consequences of advancing age and an increased risk of illnesses (Altman 2010), such as cancer, heart disease and cognitive disorders (Kirkwood 2008). These illnesses are not a natural part of ageing, but in older age are risk factors for certain age-related diseases. Therefore, ageing is not an illness in itself, but increases vulnerability to several diseases (Hayflick 2007) and causes isolation from social relationships (Camacho-Soto et al. 2011).

Physical changes refer to the physical ability to function as well as functional disabilities. Physical ability to function is linked to the activity concerned, which is also important for the increase or prevention of muscle strength and power, maintenance of mobility, and prevention of falls and fractures. Physical ability to function is also connected to older people's mental health (Harrison et al. 2010, Windle et al. 2010). Furthermore, functional disabilities are often linked to functional autonomy including older people's ability to manage everyday activities (Musaiger & D'Souza 2009).

The biomedical view has been criticized for its illness-centred approach and its one-sided as well as narrow perspective of ageing, where ageing has been seen as unwanted and divergent from normal and healthy life (Barrett & Cantwell 2007, Joyce & Meika 2010). Furthermore, in the communities idealizing youth, ageing might have been seen as unwanted (Joyce & Meika 2010) and as the period of physical and mental decline when older people become dependent and helpless (Koskinen 2004, Calasanti 2005, Fernández-Ballesteros et al. 2011).

Sociocultural view of ageing

The sociocultural view of ageing is based on the social definition of older people. The sociocultural view is culturally bounded and perceives ageing as a positive part of life referring to health, ability to function, social activity and economic welfare. Furthermore, the sociocultural view is focused on a context that combines older people's life history and their interaction with society (Hakonen 2008, Vuoti 2011). The sociocultural view highlights older people's own assessment of their age, underlining personal sense of life satisfaction, social participation and functioning as well as psychological resources, including personal growth (Söderhamn et al. 2013) as well as social position in society and changes with growing age including rights and duties (Drennan et al. 2009). From the perspective of society, the sociocultural view has been described as a trend, where older people have been accepted with their values and as equal people to contribute to society's development. This

trend is crucial for older people with greater health and well-being in later life so they can age successfully (Hinterlong 2008).

According to the sociocultural view of ageing, older people have active roles and are responsible for their own lives. This can be described as an active lifestyle that can be achieved when people define goals and select tasks that they can do, optimize their capacities, and compensate for possible disabilities by finding new means to achieve goals (Hinterlong 2008, Thanakwang & Isaramalai 2013). Consequently, sustaining an active role in life is not only beneficial to society but is also positively related to the mental well-being of older people. This may in turn increase their potential to age healthily (Caro et al. 2009, Thanakwang & Isaramalai 2013). In addition, the sociocultural view focuses on older people's individual resources and strengths, including elements of expertise in one's own life and becoming a fully authorized member of society (Koskinen 2004, Tepponen 2009, Vuoti 2011). The sociocultural view also highlights perspectives in which ageing is seen as a normal phase in the course of one's life and older people are resources of society (Koskinen 2004, Hakonen 2008, Arnold-Cathalifaud et al. 2008).

However, there is a critical opinion in the literature that the sociocultural view highlights only favourable viewpoints of older people without noticing them as a whole. This opinion may be due in part to the dominant view of older people that emphasizes ageing as a disease (Thane 2003, Joyce & Meika 2010).

Holistic view of ageing

The holistic view of older people can be described as a combination of biomedical and sociocultural views. The holistic view of older people highlights individuals' physical, mental and social dimensions, including intellectuality and spirituality (Koskinen 2004). In the holistic view, people are seen as a whole, warts and all as well as their strengths. The main issue concerns individuals seen not only in the context of objects but in the centre of their own lives, including their unique life situation, such as their relationships and connection to the environment (Allan & Johnson 2009). Moreover, older people are entitled to keep their autonomy and belong to social networks and society. From the perspective of older people, their life consists of the same elements as younger people, but they have unique and individual aspects enabled by their life course (Koskinen 2004, Arnold-Cathalifaud et al. 2008, Tepponen 2009).

On the other hand, although there are different opinions between biomedical, holistic and sociocultural views, more consensus between different views is needed to promote older people's health and to keep their autonomy and enable them to belong to social networks as well as society (Koskinen 2004). The influence of normative age-related and developmental changes in health, social interaction and socio-economic resources upon satisfaction with life should not be underestimated (Arnold-Cathalifaud et al. 2008).

2.1.2 Perspectives of older people's health

Older people's health is a multifaceted topic and can be described and evaluated from different perspectives. According to earlier studies, older people's health condition is closely linked to health expectancy, which can be observed using register data (Jeune & Brønnum-Hansen 2008). In addition, perceived health (Nordenfelt 2009), self-care ability (Dale et al. 2012b) and quality of life (Borglin et al. 2006) have been studied using questionnaires and interviews concerning older people's opinions of their own health.

Health expectancy is a summary indicator of a population's health that explains both the quantity and quality of life dimensions of health (Jeune & Brønnum-Hansen 2008). As an indicator, health expectancy extends measures of life expectancy to account for health states by combining information about morbidity, mortality, disability and health status (Jeune & Brønnum-Hansen 2008) as well as reflecting changes in social and economic conditions, lifestyle changes, medical advances and better access to health services (Parker et al. 2005, Sarkeala et al. 2011). The calculation of health expectancies makes it possible to estimate

differences between socio-economic categories or regions, and to observe the changes that occur. In relation to older people's health, recognizing health expectancy on the level of health policy is crucial. It is an indicator that predicts needs for care and service in the future (Vaalavuo et al. 2013**).**

Perceived health refers to the individual level, in terms of a person's subjective perceptions of their own health. It means not only the absence of disease or injury but also physical, mental and social well-being and a person's ability to realize goals (Nordenfelt 2009). As an indicator, perceived health is a predictor of mortality, even when physical health and demographic variables have been controlled for. Therefore, establishing what physical and psychosocial elements relate to perceived health will help enhance positive perceptions of one's own health for ageing (Nordenfelt 2009). Perceived health has been found to vary among older people. According to an earlier study, older people aged 75 perceived their health as good or very good but at the same time they described many health problems (Sherman et al. 2012). Having positive expectations about health has also been found to be important for older people's perceived health (Kim 2009). Older people with a positive perception of their health exhibited a higher degree of life satisfaction than those with a negative perception (Kim & Sok 2012). Therefore, older people's assessment of their own health has been considered to be a significant aspect to acknowledge in the field of health research (Nordenfelt 2009).

According to earlier studies, older people's experience of their health is found to be one of the most frequently mentioned elements influencing their quality of life (Bowling et al. 2003, Tan et al. 2013, Wu et al. 2013). Quality of life can be approached both objectively and subjectively. From the objective point of view, health, behaviours and standards of life can be observed from the outside, and a subjective point of view approaches well-being, life satisfaction and happiness from individual experiences (Netuveli & Blane 2008). In addition, quality of life is related to individual experience of abilities and disabilities (Hsu & Tung 2010). It is worth noting that objective and subjective evaluations of quality of life can be contrary. Despite the fact that most health problems are highly prevalent and have consequences for managing everyday activities in old age, older people with a high quality of life adapt to variable health conditions (Sims et al. 2007, Savikko 2008). Quality of life improves if older people understand and accept their own condition (Hsu & Tung 2010). Furthermore, age does not always influence quality of life negatively and good quality of life is possible to achieve at advanced ages, depending on individual elements and the availability of support resources (Rodriquez-Blazquez et al. 2012).

Self-care ability is a part of individuals' lifestyle and can be defined as the practice of activities that individuals initiate on their own behalf in maintaining health and well-being (Cohen-Mansfield & Jensen 2007, Kwong & Kwan 2007). Self-care ability is connected to activities of daily living (ADL), such as eating, bathing and dressing, and instrumental activities of daily living (IADL), such as managing money, shopping, telephone use, housekeeping and preparing meals (Høy et al. 2007, Janlöv et al. 2011). According to an earlier study, high self-care ability enables older people to enjoy autonomous and independent living in their own homes (Beswick et al. 2010). Sufficient self-care ability enables active involvement in their own health (Høy et al. 2007). Reduced self-care ability is found to reduce life satisfaction among older people and their abilities to manage everyday activities (Borg et al. 2006). When older people need help to manage daily activities, it is necessary to discover their self-care routines, in order to achieve a sense of continuity in their lives (Cohen-Mansfield & Jensen 2007).

In sum, older people's health can be approached from different views. Health is a natural part of ageing and, in contrast to declining health, understanding of satisfactory health and resources enable older people to have the capacity to define and find strategies to manage everyday activities by adjusting disabilities and diseases (Donahue et al. 2008). Awareness of multidimensional approaches to older people's health is an opportunity to recognize the

individuality of older people and resources and thus to find suitable ways to support their health and everyday life.

2.1.3 Aspects of resources in older people's lives

There has been increasing research attention to the resources of older people in recent decades. In the literature, there were several classifications and definitions of older people's resources emphasizing different features (Tornstam 1982, Koskinen 2004, Hokkanen et al. 2006, Eloranta 2009, Tan et al. 2013), but there was a consensus on a view that resources are subjective experiences of existing and potential abilities and opportunities to achieve individual goals (Tornstam 1982, Koskinen 2004, Eloranta et al. 2008a).

Individuals have different resources and the set of resources varies between people. In addition, the same issue, for example memories from childhood, can be a resource for someone but not for others (Weismann & Hannich 2013). Resources can be recognized subjectively, such as experience of life satisfaction (Wiesmann & Hannich 2013), but also observed objectively, such as health condition (Söderhamn et al. 2013). Thus, resources concern non-material issues such as attitudes and capability (Tan et al. 2013) and material issues such as personal aids and finance (Borg et al. 2006, Borg et al. 2008). Although the separation of different classifications is in some cases artificial and the content of resources is often parallel, definitions are used as a tool to recognize and make them visible. In this study, older people's resources are seen as individual experiences of their personal capacities as well as those connected to the material world around older people's lives. Based on these perspectives, individual resources have been classified into two main categories: personal and external resources.

Personal resources

Personal resources refer to the experience of human dignity, health condition and life satisfaction, sense of coherence, as well as one's positive attitude towards life. Human dignity refers to older people's experience of being respected and valued in their private lives and society (Woolhead et al. 2004). As a resource, it supports older people's self-esteem, identity and well-being (Bayer et al. 2005) as well as their internal safety (Koskinen 2004). Previous studies have reported that the dignity experienced by older people has substantial meaning both for them personally and as a resource for managing their everyday lives (Koskinen 2004, Hokkanen et al. 2006, Anderberg et al. 2007) and protects against vulnerability (Jacelon et al. 2004, Woolhead et al. 2004). In addition, dignity creates the feeling of responsibility for their own life and the experience of being a needed, useful and valuable citizen (Jacelon et al. 2004, Koskinen 2004, Woolhead et al. 2004).

Health condition concerns physical and mental health (Koskinen 2004, Hokkanen et al. 2006, Tan et al. 2013) and as a resource it creates a functional basis and abilities for cognitive, mental and physical activities (Veenhoven 2008, Fagerström 2010, Karlsson et al. 2013). Health condition can be observed objectively by biomedical measures such as muscular strength (Van Kan et al. 2009), but experienced, subjective health has a crucial role in older people (Burr & Mutchler 2007, Coleman et al. 2010, Shearer et al. 2010).According to previous studies, despite objectively evaluated illnesses and disabilities, most older people have experienced themselves as healthy, because they have described compensating for their loss of functionality by adjusting and adapting to their changed situation (Koskinen et al. 2007, Sims et al. 2007, Savikko 2008). Older people's health has been connected to life satisfaction and spiritual life (Choi & McDougall 2009, Coleman et al. 2011) as well as life story and memories (Hokkanen et al. 2006, Tan et al. 2013). Spirituality, including religious life, has been reported to be an important resource for older people (Hokkanen et al. 2006, Fagerström et al. 2009, Tan et al. 2013). Thus older people have connected their personal experience of health to the wider whole, which is related to mutual interaction between individual and environment (Hokkanen et al. 2006, Koskinen et al. 2007, Reichstadt et al. 2007, Söderhamn et al. 2013).

Life satisfaction refers to individuals' experience of the meaning of life, attitude to the past, current and coming time, as well as understanding of personal opportunities to influence their life (Wiesmann & Hannich 2013). As a resource, life satisfaction strengthens older people's self-esteem (Hokkanen et al. 2006, Vaarama 2006), and their experience of managing everyday life in terms of physical and mental challenges (Karlsson et al. 2013). Life satisfaction has also been recognized as preventing loneliness, contributing to positive perceived health and successful ageing (Forssén 2007, Reichstadt et al. 2007).

Sense of coherence refers to the experience of health (Antonovsky & Sagy 1990, Dale et al. 2012a) and ageing and the ability to influence different life changes (Hokkanen et al. 2006, Koskinen et al. 2007, Reichstadt et al. 2007, Ravanipour et al. 2008). As a resource, a sense of coherence helps older people to encounter different life changes, such as coping with losses of health and functional and cognitive disabilities (Tan et al. 2013, Wiesman & Hannich 2014). Experience of health has been connected to sense of coherence, which determines psychological adaptation in older age but also a person's ability to realize goals (Nordenfelt 2009). In this point of view, health is considered a resource for older people's everyday life and practice towards population health (Antonovsky 1996, Eriksson & Lindström 2006, 2008, Lindström & Eriksson 2009). According to previous studies, older people with a higher sense of coherence perceived themselves to have better physical, social and mental health (Read et al. 2005, Drageset et al. 2008, Söderhamn et al. 2008). Moreover, relationships between sense of coherence, self-care ability and perceived health have been shown (Sherman et al. 2012). It was reported in an earlier study that older people with a stronger sense of coherence and higher self-care ability were more likely to perceive good health (Dale et al. 2012b).

Older people with a positive attitude towards life are also more likely to maintain and improve their health and physical abilities and to look forward in their life (Koskinen et al. 2007, Reichstadt et al. 2007). As a resource, a positive attitude towards life is connected to confidence in one's own personal capacities (Hokkanen et al. 2006, Coleman et al. 2010). In addition, a positive attitude towards life refers to older people's experience of being able to influence things that are significant to their own life and to solve variable situations (Ravanipour et al. 2008, Tan et al. 2013).

External resources

External resources refer to the individual significance of home, economic situation and social relationships as well as societal resources including availability of services. For older people, home is connected to the experience of a familiar environment with memories, life story and personal items (Elo 2006, Koskinen 2004, Koskinen et al. 2007, Bone et al. 2010, Goodman et al. 2013). As a resource, home represents for older people an environment where they can manage their everyday activities (Hokkanen et al. 2006, Koskinen et al. 2007) despite their increasing age and prospective functional and cognitive disorders (Reichstadt et al. 2007, Borg et al. 2008, Salguero et al. 2011, Hirao et al. 2012). Home as a resource has been recognized as providing security, refuge and a place for expressing one's individuality and freedom as well as supporting older people's autonomy and identity (Zhou et al. 2011). According to earlier study, the opportunity to live in a familiar environment allows for a longer life expectancy (Zhou et al. 2011). Personal aids have been reported as enabling living at home and increasing functionality and safety and thus supporting older people's experience of home as a resource (Reichstadt et al. 2007, Hirao et al. 2012).

Economic situation concerns material issues and disposable income (Borg et al. 2006, Borg et al. 2008), and as a resource it means for older people mental security, material refuge and well-being. As a resource, it is related to older people's opportunities to enjoy different leisure time activities, such as travelling and hobbies, as well as to abilities to buy health, welfare and home services (Koskinen 2004). In turn, increased economic

dependence may decrease the resources of older people. On the other hand, loss of economic resources over time may reduce subjective well-being (Bishop et al. 2006).

Social relationships with family members, relatives, friends and home care professionals have been described as a resource for older people to support their psychological well-being and life satisfaction and in managing their daily chores (Chan et al. 2009, Coleman et al. 2011, MacKean & Abbott-Chapman 2012). According to previous studies, social relationships signify for older people the experience of involvement (Chan et al. 2009, Coleman et al. 2011) and a sense of solidarity, as well as opportunities to influence the community (Chan et al. 2009, Coleman et al. 2011, Johannesen et al. 2004, Elo 2006, Hokkanen et al. 2006, Kulla et al. 2006, Reichstadt et al. 2007, Dean et al. 2008). Participating in social activities with other people is connected to high levels of well-being (Routasalo et al. 2006, Walker 2006, Low & Molzahn 2007) and quality of life (Chan et al. 2009, Coleman et al. 2011).

As resources, social contacts with professionals are essential. The relationships with home care professionals that acknowledge older people as individuals connect social interaction with a familiar nurse and thereby encourage older people to manage everyday activities (Bone et al. 2010, Goodman et al. 2013). The quality of the relationship with the home care professionals is significant because it may open up possibilities for a deeper relationship and could mean mutual exchange of support (McGarry 2009, Gilbert et al. 2010). Having the same nurse makes a great difference, partly due to being aware of an individual's life story, resources and disabilities as well as the need for individual help (Eloranta et al. 2009, Bone et al. 2010, Goodman et al. 2013). In contrast, experience of social isolation (Collins et al. 2006) has been found to lead to depression, loneliness and early institutionalization among older people (Savikko 2008).

Societal resources can be divided into surrounding culture and organized societal services, such as awareness of social and health care services; they create external resources but also circumstances for the use and enabling of internal resources by older people (Koskinen 2004). Surrounding culture refers to the prevailing comprehension of older people's role and tasks in society, including traditions and relationships between generations (Koskinen 2004, Koskinen et al. 2007). As a resource, it is connected to older people's experience of cultural value and respect in society and is thus closely connected to human dignity (Koskinen 2004, Forssen 2007).

Organized societal services refer to the surrounding infrastructure and as a resource they enable as active as possible a life for older people (Borg et al. 2008, Tan et al. 2013) with financial support, if needed (Glaser et al. 2004). This includes a public structure for shopping, taking part in hobbies, and cultural events (Bishop et al. 2005, Borg et al. 2006, Zhou et al. 2011, Tan et al. 2013) such as access to art, theatre, music, dance and literature. As a resource, organized societal services are important elements that affect life satisfaction, well-being and the strengthening of social networks. Older people are aware from experience that cultural events and social relationships belong closely together (Reichstadt et al. 2007, Burr & Mutchler 2007, Coleman et al. 2010). At the same time, meaningful and inspirational activities promote clients' positive attitudes towards life (Forssén 2007, Koskinen et al. 2007, Savikko 2008, Routasalo et al. 2009).

Awareness of social and health care services refers to the availability of home care services (Hokkanen et al. 2006) and is connected to older people's political rights (Koskinen 2004). As a resource, awareness of available services increases older people's ability to plan for the future, taking into account their remaining resources (Hokkanen et al. 2006). Therefore, it is the society's responsibility to create service models where the resources can be seen and supported (Act on supporting the functional capacity of the older population and on social and health services for older persons 980/2012).

Table 2. Individual resources of older people

Individual resources	References
Personal resources	
Individual experience of human dignity	Stabell & Lindström 2003, Jacelon et al. 2004, Koskinen 2004, Woolhead et al. 2004, Bayer et al. 2005, Hokkanen et al. 2006, Anderberg et al. 2007.
Health condition	Koskinen 2004, Hokkanen et al. 2006, Burr & Mutchler 2007, Koskinen et al. 2007, Reichstadt et al. 2007, Sims et al. 2007, Savikko 2008, Veenhoven 2008, Choi & Mc Dougall 2009, Fagerström et al. 2009, Fagerström 2010, Van Kan et al. 2009, Coleman et al. 2010, Shearer et al. 2010, Karlsson et al. 2013, Söderhamn et al. 2013, Tan et al. 2013.
Life satisfaction	Hokkanen et al. 2006, Vaarama 2006, Forssén 2007, Koskinen et al. 2007, Ravanipour et al. 2008, Reichstadt et al. 2007, Coleman et al. 2010, Karlsson et al. 2013, Tan et al. 2013, Wiesmann & Hannich 2013.
Sense of coherence	Antonovsky 1987, 1996, Antonovsky & Sagy 1990, Read et al. 2005, Hokkanen et al. 2006, Eriksson & Lindström 2006, Koskinen et al. 2007, Reichstadt et al. 2007, Drageset et al. 2008, Eriksson & Lindström 2008, Ravanipour et al. 2008, Söderhamn et al. 2008, Lindström & Eriksson 2009, Nordenfelt 2009, Coleman et al. 2010, Dale et al. 2012a, Tan et al. 2013, Wiesman & Hannich 2014.
Positive attitude towards life	Hokkanen et al. 2006, Koskinen et al. 2007, Reichstadt et al. 2007, Ravanipour et al. 2008, Coleman et al. 2010, Tan et al. 2013.
External resources	
Home	Koskinen 2004, Borg et al. 2006, Elo 2006, Hokkanen et al. 2006, Koskinen et al. 2007, Reichstadt et al. 2007, Borg et al. 2008, Salguero et al. 2011, Hirao et al. 2012, Bone et al. 2010, Zhou et al. 2011, Goodman et al. 2013.
Economic situation	Koskinen 2004, Borg et al. 2006, Borg et al. 2008.
Social relationships	Johannesen et al. 2004, Collins et al. 2006, Elo 2006, Hokkanen et al. 2006, Kulla et al. 2006, Routasalo et al. 2006, Walker 2006, Low & Molzahn 2007, Reichstadt et al. 2007, Dean et al. 2008, Savikko 2008, Chan et al. 2009, Coleman et al. 2011, MacKean & Abbott-Chapman 2012.
Societal resources	Glaser et al. 2004, Koskinen 2004, Bishop et al. 2005, Borg et al. 2006, Hokkanen et al. 2006, Burr & Mutchler 2007, Forssén 2007, Koskinen et al. 2007, Reichstadt et al. 2007, Koskinen et al. 2007, Borg et al. 2008, Savikko 2008, Eloranta et al. 2009, Gjevjon & Hellesø 2009, McGarry 2009, Routasalo et al. 2009, Verbeek et al. 2009, Bone et al. 2010, Coleman et al. 2010, Eloranta et al. 2010, Gilbert et al. 2010, Janlöv et al. 2011, Miller 2011, Zhou et al. 2011, Goodman et al. 2013, Tan et al. 2013.

2.2 CURRENT HOME CARE SERVICES FOR OLDER CLIENTS

The effects of population ageing on the need for health and social services depend on the health of older people. Thus, the relationship between ageing and service use is not continuous (National research and development centre for welfare and health 2006, National institute for health and welfare 2013). In Finland, municipalities have a legislative responsibility to organize home care services in collaboration with the private and third sectors, as well as with older clients, to plan and realize home care services consisting of support for older clients at home by offering care and services based on clients' personal needs (Act on electronic processing of patient documentation in social and health care 159/2007, Act on supporting the functional capacity of the older population and on social

and health services for older persons 980/2012). Therefore, the goal of social and health services for older people is to provide home care services that support independent living at home and to maximize clients' resources. This requires home care services to make possible meaningful activities and social relationships in relation to the quality of life and psychological well-being of the older client despite their decline in functional, cognitive, psychological and social abilities and the need for the highest level of care (Act on the status and rights of patients 1992, Act on supporting the functional capacity of the older population 980/2012).

2.2.1 Needs for and use of social and health care services

Older people are becoming even older and therefore the risk of multiple diseases with loss of function is increasing (Hayashi et al. 2011, Salguero et al. 2011, National institute for health and welfare 2013). The loss of function is linked to health but also strongly to everyday activities such as housekeeping. Assistance is needed not only with everyday activities, such as shopping and household chores, but also with activities such as basic hygiene (Hammar et al. 2009). The reduced ability to plan, judge or organize complex tasks leads to difficulty in performing household tasks. Marked differences have been found in managing everyday activities among older people with cognitive disorders and other disabilities (Gustafsson et al. 2011) such as a decline in muscle mass and strength, which are required to manage everyday activities (Lönnroos 2009, Camacho-Soto et al. 2011).

Specifically, the progression of a cognitive disorder has consequences for everyday activities, implying increased need for care (Gustafsson et al. 2011). The most common cognitive disorder is Alzheimer's disease with neuropsychiatric symptoms (Kendig et al. 2010, Gustafsson et al. 2011). It usually plays a key role in older people's daily lives, with difficulties performing everyday activities, and the need for care is usually correlated to the stages of Alzheimer's disease. At the mild stage of the disease, symptoms in terms of memory are minor, and independent living is possible, but support is needed with complex tasks, such as paying bills (Kaduszkiewicz et al. 2008, Gustafsson et al. 2011). At the moderate stage, Alzheimer's disease is characterized by severe memory impairment. Logical reasoning, planning and organizing deteriorate significantly during this stage. Language difficulties become more obvious, as the difficulty in finding the right word increases. Reading skills deteriorate, as well as writing abilities. At that stage, people need help for such daily tasks as putting clothes on in the right order or picking the right clothes, and later bathing and using the toilet (Delrieu et al. 2011). At the severe stage, a person with Alzheimer's has serious difficulties with short- and long-term memory and disorientation of time and place frequently occurs. The disease also influences the physical ability to carry out simple tasks (Delrieu et al. 2011). The need for help is generally round the clock with regard to all sectors of daily life (Delrieu et al. 2011).

Currently, approximately 130,000 people in Finland have a cognitive disorder and 40,000 of them are living at home (Ministry of social affairs and health 2012), while 7998 of them are living at home with regular home care services (National institute for health and welfare 2011). The public costs and stage of cognitive disorder have been linked together (Gustavsson et al. 2010). A client with a cognitive disorder being cared for while living in their own home is far less costly to society than a patient being cared for in a long-term care facility (Jumisko 2007, Bone et al. 2010, Goodman et al. 2013). However, cognitive disorders are the most significant predictor of long-term care among older people (Kendig et al. 2010, Wells & Thomas 2010). In a six-year follow-up study in Finland, 70% of women with a cognitive disorder and 55% of men with a cognitive disorder were institutionalized (Nihtilä & Martikainen 2008). According to Voutilainen et al. (2007), 95% of long-term institutional care clients and 60% of home care clients have some cognitive disorder.

In addition to cognitive disorders, other common diseases among older people (75+ years) include diseases of the circulatory system, musculoskeletal disorders and diseases, malignant tumours and diabetes (Koskinen et al. 2012, Salminen et al. 2012, Official

Statistics of Finland 2013). Projections of other disabilities show that the number of older people with limited mobility will increase by 70% from 2000 to 2030 if the age-group-specific proportions stay the same as in the years between 1980 and 2000. Even so, if physical ability continues to improve at the same rate, the number of people with disabilities will increase more slowly (National institute for health and welfare 2013). These trends connected to the ageing of the population will increase needs for and use of social and health care services.

Older people mostly use the same health care services as other age groups, but there are some services that are specifically targeted at older people such as home care services with regular help. The number of people aged 75 or over with disabilities has continued to rise continuously, despite the trends for health promotion and rehabilitative nursing (Voutilainen et al. 2007, National institute for health and welfare 2013).

2.2.2 Structure of home care services

In Finland, home care services consist of three main service providers as formal care: municipal home care services, the private and third sector (Act on supporting the functional capacity of the older population and on social and health services for older persons 980/2012) and informal care as realized by family members (Kattainen et al. 2008). Local authorities can provide services independently, or in collaboration with other players (Voutilainen et al. 2007, Act on supporting the functional capacity of the older population and on social and health services for older persons 980/2012).

Home care services are organized by home help service units (under social welfare) and home nursing units (under health care) either separately or together. Home care services consist of domestic help, including personal and physical care (e.g. meals on wheels, bathing and electronic alarm service) (Social welfare act 710/1982), and care based on nursing (e.g. taking care of medication and wound care) (Public health act 66/1982). The roles and responsibilities of the private and the third sector vary in different services. The private sector's care and services consist of residential homes, service housing with 24-hour assistance and home care services realized in clients' homes. The third sector's care and services consist mostly of home care services in older clients' homes (Private health care act 152/1990, Private social services act 922/2011). However, it is recognized that current home care services do not consider clients' individual needs and resources when developing care and services, and therefore cannot respond to the challenges of the future (Del-Pino-Casado et al. 2011, Janssen et al. 2012). Moreover, available services are similar for all clients without acknowledging potential individual variations (Janlöv et al. 2006, Forma 2011).

In Finland, 11.9% of people aged 75 years or older are municipal home care service clients, varying regionally in terms of gender and age structure (National institute for health and welfare 2012a). Care and services comprise two fields. The first field is long-term care, including 24-hour institutional care provided by health centres. The indicators for institutional care are based on medical justifications. Institutional care also presents a justified perspective of older people's safety and dignified life (Act on supporting the functional capacity of the older population and on social and health services for older persons 980/2012). In 2012, 6.6% of municipal home care service clients received 24-hour institutional care in Finland (National institute for health and welfare 2012b).

The second field is home care services. This includes residential homes with 24-hour assistance, service housing and care and services in older people's homes with 24-hour or part-time assistance. In residential homes and service housing, older people live in their own or shared rooms and can purchase services according to their needs (National institute for health and welfare 2012b). In 2010, 8.7% of people aged 75 years or older lived in residential homes or service housing (National institute for health and welfare 2012b).

Home care services consist of regular home visits, and the content of services is counselling and support for self-care, everyday activities and available services. Home care professionals, including practical nurses, home care nurses and home care service

managers, provide personal assistance for everyday activities such as hygiene, eating and dressing and nursing treatments such as the administration of drugs and wound care (Social welfare act 710/1982). Additional auxiliary services, such as meals on wheels, transportation and assistants, are also organized (Social welfare act 710/1982).

In 2012, 5.3% of municipal home care service clients received home care services in Finland (Official Statistics of Finland 2013). The average age of clients in regular home care was 79.4 years and a total of 53,703 (76.2%) clients were aged 75 or over. In most cases, the older clients' need for home care was assistance with everyday activities related to personal care and housing, and 64.7% received auxiliary home care services regularly (National institute for health and welfare 2012a). Over half (51.9%) of home care service clients received regular home visits, whereas 41.2% received between one and nine visits in one month and more than a quarter (25.3%) of clients had over 60 visits a month (National institute for health and welfare 2012a).

2.2.3 Realizing home care services

Older people's home care services are realized in clients' homes by home care professionals (practical nurses, home care nurses and home care service managers) in collaboration with other social and health care professionals. The realization of care and services is based on legislation and ethics, and it consists of care planning and professionals' practice in daily care.

Guiding legislation and ethics for care planning and care in home care services

According to the current act (Act on supporting the functional capacity of the older population and on social and health services for older persons 980/2012) in Finland, every client who regularly receives home care services has a right to have an individual and valid care and service plan. In addition, they have a right to participate in decision making and decisions have to be made in agreement with older clients (Act on the status and rights of patients 1992/785, Act on the status and rights of social welfare clients 812/2000). Home care professionals have a legislative obligation to produce and document a care and service plan for all home care clients. The plan has to include care and services according to the clients' needs in order to support older clients living at home as long as possible. Also, the goals of clients' care and services, planned interventions and evaluations have to be documented (act on supporting the functional capacity of the older population and on social and health services for older persons 980/2012**,** Act on electronic processing of patient documentation in social and health care 159/2007).

Older people's care and services are also guided by ethics. According to the ETENE (2008, 2011), clients have the right to be respected as the baseline for their care is the clients' best. The communication between client and professional has to be respectful and human. Professionals are responsible for the quality of their work. In addition, professionals' work is guided by professional codes of ethics for each profession (The Finnish nurses association 1996, The Finnish union of practical nurses 2012).

The structure and content of care and service planning

The planning of care and a service plan is the first phase of care. Home care professionals in collaboration with clients and their family members make assessments and decisions and perform interventions by realizing care and services (Act on supporting the functional capacity of the older population and on social and health services for older persons 980/2012). Clients are experts on their own lives and they bring their own expertise to the care planning. Older clients' ability to influence care planning and decisions has direct consequences for their future home care services.

Care planning is based on the assessment of clients' demographic history, functional and cognitive status, mood, behaviour and activity habits, and preferences, including recognizing the significance of meaningful activities and social relationships in relation to

the clients' quality of life and well-being (Hammar et al. 2009, Eloranta et al. 2010, Del-Pino-Casado et al. 2011). The content of home care services depents on clients' needs for care and services and for help and support with everyday activities and personal care as well as respite care provided to informal caregivers (Stajduhar et al. 2011). It includes evaluation of individual resources and how the goals of care and services are to be achieved (Lindeman & Pedler 2008, Marcinowicz et al. 2009).

The form of documentation of the care and service plans vary, but the typical, standardized form of documentation includes goals, interventions and expected outcomes of the care and service process that are planned and agreed upon in collaboration with clients and professionals (Lee et al. 2009). It is found to be an appropriate tool for documenting care and service plans, because of its practical accessibility, but also because of its impacts on the quality of nursing and care planning (Ward et al. 2011, Lee 2012). Standardized terminology, classifications and codes are crucial to the efficient use of electronic nursing documentation systems and structured communication among professionals, patients and clients (Munyisia et al. 2011).

Realizing care in clients' homes

The personal nurse has the main responsibility for planning, taking care and evaluating the realization of and changes in care (Bosman et al. 2008, Hammar et al. 2008). The personal nurse, as well as other professionals, makes a key contribution in encouraging and promoting clients to play a more active role in their care and services, thus helping them to maintain their independence within the home and community (Bosman et al. 2008, Hunter & Levett-Jones 2010, Goodman et al. 2013). Realizing care in clients' homes includes professionals' tasks concerning personal assistance for everyday activities and nursing treatments (Bosman et al. 2008, Hammar et al. 2008). Individual assistance is intended to provide support that is tailored to a client's needs and to optimize their influence over how this support is arranged. Accordingly, the individual receiving assistance has the right to decide what a professional should do, and when and how it should be done (Clevnert at al. 2007, Finnbakk et al. 2012). In daily care, personal nurses are involved in clients' daily lives with all the dimensions that affect their health situation, including their ability to function and use personal resources (Miller 2011, Sockolow et al. 2012).

However, studies have pointed out the limited involvement of older clients in this context. It is recognized that the professionals dominate the communication, and approaches that encourage clients to express their personal wishes are not always satisfactory (Widar & Ahlström 2007, Eloranta et al. 2010, Burt et al. 2012). From the older clients' perspective, they are filtered out in the care and services assessment process, and care routines tend to exclude both older clients and professionals from active decision making (Bone et al. 2010, Goodman et al. 2013).

From home care professionals' perspective, being able to realize care that takes into account clients' resources depends on older clients' capacity and remaining resources, what kind of and how much help they need in everyday activities, and health issues (Hammar et al. 2008). In daily care, professionals clarify clients' own opinions about their ability to manage everyday activities, and their needs for help (Bosman et al. 2008). This kind of care is found to be significant, especially for clients with chronic illnesses or disabilities and declining cognitive disability. The relationship and communication with the client and support for the maintenance of personhood in spite of declining cognitive ability are deemed considerable (Bone et al. 2010, Goodman et al. 2013). Moreover, certain interventions and activities, such as recording and utilizing clients' life stories to individualize both care itself and its environment, sharing decision making, individualizing everyday activities and getting family members involved in care have different dimensions of providing daily care (Chenoweth et al. 2009, McKeown et al. 2010, Teitelman et al. 2010).

By supporting clients' resources it is possible to enable their resources to include their chosen lifestyle, abilities, quality of life, well-being and sense of security (Gjevjon & Hellesø

2009, Bosman et al. 2008, Hammar et al. 2008). Thus, older clients' satisfaction with home care services increases when professionals focus on clients' perspectives and take into consideration their opinions in daily care (Bosman et al. 2008, Eloranta et al. 2008a, Janlöv et al. 2011, Salguero et al. 2011). According to earlier studies, clients report that home care services do not always provide enough help and they often feel that their perceptions concerning resources are not always recognized in daily care and services. However, an attitude of having to be grateful for any help at all was significant (Eloranta et al. 2008a, Janlöv et al. 2011).

Currently, the demand for home care professionals' skills in older clients' care has increased due to the complexity of clients' numerous challenges (Hunter & Levett-Jones 2010). Home care professionals who work with older clients need to have expertise in planning and realizing care that promotes the highest possible quality of care to clients (Hayashi et al. 2011, Goodman et al. 2013.) The work of home care professionals has also been criticized, due to its expert orientation and "doing tasks on behalf of their clients" mentality, i.e., helping without assessing clients' own ability to take part in everyday activities. Thus, the work of home care professionals has tended to have an illness-centred approach focusing only on clients' physical needs (Hayashi et al. 2011, Salguero et al. 2011) and physical activities in daily living (Hammar et al. 2009).

Thus, quality of care is dependent not only on the planned services, but also on the way that daily care is delivered (Russell et al. 2008, Webster & Bryan 2009). Individualized assessment and care planning for clients confirms the promotion of autonomy and independence. In practice, it appears from the perspective of clients that even the ability to make quite small decisions about their everyday activities can have a significant impact on their sense of control (Webster & Bryan 2009, Lin et al. 2012). Arriving at this point requires a process in which home care professionals assess and coordinate care and services through interaction with their clients (Verbeek et al. 2009, Burt et al. 2012).

2.3 SUMMARY OF THE LITERATURE

National and international research concerning older people is highly topical (Ekmann et al. 2010, WHO 2012a). In western countries, older people are healthier, life expectancy is longer, and population of older people is growing more rapidly, than ever (Genet et al. 2011, Salminen et al. 2012, WHO 2012b).

Previous research has focused on the comparison of older people's institutional care and home care services from the viewpoint of cost efficiency (Hammar et al. 2008, Burt et al. 2012). There is a risk that older people have only been seen as service users and their individual experiences of meaningful daily living has been ignored. Recently, the number of studies focusing on older clients' home care services has increased (Forma 2011, Rabiee & Glendinning 2011). Studies have focused on rehabilitation (e.g., Parker et al. 2011, Zhou 2011), functional ability (Hammar et al. 2009, Coleman et al. 2011) as well as multidimensional aspects of health (Nordenfelt 2009, Dale et al. 2012b) in home care services.

Most older people prefer to live healthy lives in their own homes before institutional care (Fagerström et al. 2009, Shearer et al. 2010). This fact challenges health care services to respond to their expectations and requires comprehensive care planning and daily care targeted at the multidimensional needs and resources of individual clients (Del-Pino-Casado et al. 2011, Janssen et al. 2012). This is also the basis for continuing a resource-based care perspective of promoting clients' ability to live at home (Janlöv et al. 2011).

Based on previous studies, resources of older people are well-known and have been described from many perspectives (Eloranta et al. 2009, Tan t al. 2013, Wiesmann & Hannich 2013). Resources include personal and external resources, such as health condition (Karlsson et al. 2013) and economic situation (Korg et al. 2008). Based on earlier studies,

older people's resources are closely linked to health (Drageset et al. 2008, Söderhamn et al. 2008). Older people's assessment of their own health has been considered an important aspect to be acknowledged in the context of management of everyday activities (Borglin et al. 2005, Borg et al. 2008).

It is not enough to merely focus on older people's resources; additionally, attention must be extended to the realization of resources in the everyday practices of home care services and also home care professionals' abilities and working methods must also be taken into account. Professionals are in a key position, as they realise daily care based on clients' resources. It is essential that professionals take into consideration clients' opinions regarding daily care. On the national level, the target of home care services is to support clients in living at home for as long as possible by recognizing them as individuals while acknowledging their needs and resources. This requires from home care professionals expertise to plan and implement daily care based on a continuing evaluation of clients' full conditions during care planning and daily care (Act on the status and rights of patients 1992, Act on supporting the functional capacity of the older population 980/2012).

Although there are publications available on older clients' resources in the context of home care services, there is only a small number of studies systematically describing and evaluating clients' resources in a way that takes into account perceptions of older clients and home care professionals. It is critical to note that, in previous studies, less attention has been paid to views of older people and approaches of daily care. In addition, home care professionals' viewpoints on clients' total resources related to daily care have been rarely investigated.

In order to be able to produce home care services taking into account older people holistically, there is a need to respect older people and to consider their opinions concerning their own care and services (Karlsson et al. 2013). This kind of appreciative action requires home care professionals' understanding of ageing specific needs and ethical principles, such as autonomy (Finnbakk et al. 2012). It is significant to focus on these issues when organizing and providing home care services for older people, as concepts and perceptions about older people affect attitudes towards them (Koskinen 2004, Higgins et al. 2007, Gallagher et al. 2008). A crucial challenge is to gain clients' trust. Based on earlier studies (e.g., Miller 2011, Hirao et al 2012), older clients' confidence in home care professionals increases when professionals focus on clients' own perspectives. This kind of a method of work in an environment of trust is based on an ethical perspective (Coleman et al 2011).

In this study, older people are seen as full members of society where they are perceived as healthy and active citizens (Figure 1). This viewpoint of older people is based on a sociocultural approach which highlights older peoples' individual resources and their competence in making their own decisions. Comprehension of ageing is based on the view in which old age is perceived as a natural phase of the course of life and older people are seen as a resource of society.

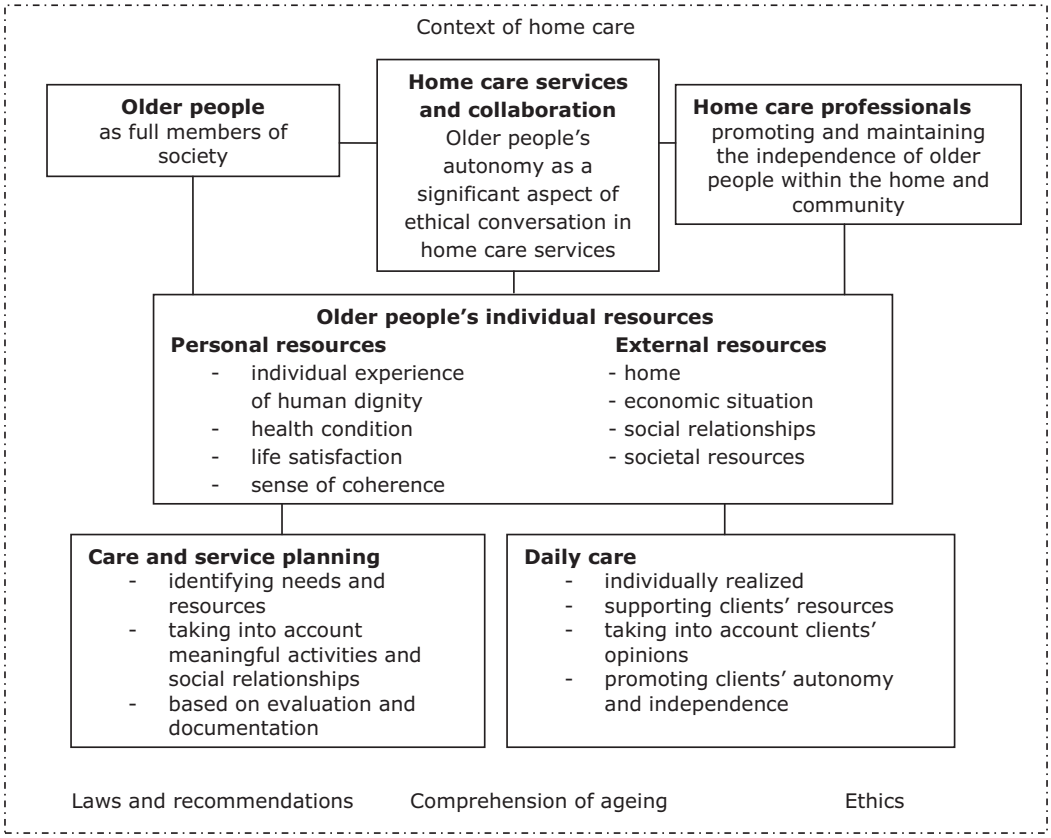

Figure 1. Summary of the literature

3 Aim of the study

The aim of this study was to describe and evaluate the recognition and realization of older people's resources in daily home care services from the perspectives of clients and home care professionals. The ultimate aim was to point out the multidimensional nature of the research phenomenon, resources and also the elements of meaningful daily life based on older people's views.

The specific research objectives were the follows:

1. To identify the resources of older people from the perspectives of home care professionals and older people (articles I, II and IV)
2. To describe and evaluate how clients' resources have been taken into account during care planning (articles II and III).
3. To describe and evaluate the structure of home care services and daily care based on clients' resources (articles II and IV).
4. To describe views of clients and home care professionals about aspects of home care services that should be developed and that could promote older clients' living at home for as long as possible (articles II and IV).

4 Methods

Data were collected using a variety of methods to provide real insight into the number of older peoples' resources in the context of home care services (Topping 2010). The first phase focused on identifying older people's resources from the perspectives of home care professionals and older people. The second phase described and evaluated how clients' resources have been recognized in daily care, and the third phase evaluated older clients' care and service plans in order to gain an understanding on how clients' resources had been taken into account in the care planning process. Finally, the fourth phase described realizing daily care based on resources of older people, and presented visions for future home care (Figure 2).

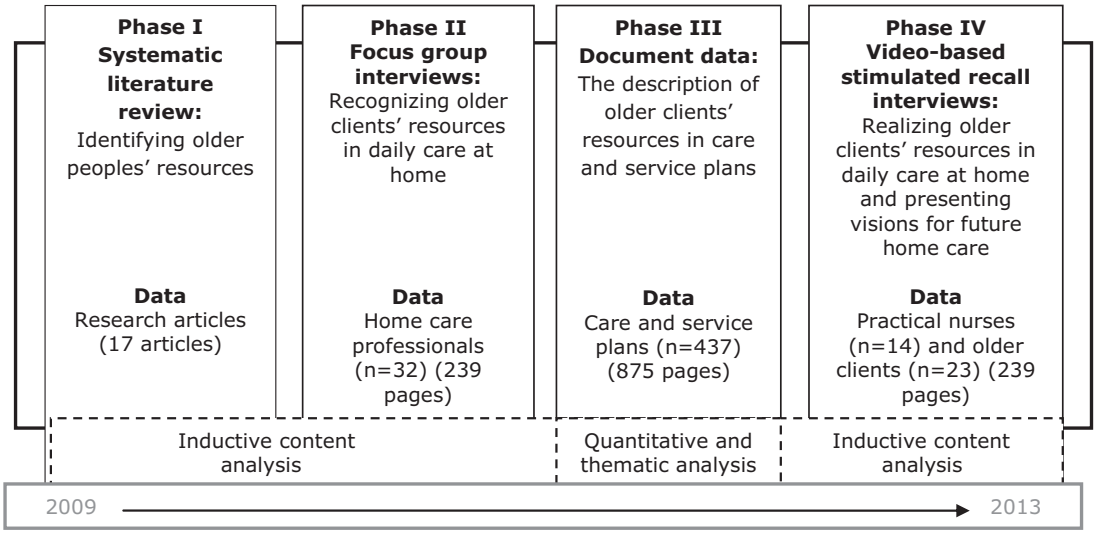

Figure 2. Summary of study design, including data collection and data analysis

4.1 SYSTEMATIC LITERATURE REVIEW

A systematic literature review was used to define research questions and methodological choices for this study. The aim of the literature review was to describe the content of older people's resources and to find out what methodologies had been used in previous studies (Table 5). A systematic literature review protocol was conducted to provide a synthesis about the research questions (Bearman et al 2012). Studies with different methodologies were included in the review to achieve multiple views of the topic (Whittemore 2007).

Searches and selection of literature

The literature was searched from the following databases: Cinahl, Cocrane Library, Josku, Linda, Medic, PubMed and PsycInfo (see Figure 1 in the original article I). In addition, a manual search was conducted for the bibliographies of selected articles. The search terms were formulated in collaboration with the research group and the information specialist in order to ensure rigorous searches (Bettany-Saltikov 2010). The search phrases used for the English databases were (resource* OR empower*) AND MW (aged OR elder* OR old*

people*"), and in Finnish (voimavara AND vanhus OR iäkäs OR ikääntyvä). The inclusion criteria for the searches were as follows: i) published scientific articles ii) published in English, Swedish or Finnish iii) published between 2005 and 2009, iv) abstract and full text available, v) responded to the research questions and vi) focused on the perspective of older people or home care professionals. The exclusion criteria used were: i) duplicate publication, ii) focus was on institutional care, diseases or family members iii) not a scientific publication or iv) did not respond to the research questions.

The literature search produced 1339 publications (Table 3). According to the inclusion and exclusion criteria, studies were selected in stages based on titles (n= 81) abstracts (n=38), and full-texts (n=17). Until the full text literature stage, the selection was conducted by one researcher (RT), but the decision to include articles was conducted in agreement with the research group (Whittemore 2005, Bettany-Saltikov 2010).

Table 3. Databases, numbers and selection in literature review (Original article I)

Databases Years (2005-2009)	**Amount**	**First selection: title** (search term/terms exist in the title)	**Second selection: abstract** (description of the phenomenon)	**Final selection: full text** (description of the phenomenon based on older people's or/and professionals' views)
Cinahl	1261	68	28	10
PubMed	30	5	4	2
PsycInfo	20	3	2	1
Cochrane Library	10	1	0	0
Linda	7	0	0	0
Josku	6	0	0	0
Medic	1	0	0	0
Manual search	4	4	4	4
Total	**1339**	**81**	**38**	**17**

Evaluation of the literature

The quality of the selected articles was evaluated using the evaluation form for qualitative and quantitative studies (Table 4). The form that was created was a summary of three commonly used evaluation criteria (Nursing Research Foundation 2004/2013, Johansson et al 2007, Centre for Reviews and Dissemination 2009), focusing on four main themes and providing 18 quality domains for the study: i) background and aims, ii) materials and methods, iii) reliability and ethical issues and iv) results and conclusions. The evaluation of each quality domain was categorized by "yes" (1 point) and "no" (0 points). The maximum was 18 points. According to the evaluation (Table 2, original article I) the grading of the selected articles varied between seven and 16 and the mean was 12.76. In all articles the description of the background and aim of the research, data collection and results were extensive. The description of data analysis was partly defective in three qualitative articles. The reliability of the research received little attention and the ethical issues were only considered in four of the articles. The articles all had conclusions but reflection was partly shallow. All the evaluated articles were included in the review.

Table 4. Evaluation form with evaluation themes and quality domains (modified based on Nursing Research Foundation 2004/2013, Johansson et al. 2007 and Centre for Reviews and Dissemination 2009)

Evaluation theme	Quality domains
Background and aims of the study	1. The phenomenon was defined clearly 2. The aim of the study was based on literature review and was validated including methods and ethical issues 3. The aim of the study, purpose of the study and research were stated. 4. Research questions were clearly defined.
Materials and methods	5. The data collection was validated and described in detail. 6. The data collection was described. 7. The data was collected from people who were informed about the purpose of the research. 8. The sufficiency of the materials' content was evaluated 9. The processing of the material and phases of the analysis were described. 10. The analysis method was suitable for the researched phenomenon.
Reliability and ethical issues	11. The researcher described the criteria and how the reliability of the research was evaluated. 12. Triangulation of material or methods were used to increase the reliability of the research. 13. The researcher carefully considered the ethical issues of the research. 14. The participants in the research evaluated the results and confirmed the results' equivalence to their own experiences. 15. The researcher wrote the research diary or noted the sources that the research was based on.
Results and conclusions	16. The results provide novelty value and meaning for developing nursing. 17. The results were produced clearly, logically and a rich way and results can be compared to earlier studies. 18. The conclusions are based on results and are recoverable.

Analysis of results

The analysis was conducted using inductive content analysis (Gibbs 2007, Tuomi & Sarajärvi 2009, See Original article I). In the first phase of the analysis, all studies were read several times in order to get an overview of the content. After that the content was coded according to the research questions. Coded expressions were categorized according to the

similarities and differences to the sub-categories and again to the upper categories. Finally, upper categories were created as main themes. All categories and themes were named by the content. The final phase of analysis was conducted by the entire research group, to ensure the quality of the analysis (Gibbs 2007). Selected studies were tabulated according to the author(s), publication years, country, aims of the research, data, research methods and main results.

Description of selected studies
Ten of 17 selected studies used quantitative methods and seven used qualitative methods. In 16 papers the informants were older people or older home care clients and in one paper the informants were home care professionals. In the studies the resources were observed from the perspective of subjective health, the ability of older clients' to manage everyday activities and individual and financial resources, their social abilities, how well they adapted to ageing and meaningful ageing, their quality of life, health promoting home care services, the resource-based care produced by the home care professionals and the multi-professional collaboration involved in older clients' home care services. Questionnaires were used to collect data in the quantitative studies and the qualitative studies used individual interviews or focus group interviews as a method.

4.2 QUALITATIVE INTERVIEW METHODS

Qualitative methods were used in the phases II and IV to provide rich and comprehensive descriptions of the perceptions of older people and home care professionals on recognizing and realizing older home care clients' resources in daily care (Burns & Grove 2009). Focus group interviews and video-based stimulated recall interviews were used. The summary of the themes that were used is presented in Table 5.

4.2.1 Research environment
The empirical phases of the study were carried out at one older clients' home care service in an urban region of Eastern Finland. In 2014, approximately 850 people aged over 75 were registered as home care clients in that region. The home care services were provided in collaboration with private and third sector organizations. They included home visits for daily care and other services such as an alarm system as well as meals-on-wheels and pharmacy services. Older clients' home care services were carried out by educated home care professionals working as practical and home care nurses and home care service managers. In 2014, more than 100 professionals were working in older clients' home care service in this region.

The aim of home care services is to support clients so that they can live at home for as long as possible. Based on legislation, all clients have the right to an individual care and service plan (Act on supporting the functional capacity of the older population 980/2012), based on the evaluation of their life situation, needs and their ability to function. Care and service plans are conducted by home care professionals in collaboration with older clients and family members and documented in electronic form. In this study, the data concerning home care professionals were collected at social and health care centres and in clients' private homes.

4.2.2 Participants and data collection
The target group for interviews (Figure 2, study phases II and III) consisted of home care professionals and older clients using home care services. The home care professionals were contacted with the help of the head nurse of home care in May 2010. The researcher took part in three monthly meetings involving home care professionals in order to enroll the participants. The potential participants were informed about the aims of the study, both

orally and in writing, together with the professionals' role in recruiting their clients, conducting interviews and the voluntary and confidential nature of participation. A total of 87 home care professionals took part in the meetings: 12 home care service managers, 25 home care nurses and 50 practical nurses. The following criteria for participation were presented: i) willingness to take part, ii) experience of working as a home care professional with home care clients aged 75 or over and iii) Finnish or English speaking. Within two weeks, 32 home care professionals enrolled by returning the signed, informed consent form by post.

All of these 32 home care professionals worked in home care: 14 were practical nurses, 12 were home care nurses and six were home care service managers. The youngest participant was 28-years-old and the oldest was 65-years-old and the mean age was 48. Their experience of working in home care varied from one to 40 years and the mean years of experience was 14 years.

Older home care clients were contacted in January and February 2011 with the help of the 14 practical nurses. The nurses informed their clients about the study, both orally and in writing, obtained signed, informed consent and gave the researcher contact details of those who volunteered to take part. The criteria for clients' participation were as follows: i) they were customers of the home care services, ii) were 75-years-old or over, iii) had a minimum of one to two home visits per day, and vi) were Finnish or English speaking. Within two weeks, 23 voluntary older clients were enrolled.

The age of the home care clients ranged from 75 years to 93 years, and the mean age was 84. They had been home care customers for between one and 10 years, with the mean time being three years. The participants consisted of one married couple, with the other 21 clients living alone. Two of the participants lived in a detached house and the rest lived in flats. Most of the clients had been diagnosed with dementia: 19 had mild dementia and two had moderate-stage dementia.

Focus group interviews

Focus group interviews were used with the home care professionals to achieve a group understanding of older home care clients' resources. This method enabled discussion among participants, thus generating rich data (McLafferty 2004, Barbour 2010). The researcher contacted enrolled participants by telephone and by email in order to arrange the focus groups. Interviews were conducted during the home care professionals' working time in the meeting room at the social and health centre during November and December 2010.

Nine focus groups, each with three or four participants (n=32), were conducted. Because of different work descriptions, home care service managers, home care nurses and practical nurses participated in separate groups according to their titles. The same themes were used in all focus group interviews (Table 5). The themes were based on the systematic literature review conducted during this study. Interview themes were pretested during a pilot study of 12 home care professionals and, because no changes were suggested for the themes, the same themes were used in this study. Focus groups lasted from 60 to 135 minutes.

Video-based stimulated recall interviews

Video-based stimulated recall interviews (n=37) were used to identify what home care the clients were currently receiving and the elements that were helping them to live at home. This method was suitable because videotaping meant that the original home visit could be recalled and revived and the researcher and participants could observe the actual visits (Caldwell & Atwall 2005). The researcher, in collaboration with practical nurses and clients, scheduled the appropriate days for videotaping and carrying out the interviews. Videotaping was conducted by the researcher at the clients' homes during home visits in April and May 2011.

Home visits providing daily care, excluding intimate care, were selected for videotaping. Two different groups of participants were observed. The first group consisted of 14 practical nurses and the second group included older home care clients (n = 23). Altogether 51 situations were recorded. The length of videotaping varied between four minutes and one hour and nine minutes, and the mean duration was 42 minutes. The total length of footage generated was eight hours and 45 minutes.

Video-based stimulated recall interviews were conducted with 23 clients at their homes and with 14 practical nurses at social and healthcare centres one or two days after the videotaping. Two themes were used for the interviews: i) current structure of the older clients' home care, and ii) elements that promote clients' living at home (Krueger & Casey 2009, Sandelowski 2000). Themes were based on the systematic literature review and focus group interviews conducted in this study. Firstly, the researcher and participant watched the full recording without interruption. Next, during the second viewing, the video was stopped from time to time and participants were encouraged to reflect on the contents of the video. The researcher also asked specific questions, if needed. All interviews were recorded and they lasted from 35 minutes to 85 minutes with the mean duration being 60 minutes.

Table 5. Summary of the themes used in systematic literature review and empirical study

Phases	Themes
Systematic literature review	1. What are the resources provided for older people and older home care clients? 2. What are the elements that provide support for older people and older home care clients living at home?
Empirical part of study	
Focus group interviews	1. Describe how older people are able to cope at home. 2. Describe the individual factors that support living at home, which you recognize during a home visit with new older home care clients. 3. Describe the individual factors that support living at home, which you recognize during home visit with existing home care clients.
Stimulated recall interviews	1. Evaluate how you see the current structure of older clients' home care. 2.Describe the elements that promote clients' living at home. 3. Describe the developmental aspects in older clients' home care.
Document data	1. Describe and evaluate the contents of older home care clients' electronic care and service plans.

4.2.3 Analysis of empirical data

Focus group interviews (original article II) and video-based stimulated recall interviews (original article III) were analyzed separately using inductive content analysis (Hsieh & Shannon 2005, Gibbs 2007). In the first phase, all interview data were transcribed literally. Focus group interviews consisted of 239 A4 pages and the video-based stimulated interviews comprised 392 A4 pages. After that, the data were read several times to get an overview of the content. After reading, the meaning units, that is the words, combination of the words, sentences or the whole paragraphs were identified according to the research objectives. Identified meaning units were grouped into sub-categories and the sub-categories were abstracted again to the main-categories (see original article II, Tables 2, 3 and 4, and original article III, Figures 2 and 3).

4.3 DOCUMENT DATA

Document analysis was used to describe and evaluate how older clients' resources had been taken into account in their care and service plans and how they had been electronically documented. Document data were used to enable the retrospective knowledge without the researchers' intervention (Rapley 2007, Corbin & Strauss 2008). Thus the order of the analysis of care and service plans confirmed the reality of the care planning based on empirical knowledge (Rapley 2007).

4.3.1 Material and data collection

The care and service plans were collected in collaboration with six home care service managers in July 2010. The researcher informed the managers delivering care and service plans of all current clients but without identification information. Altogether 501 plans were identified, but only the documents of clients who were 75 or older were included in the study.

The data consisted of 437 care and service plans and 82% of these were for female clients. The age of the clients varied from 75 to 103 and the mean age was 84. Most clients had one or two home visits per day (56%) and the goal of the majority of home care visits was to help clients manage every day activities (98%).

The plans were drawn up by home care professionals in collaboration with clients and their family members. The plans were documented using Finnish Care Classification version 2.0.1. (FinnCC), which encompasses elements of the international Clinical Care Classification System (CCC) (Saba 2012). The software has two different functions: it provides a structured menu of 19 components, including physical, psychological and social aspects and also provides space for free text. Home care professionals select the components from the menu and enter the written descriptions if needed.

4.3.2 Analysis of document data

According to the document analysis, both quantitative and qualitative methods were used (Lee & Smith 2012). In the first phase, all quantified data from the care and service plans were processed with the Statistical Package for Social Sciences (SPSS), version 20.0. Subsequently, the open text areas of the CS plans were analyzed using a thematic content analysis according to 19 components (Hsieh & Shannon 2005). The open text areas were read and meaningful concepts and information were grouped under components. The open comments area was comprised of single words, phrases or short sentences (e.g., 'home care service delivered drugs'), which described or more closely defined current components. The aim of the analysis was to produce descriptions and quantifications of the content and the number of notes. The first step of the analysis was to identify and group notes that were given for components (e.g., administration of drugs, etc.), and the second step was to quantify frequencies and percentages (Table 6).

Table 6. An example of the most frequently documented components (2/19) in the older home care clients' care and service plans

Component[a] **n (%)**	**Content of component**	**Notes**[b] **n (%)**	**Number of all notes**	**Notes**[c] **n**	**Notes**[d] **%**
Medication 405 (92.7)	1) Administration of drugs	271 (62.0)	1104	24.5	33.0
	2) Pharmacy services	240 (54.9)		21.7	
	3) Dose dispensing	173 (39.6)		15.7	
	4) Observing taking drugs	146 (33.4)		13.2	
	5) Renewing prescription	131 (30.0)		11.9	
	6) Warfarin	75 (17.2)		6.8	
	7) Drug storage	65 (14.9)		5.9	
	8) Effectiveness	2 (0.5)		0.2	
	9) Adverse effects	1 (0.2)		0.1	
Self-care 373 (85.4)	1) Taking care of eating	348 (79.6)	1027	33.9	31.1
	2) Taking care of intimate hygiene	242 (55.4)		23.6	
	3) Monitoring if walking devices provide sufficient support	194 (44.4)		18.9	
	4) Help with toileting	144 (33.0)		14.0	
	5) Help with dressing	99 (22.7)		9.6	

a Number of care and service plans with notes.
b Notes in component.
c Notes in component related to total notes in component.
d Notes in component related to total notes in all components.
No notes for components such as respiratory, follow-up treatment, life cycle, and health behaviors.

4.4 ETHICAL CONSIDERATIONS

The research ethics can be observed to range from the choice of the research issue to the results produced. Various ethical aspects of the scientific process especially recruitment, data collection, the choice of research methods as well as beneficence and nonmaleficence, were followed (Medical research act 1999/488, 2010, 794, Declaration of Helsinki 2013). Justification and beneficence for this study can be assessed from two points of view: Firstly, every human has a right to equitable care, especially older clients in their own homes and home care professionals are obliged to ensure that their work is high-quality (ETENE 2008). Secondly, most studies have targeted older clients' home care services, but mostly, concerned home care services including financial resources, rehabilitation, physical ability to function, and everyday activities. Little has been studied from clients own perspective

how the home care services should be conducted. Therefore, more information about reality of daily care and also older clients' viewpoints is needed.

The videotaped home visit situations of the older home care clients were the most sensitive part of data collection. In this study, most of older clients' who participated to the research was diagnosed dementia. Older people with cognitive disorders can be regardless as a vulnerable (Medical research act (488/1999, 295/2994, 794/2010). The legislation (Medical research act 1999/488, 2010, 794) emphasize that participants should have autonomy in deciding whether or not to participate in a research. This means that relevant information must be given to the participants and their competence to make the decision should be evaluated (Medical Research 488/1999, 295/2994, 794/2010, Beauchamp 2011). Person, who has Mild dementia, can give the written informed consent. However person, who has a diagnosed moderate-stage of dementia can give the verbal informed consent but written informed consent have to request from the next of kin. When the person has diagnosed severe-stage of dementia the written informed consent have to request from the relatives (Rauhala & Topo 2003, Diener et al. 2013).

The recruitment process was planned carefully. Before obtaining the written consent, the participants were given written and verbal information and also time to consider. They were told that participation was voluntary and that they had the right to withdraw at any time. After information participants had two weeks' time to consider their participation. Those who did not display any interest were not reminded or persuaded. In this study, written informed consent was obtained from all home care professionals and older clients. In addition, informed consent was obtained from two clients` relatives, because these clients have diagnosed moderate-stage of dementia. (Diener et al. 2013.)

Moreover, planning the appropriateness of data collection the researcher had to take into account that older clients with dementia have both good and bad days as well as how much data collection can put a train the clients (Hellström et al. 2007). Stimulated recall interviews conducted with practical nurses in social and health centre in a quiet place and with clients' in their own homes to ensure physical privacy (Leino-Kilpi et al. 2001). Participants were told that videotaping material is confidential and only these participants who are involved in home visit situations' videotaping can see the tape. After interviews, participants allowed and encouraged to reflect their feelings.

Documentary materials' confidentiality was ensured by home care service managers. Before delivering the plans to the researcher, home care service managers were de-identified the plans by excised clients' name and date of birth, only year of birth and gender were kept. All information was treated confidentially and the data were kept in a locked place at the researchers' home.

The principles of beneficence and nonmaleficence obligate researcher to both maximize possible benefits and minimize possible risks, and to not harm participants. Moreover, the nonmaleficence can be observed perspective of social privary referring to the individuals' right to control social contacts (Leino-Kilpi et al. 2001). In this study, the paucity of the studies which hightlights the clients own perspective of home care services and reality of daily care and therefore, recommends this study. Perspective of nonmaleficence, there is no direct benefit for clients and professionals. However, they were pleasured to tell their own opinions and take a part the study. It is self-evident that the video-taped home visit situations are sensitive situations for the clients, and thus the recruitment process was conducted by own familiar nurse to ensure clients' voluntary involvement to the research without researcher presence (Leino-Kilpi et al. 2001).

In this study, the Research Ethics Committee of the Hospital District of Northern Savo Central Hospital Region has commented favourably on this study (date 15.12.2009, Dnro 126//2009) and the appropriate permission was obtained from the organizations concerned.

5 Results

The main results are presented in four parts, according to the research objectives. In this summary, the main results are introduced and more detailed results are presented in the original articles I-IV.

5.1 DESCRIPTIONS OF OLDER PEOPLE'S RESOURCES (ORIGINAL ARTICLES I, II AND IV)

Based on a systematic literature review (Original article I) and interviewed older people (Original article IV), their resources consisted of social relationships, psychological well-being and elements of meaningful life. According to the interviewed home care professionals, older people's resources refer to support, in-home-activities, out-of-home-activities and environment as well as meaningful life (Original articles II and IV) (Figure 3).

Social relationships as resources refer to the confidential relationships with family members, friends and neighbours, others participating in voluntary work and home care service nurse appointed to the client. According to the older people (Original article IV), a relationship with the personally appointed nurse formed a significant part of life. This indicated reciprocal interaction and listening. The older people also emphasized that the relationship with their nurse was linked to the regularity and continuity of care, improving construction of a confidential relationship based on collaboration and practical help. In general, practical help referred to helping with everyday situations, such as finances, shopping and preparing food. Older people had the common opinion that they needed positive feedback and encouragement in order to cope with activities of daily living. They also described that their nurses' home visits promoted their psychological well-being and, subsequently, reduced depression. For instance, they criticized that services were often focused on their physical ability to function and the most attention was paid to routine-like services.

Based on review (Original article I), psychological well-being was crucial for older people living at home. As a resource, psychological well-being means the ability to influence the course of one's own life and possibility to make own decisions regarding it and take a part in the society. As assessed by the older people, these aspects enabled positive attitudes towards life and helped to build self-confidence. The older people highlighted the importance of having the possibility to make decisions about their own lives without being influenced by outsiders, such as relatives and home care professionals. This view reflected an attitude of the older people that they do not give up or accept help with their everyday tasks until they have exhausted their own resources.

Meaningful life means the ability to manage everyday activities as well as physical and psychological well-being. As a resource, meaningful daily living is connected to household work, leisure time activities and the ability to run errands. Older people experienced physical well-being as one of the most significant resources from the perspective of living at home for as long as possible. Furthermore, they assessed physical and psychological well-being to be strongly connected to each other.

According to the home care professionals (Original articles II and IV), older people's resources refer to the meaningful life, support, in-home-activities, out-of-home-activities and environment. Professionals perceived a meaningful life for older people to be reflected in a positive attitude towards life and spirituality. They emphasized the value of a positive

attitude in spite of illness and weakness, and considered it to be a part of life values and religion. Professionals also perceived economic safety as a part of meaningful life, including the ability to buy welfare services, to travel, and otherwise enjoy life.

Professionals assessed that support from family, friends and neighbours was meaningful as it provides social interactions and practical help. Moreover, support from next of kin is the key for living at home for as long as possible.

According to the professionals, everyday activities of older people, such as tidying up the house and preparing meals, formed a primary content of in-home-activities. In order to help older people to manage everyday activities, the professionals highlighted the importance of the availability of personal aids, which allow free mobility.

As described by the professionals, out-of-home activities and environment were connected. They highly emphasized having a home and external surrounding of the home without physical barriers, especially in the case of older people who had walking aids, as this made it possible to meet other people and to manage daily living. The professionals assessed that having the possibility to exercise outdoors positively influenced both older people's social relationships as well as their psychological well-being.

Based on results (Original articles I, II and IV) older people's resources as a whole were considered significant. Older people's descriptions of resources were mostly in line with the views of home care professionals. However, there were some differences in emphasis. The resources of social relationships and elements of meaningful life came up most frequently in the older people's descriptions. These contents of resources emphasized older people's own life experiences and comprehensive well-being, and can be described as personal and external resources. On the other hand, descriptions of home care professionals focused on the home, economic situations and social relationships. The contents of such resources can be described as external resources. However, some professionals noted that there needs to be a balance in the resources: clients living at home should not be pressurized to use their resources and, on the other hand, they should not be promised too much from their current home care services. The professionals pointed out that they took full responsibility for clients and promoted their living at home.

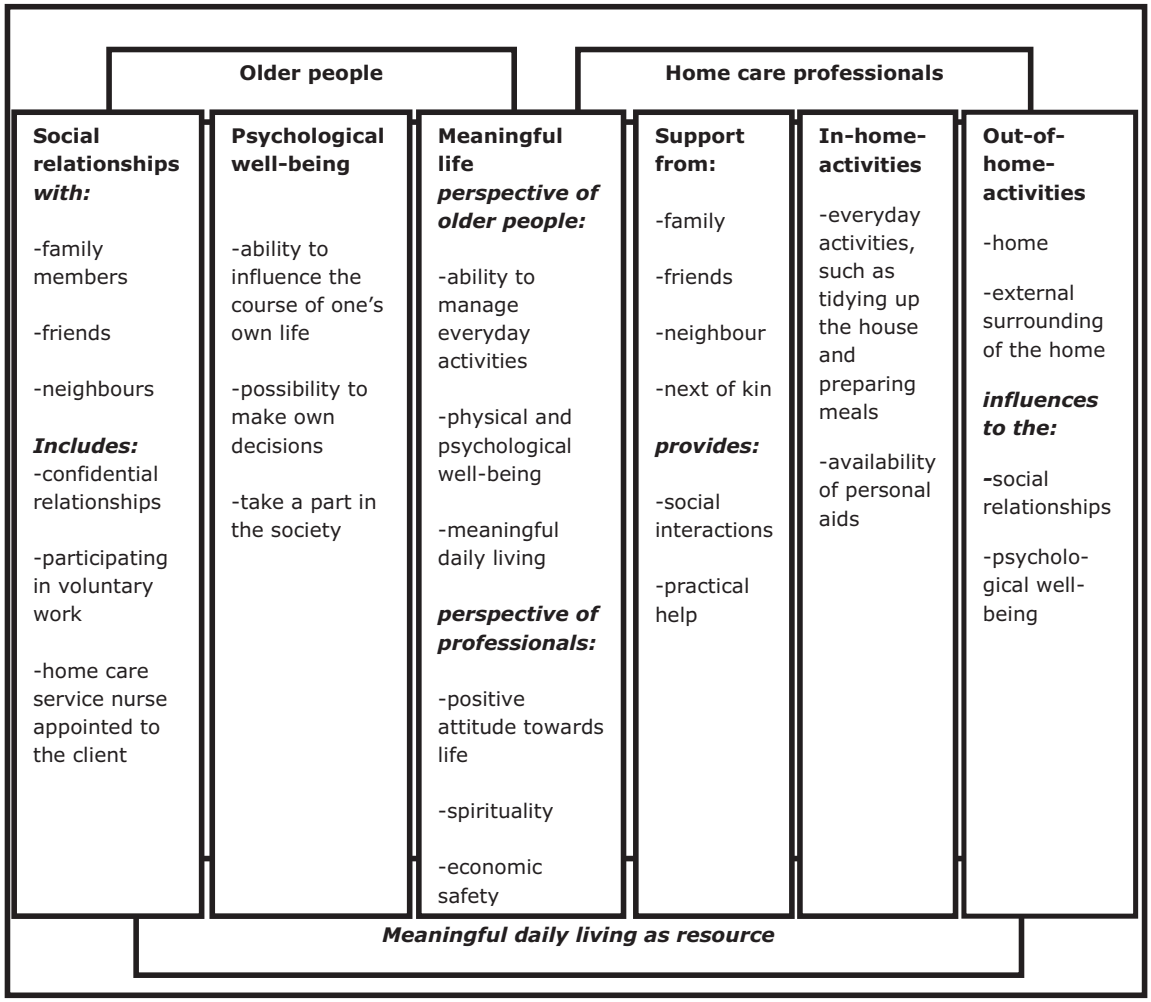

Figure 3. Older people's resources described by older people and home care professionals

5.2 TAKING INTO ACCOUNT OLDER CLIENTS' RESOURCES DURING CARE PLANNING (ORIGINAL ARTICLES II AND III)

Home care professionals' descriptions (Original article II) and documentation of plans (Original article III) addressed taking care of medication and older clients' physical needs, as well as managing everyday activities such as eating, intimate hygiene and assess the need for sufficiency-assistive walking devices (Figure 4). As reported earlier, professionals described older people's resources in a variety of ways. However, this diversity was missing when the professionals described older clients' care planning based on resources (Original article II). During the care planning, professionals recognized clients' resources through personal support, everyday activities and environment (Original article II).

Based on professionals' descriptions of clients' resources, the perspective of support was narrow and referred only to family and basic services. As a whole, clients' support manifested through partnerships, but was seen mainly in the context of daily care and daily activities. According to the professionals, it was evident that managing everyday activities was the element most recognized by clients. The professionals focused on recognizing clients' ability to manage everyday activities from the perspective of physical and cognitive

abilities. Generally, this means focusing on addressing clients' physical needs and taking into consideration the facilitation of independent actions, including helping with intimate hygiene, eating, and medication. Professionals' descriptions were fairly similar with both older people and home care clients. However, professionals emphasized older people's personal capacity to manage everyday activities and took notice of their individual habits and their meaningful daily living.

The professionals did not consider out-of-home activities to be as significant as older clients did. There were only few comments from the perspective of considering clients' possibilities and willingness to partake in out-of-home activities. The same narrowness is visible in the professionals' descriptions concerning environment as a resource. They divided older people's environment into the home itself and home's external surroundings. This also included functionality inside and outside the home and its surroundings. Professionals highly valued older people's free mobility without barriers, especially in the case of persons who had walking aids, as having no barriers made it possible to meet other people and manage everyday activities. All these aspects were missing when professionals described clients' environment as a resource. Generally, the professionals' descriptions did not include out-of-home activities, and they did not see these activities as relevant to their clients.

Based on an analysis of older clients' care and service plans, the view on clients' needs focused on taking care of medication, addressing clients' physical needs and managing everyday activities. Documentation of medication was instrumentally orientated in terms of the administrating drugs, pharmacy services, dispending doses, monitoring medication, renewing prescriptions, and storing medication. In contrast, effectiveness of drugs and adverse effects were only described in few cases. Similarly, documentation of addressing clients' physical needs as well as managing everyday activities was task-oriented. Generally, the documentation was based on routines conducted by professionals and a philosophy of 'doing things on behalf of clients', i.e., documentation was based on professionals' perspectives. Thus, less attention was given to clients' own opinions of their possibilities to manage everyday activities and meaningful life. According to the analysed plans, supporting and encouraging clients was only mentioned in one documentation and collaborating with clients and their family members was described only in a few documentations.

All clients had filled out care and service plans, but the lack of sufficient documentation was visible in certain areas, such as nutrition. In practice, clients' nutrition was noted in only 3.2 % of all of the care and service plans. The existing documentation concerning nutrition was concerned with technical matters, such as clients' need for help with meals and, having Meals-on-Wheels service. In addition, there were some areas that were not documented, e.g., concerning health behaviour.

In practice, home care professionals often made assessments and decisions and performed interventions by themselves without the presence of a colleague. Professionals thought that they were involved in clients' daily lives in all of the dimensions that affect clients' everyday activities and use of resources. The professionals agreed that care and service planning should be conducted based on standardized evaluation using assessment tools and should take place in collaboration with older clients and family members. However, despite the availability different assessment tools, their actual use was occasional.

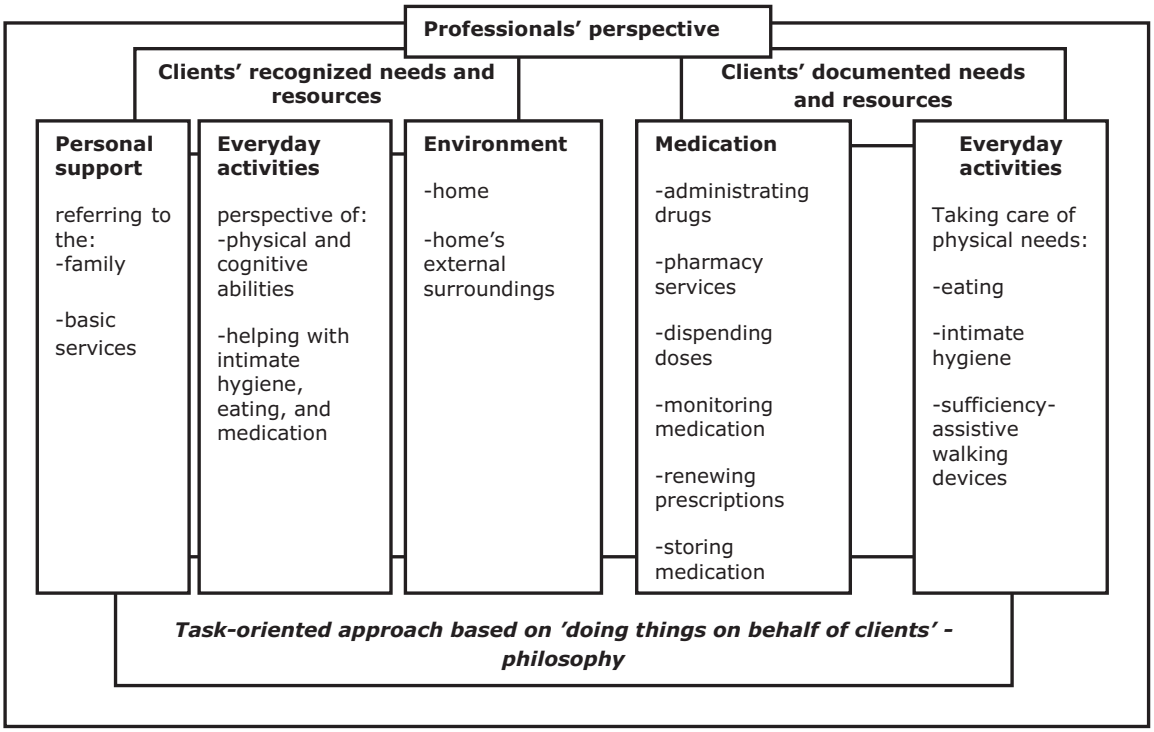

Figure 4. Aspects of care planning based on older home care clients' resources

5.3 STRUCTURE OF HOME CARE FOR OLDER CLIENTS BASED ON RESOURCES (ORIGINAL ARTICLES II AND IV)

Based on the views of clients and professionals, home care services can be seen as organizationally-driven, but also as individual encounters in a multifaceted system (Original articles II and IV). (Figure 5). Organisationally-driven home care services consist of activities of daily living including routine, mechanical medication and life-sustaining nursing care. According to the clients and professionals, organizationally-driven home care services consisted of routine-like daily care where evaluation of clients' individual needs and resources was forgotten. Both groups assessed that despite such daily care is routine-like, there should still be time for care planning, which would also take into account clients' social relationships and elements of meaningful life.

Both groups reported that the focus of care was on everyday activities based on clients' physical needs. From clients' perspectives, routine-like activities of daily living revealed predominantly hasty and restless behaviour of practical nurses. Clients' personal nurses had to conduct several tasks simultaneously, e.g., heating meals in microwave and administering morning medications at the same time. In addition, care was described from the perspective of clients to proceed similarly as an assembly line in a factory: getting the client out of bed, assisting them to use the toilet, helping them with dressing up and serving them breakfast. The contents of clients' and professionals' descriptions of care were in line with each other. Professionals also described their work to be based on a philosophy of doing tasks on behalf of their client, which means that their work was mechanical and standardized, and clients' abilities to take part in everyday activities were ignored. Professionals have set about helping their clients on the basis of doing things for them, rather than doing things with them.

The clients and professionals criticized home care services due to their service orientation. The service orientation meant that home care was based on available services and clients' individual resources were not taken into consideration in care planning and or in daily care. Moreover, home care professionals explained that they did not use assessment tools regularly to help them plan and realize comprehensive care and services based on clients' individual resources. Professionals also assessed that current daily care is not solely dependent on the ability of professionals to assess and support clients' resources and needs. It is also reliant on municipalities, which provide the home care services.

Based on the opinions of clients and practical nurses, medication was the dominating content of care, but the approach to it was mechanical. Professionals also assessed taking care of medication as the most significant task in their daily work. Professionals' descriptions concerning medication focused on the administration of drugs, dose dispending, observing clients taking their drugs, and renewing clients' medical prescriptions. Clients described their personal nurses' role as being significant in reminding them to take medications during every home visit. According to the interviewed clients and professionals, daily care based on life sustaining nursing care including different nursing treatments, such as wound care and measurements, e.g., blood glucose level and blood pressure. Thus, the view of care was based on clients' chronic illnesses. Professionals also mentioned that an important task for them was to observe and evaluate clients' cognitive abilities, including memory, and, specifically, to assess how clients manage living at home independently.

The clients and professionals assessed that current home care services included multiprofessional but fragmented care and confidentiality in care. Both of the studied groups expressed the view of home care services being multiprofessional but, at the same time, fragmented by nature. They pointed out that home care consisted of several services and employees. Clients in particular felt that employees from different organisations made them feel uncomfortable. They also presented the view that employees were unfamiliar with each other and, as a result, unfamiliar with their clients. In this point of view, care was multi-professional but fragmented, referring to many employees and organisations, hasty working habits and confusing management.

However, despite the fragmented nature of daily home care services, both clients and professionals found a shared positive connection in daily care that manifested as confidentiality in care. This referred to both clients and professionals long lasting relationship. Especially clients emphasised that having a personally appointed nurse enabled them to share information about personal issues. The interaction between nurses and clients highlighted trust, shared decision-making and mutual communication. These elements can be described as "individual encounters in a multifaceted care" (Figure 4).

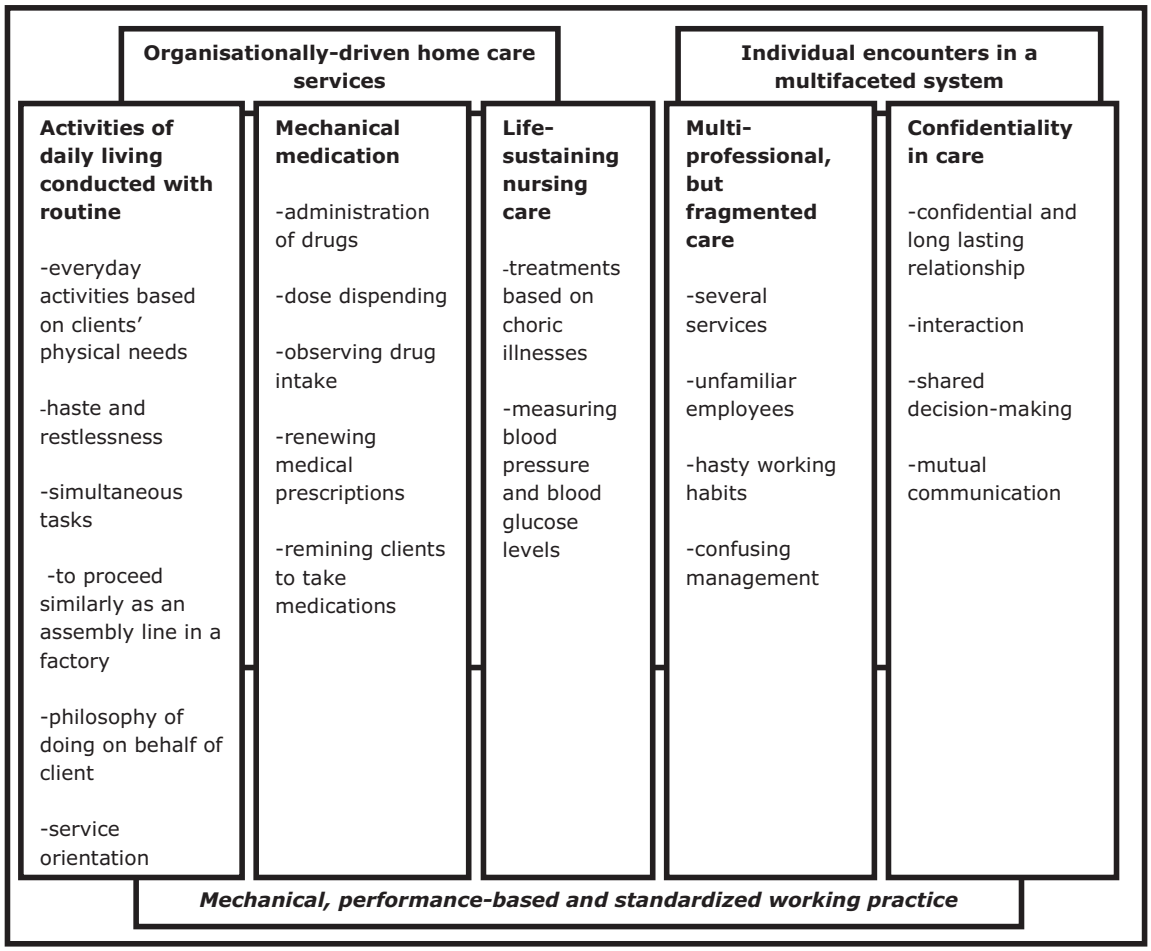

Figure 5. Current home care perspective of older home care clients and home care professionals

5.4 VISIONS FOR FUTURE HOME CARE SERVICES (ORIGINAL ARTICLES II AND IV)

Based on the descriptions by older home care clients and home care professionals, there were apparent aspects of home care that should be developed and which could promote older clients' living at home for as long as possible. The main contents of the four different elements can be condensed into individually-designed home care services of resource-based care, meaningful and inspirational activities, care relationships based on reciprocity, and safe environment as a context (Original articles II and IV).

Older home care clients and professionals described resource-based home care services from the perspective of individually designed care plan, including documented resources and the availability of a personal nurse. As the professionals pointed out, municipal home care services are responsible for providing well-organised home care, which also includes taking into account clients' resources. They also indicated that clients' resources needed merely to be made visible so that nurses could utilise them in individualised care plans and daily care. This also requires for clients' resources to be documented in the care plans for all phases of the care process. The professionals assessed that there was a lack of a systematic

use of assessment tools which would help professionals to comprehensively identify the resources of older clients.

The interviewed clients found that the first step needed to take in order to promote their living at home is having the same nurse care for them continuously. The clients described that having the same personal nurse makes it possible for them to create a familiar and confidential relationship with them. Based on professionals' opinions, a personal relationship makes it possible to take into account individual resources and habits of the clients.

It was evident that meaningful and inspirational activities produced by home care services were seen by both clients and professionals as an element that supported older clients' living at home. Both groups described these to include external and informal activities shared by clients and professionals, such as baking, taking a coffee break or reading the newspaper together. According to the professionals, these types of activities were especially significant for clients with a cognitive disorder. Moreover, activities outside the home were meaningful and helped support older clients' living at home. In addition, clients and professionals noted that nurses could act as a link or support between clients and their family members or neighbours to generate more active social interactions, such as telephoning, visiting each other or spending time together.

From the perspective of clients and professionals, having a care relationship based on reciprocity had a highly significant role in daily care. Such a relationship included mutual respect, trust and room to express personal opinions. In general, according to the clients and professionals, this was understood to not mean acting on behalf of a client, but, instead, to listen to them and support them in their daily chores and to encourage them to keep on trying to perform everyday activities. However, both groups pointed out that these kinds of relationships were time-consuming and required more time to allow conversations between clients and nurses.

Furthermore, both clients and professionals thought that a safe environment was a cornerstone for living in safety at home. A safe environment referred specifically to functional safety, including the use and availability of personal aids. Moreover, clients and professionals highlighted the importance of evaluating the use of personal aids according to individual needs. Personal nurses' knowledge about personal aids was appreciated by clients and this created not only a safe environment, but also a feeling of safety.

Professionals pointed out that taking care of accessibility at home was a practical way to promote client safety. In practice, they meant by this keeping clients' homes tidy and spacious enough to allow barrier-free mobility for clients. According to the professionals, multi-professional collaboration was the key issue for developing a safe environment for older clients. This requires evaluating client's need for personal aids and finding out the best individual solutions for them.

Both clients and professionals assessed that clients' resources were crucial for their living at home. Resources referred to a client-driven approach, where clients' own abilities to manage meaningful and inspirational activities were taken into account based on confidential relationship. Moreover, individually designed home care services require developing a safe environment with multiprofessional collaboration. The visions for future home care services from the perspective of older home care clients and home care professionals are presented in Figure 6.

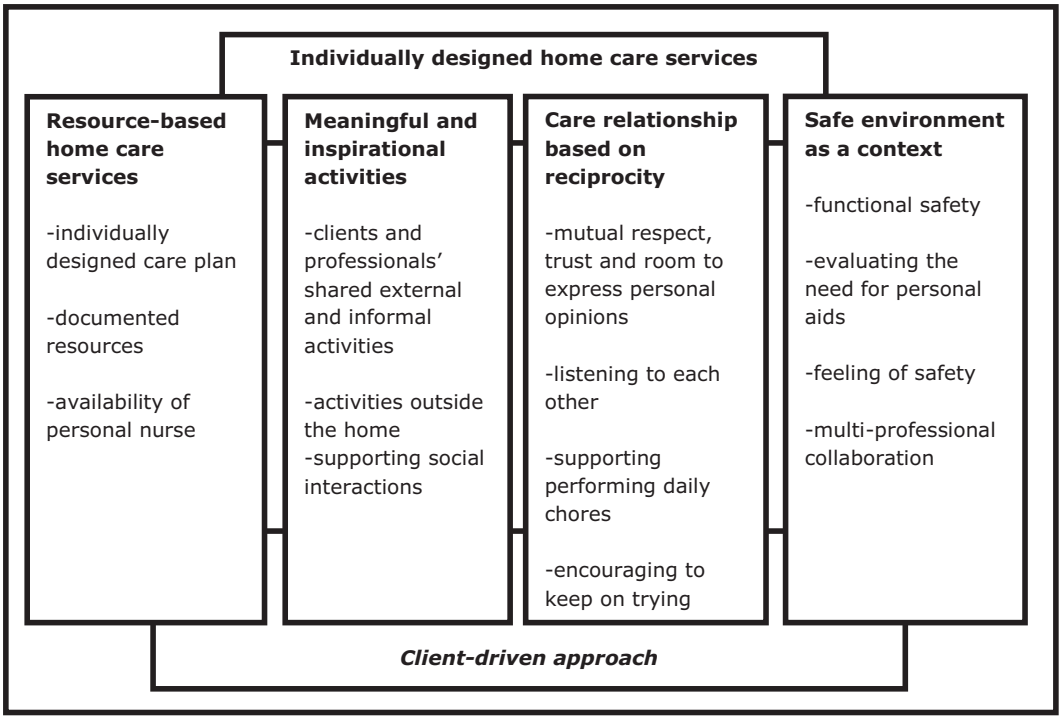

Figure 6. Visions for future home care services from the perspective of older home care clients and home care professionals

5.5 SUMMARY OF THE RESULTS

1. The older people described their resources from the perspective of social relationships and the elements of meaningful daily living. The home care professionals' descriptions were in line with the above views. Social relationships included family, friends, neighbours and others participating in voluntary work were described as significant resources by both groups. The elements of meaningful daily living manifested in clients' ability to manage their everyday activities. Related to everyday activities, physical ability to function was assessed as one of the most significant resource perspectives of physical and psychological well-being.

2. Home care professionals recognized older peoples' resources in variety ways. However, this multiplicity was missing when professionals assessed the resources of their own clients. Based on professionals' descriptions and documentation, the most significant perspective in care planning was being focused on addressing clients' physical needs and facilitating their independent actions, including helping them with intimate hygiene, eating and medication.

3. Perspectives of older home care clients and home care professionals were similar regarding daily care. The clients and professionals assessed the nature of daily care as being mechanical, performance-based and standardised. Everyday activities related to clients' physical needs formed a primary content of care. Clients and professionals characterised the care as repeating similar activities from day to day, home to home and client to client, routinely performing everyday activities.

4. According to the older home care clients and home care professionals, visions for future home care services can be condensed into an individually designed care plan, referring to home care in which clients' resources are taken into account, and different meaningful and inspirational activities. Living at home for as long as possible also requires a care relationship that is founded on reciprocity and a safe care context.

6 Discussion

6.1 DISCUSSION OF KEY ASPECTS

Based on law (Act on supporting the functional capacity of the older population and on social and health services for older persons 980/2012), several recommendations and municipal strategies concerning older people's care and services emphasize individualized care and services based on promoting older people's resources and supporting their living at home. Based on the results of this study, we may ask whether the contents of recommendations and strategies are partly rhetoric due to their promises and, on the other hand, demands. Based on the results in this study, older home care clients and home care professionals were well-aware of clients' resources. Nevertheless, there was an obvious gap between awareness and practice in taking into account clients' resources. Older clients experienced that their resources had not been taken into account or supported. Home care professionals insufficiently recognized and realized clients' resources in daily care. Moreover, there was insufficient documentation of clients' resources in care and service plans. According to clients and professionals, in the future, the development of daily care requires recognizing individual resources and aiming at maintaining meaningful everyday life, confidential and long lasting relationship between client and professionals, and safe environment at home.

Discussions about research themes in earlier literature and with participants, and the analysis of document data revealed several aspects of interest in research based on older home care clients' resources. On the basis of this, the following aspects will be discussed in this chapter: older peoples' resources, recognizing and realizing these resources in daily home care services and the aspects of home care services that should be developed in future home care services. This chapter also evaluates the trustworthiness and limitations of the study, implications for nursing practice and suggestions for future research.

6.1.1 Elements of meaningful daily living as resource in older peoples' life

From the perspective of older people and home care professionals, resources consisted of the elements of meaningful daily living, including social relationships, health promoting home care services as well as safety and functionality of the environment. The elements of meaningful daily living were manifested in the ability of older people and clients to manage their everyday activities. Moreover, physical activity was linked to everyday activities and assessed as one of the most important resource perspectives of physical and psychological well-being. All of the groups also valued the possibility to perform everyday activities and leisure time activities, including cultural events, on their own. As has been reported in earlier studies, individual lifestyles and independent activity are essential resources in older people's daily lives (Burr & Mutcler 2007, Koskinen et al. 2007).

The older people and professionals described social relationships, including those with family members, friends, neighbours and other participating in voluntary work as significant resources. Having a helpful and confidential relationship with a personal home care services nurse was highly regarded. Both of the groups assessed that the effects of social relationships had significant dimensions for the quality of life and psychological well-being and influenced elements of meaningful daily living, a finding which is accordance with earlier studies (Low & Molzahn 2007, Jopp et al. 2008, Eloranta et al. 2010). Older people and professionals perceived loneliness as one of the most crucial factors leading to unwillingness to take part in everyday activities. This is also pointed out in the literature; a lack of social support increases loneliness and depression, which might lead to hospitalisation (Høy et al. 2007, Low & Molzahn 2007).

The studied groups assessed that home care services and the safety and functionality of the environment supported their independent living at home. Home care services have centred on availability of services, collaboration with home care professionals and confidentiality of care. However, it has been recognized in earlier studies that home care services do not offer or develop care and services considering clients' individual needs. In accordance with the literature, we found that home care services were based mainly on taking care of clients' physical needs and were offered in the same form to all clients without acknowledging their potential individual differences (Del-Pino-Casado et al. 2011, Forma et al. 2011, Janssen et al. 2012). Due to limited availability, service-based home care cannot respond to future challenges of promoting clients' living at home for as long as possible.

The older people and professionals emphasized the importance of safety and functionality of the environment without barriers at home and in the home's external surroundings. The studied groups demanded that they must have the opportunity to perform activities that appeal to them personally, whether physical exercise, out-of-home activities, or going to the theatre. This result is supported by the earlier finding that professionals noticed clients' environments, but they were mainly seen in the context of clients' physical ability to move inside their homes (Hayashi et al. 2011, Janssen et al. 2012).

In summary, from the perspective of older people and professionals, meaningful daily living consists of diverse elements, including comprehensive views of resources. On the other hand, it will be challenging to define and concretize older clients' resources, especially in daily care. It is evident that older clients' resources will become one of the most relevant elements for providing future home care services, because home care that does not develop care and services considering clients' individual resources cannot answer to the challenges of the future. On the other hand, current policy puts too much emphasis on the resources of the older people, as this reasoning is used to justify leaving older people home alone without any services.

6.1.2 Narrow views of older home care clients' resources

The home care professionals interviewed for this study described recognizing older people's resources in diverse ways. Professionals recognized older people's resources and everyday activities from the perspective of meaningful life, personal support and environment. However, with home care clients, they focused only on physical abilities, such as clients' ability to get out of bed, go to the bathroom and manage personal hygiene, and make breakfast and other meals.

It has been noted in various research contexts that home care professionals focus only on recognizing their clients' physical needs (Saevareid et al. 2007, Eloranta et al. 2008b). However, professionals have a remarkable role in recognizing elements that support older clients' resources comprehensively. The fact that professionals make regular visits to the homes of their clients put them in an ideal position to form an overall picture of clients' situations and changes in it. Therefore, it is significant that they encourage clients to talk about their own situations and feelings so that professionals can recognize any threats to clients' resources well ahead of time. It is well-known that the diversity of resources available to clients need professional recognition, because clients are at a risk of a decreased sense of coherence and empowerment, which negatively affect their everyday activities at home (Donahue et al. 2008). In this study, professionals did not use their skills to support the clients using their own individual resources, nor did they explore the potential abilities of their clients. From this point of view, the professionals seemed to forget their clients' diversity of resources and thus, their ability to take part in their comprehensive care planning. This has also been pointed out in the literature: it can be difficult for professionals to take clients' multidimensional resources into account (Hayashi et al. 2011, Salguero et al. 2011), and empower older clients to qualify and utilise their strengths (Donahue et al. 2008, Raiche et al. 2012).

The results reflect today's increased attention to daily care, but paradoxically, also professionals' lack of attention to clients' ability to take part in their own comprehensive care planning. For example, important aspects, such as medication and nutrition, were comprehensively observed in care planning, but the views were based a task-oriented approach, e.g., administration of drugs and heating up meals. However, based on daily care, attention was not paid to proper or sufficient nutrition or the possibility of malnutrition, even though nutrition is a significant element of clients' lives and helps them to maintain activities of daily living (Ferdous et al. 2009). Approximately one out of five home care clients are suffering from malnutrition (18.2%), and 42% are at a risk of malnutrition (Stange et al. 2013). This major issue was neglected by professionals and, therefore, they did not promote clients' nutrition to prevent adverse health outcomes, including institutionalisation.

Clients and professionals described medication as one of the most major things to take into consideration in care planning. This emphasis was also visible in care and service plans. Nevertheless, especially from the perspective of professionals, taking care of medication was instrumentally orientated in terms of administration of drugs instead of monitoring the effectiveness or adverse effects, which were noted only in three care and service plans. However, according to previous studies, adverse drug reactions are common with older people, and they are a leading cause of hospitalisation (Hamilton et al. 2011).

In order to be able to realize individual care planning and continuing care, documented care and service plans formulated in collaboration with older clients are required. In this study, clients' care and service plans were mostly designed from the home care professionals' viewpoint, they were based on classification, and written with passive expressions. In addition, documentation was based on the philosophy of 'doing on behalf of clients' and less attention was also paid to clients' individual resources and aspects of supporting their existing abilities.

The findings of this study show that documentation focusing on clients' physical needs and recognizing resources is insufficient. Inadequate documentation is problematic from both legal and an ethical point of view. Non-comprehensiveness and inaccurate documentation present a risk to client safety and well-being and to the continuity of home care services. Moreover, there is a risk that more power is given to home care professionals and available services, and less to clients' own opinions. This kind of documentation will lead to a task-oriented approach. Thus, unawareness of the client's perception of health and abilities hinder care and service planning.

Comprehensive assessment requires that professionals consider every aspect of their clients' overall situations and see the many kinds of resources available, because clients have the capacity to define and find strategies to manage their own lives. This has been pointed out also in other studies (Chesterman et al. 2001, Coleman et al. 2010). In addition, it requires implementation of systems of care delivery which promote individualized assessment and multidisciplinary care planning, attempts to encourage clients to participate in decisions about their care, patterns of communication which avoid exerting power and control over clients, and attempts to modify the environment to promote autonomy, independence and minimize risk (Verbeek et al. 2009, Burt 2012).

On the other hand, guidelines and variations of municipalities' policies can influence the professionals' decisions of care and services. Moreover, there may be regional differences in following recommendations and home care professionals may use different tools (e.g., questionnaires) to fit unique client situations and paraphrase and supplement client responses (Kihlgren et al. 2006, Themessl-Huber et al. 2007, Cabin 2007, Bouman et al. 2008).

In conclusion, home care professionals described the resources of older people in a diversity of ways. However, this variety was reduced in the care planning process based on professionals' descriptions and documentation. In current health care services, the purpose of providing home care services for older clients is to support independent living by

maximizing clients' resources. Therefore, even though the professionals did not consider resources as a significant perspective of care planning, it is evident that taking into account clients' resources will become ever more significant in the future. On the other hand, there are two sides to this coin. First, older clients, become increasingly frail in late life due to diseases, and are vulnerable when it comes to exercising their right to participate in and influence decisions related to their remaining resources (Miller 2011). Second, not all older people want to live their own homes and additionally, they do not necessarily have the requisite resources. Therefore, there is a risk that older people with different resources are in unequal situations and, at the same time, inequality will increase. It is also possible that this new 'resource approach' leads to a meaning that clients have to survive in the health care system on their own. In terms of ethics, home care services for clients should be based on the principle that clients deserve appreciation and their right to self-determination must be respected while meeting their individual needs (Chan et al. 2009, Coleman et al. 2010).

6.1.3 Performance-based daily care

Perspectives of older home care clients and home care professionals included the idea that the current structure of home care services focused on organisationally-driven care and individual encounters of a multifaceted system. The results indicate that the current structure of home care consists of activities of daily living with routine, mechanical medication and life-sustaining care. The physical abilities of clients in everyday activities were presented, highlighting a philosophy of 'doing on behalf of clients', without ignoring clients' individual resources. In accordance with previous studies, home care has also been criticised due to its expert orientation and the 'doing on behalf of clients' mentality, which refers to the fact that professionals have set about helping their clients on the basis of doing things for them, rather than doing things with them, and without assessing their abilities. Thus, the work of professionals has tended to have an illness-centred based on tasks which focuses only on clients' physical abilities and resources (Hayashi et al. 2011, Salguero et al. 2011) and activities in daily living (Hammar et al. 2009, Parker et al. 2011, Zhou et al. 2011).

This study also found that home care professionals' views of support for older people were substantially limited to only include care and services for basic needs. This result is supported by the earlier finding that professionals make decisions about what was best for their clients and performed care-related actions on their clients' behalf (Chesterman et al. 2001, Eloranta et al. 2008b). This requires an ethical and a philosophical shift to support clients so that they can maintain their self-care and autonomy. Thus, involving clients in their daily care helps them build their confidence in their own resources. This requires collaboration and interaction to ask clients about the things that are significant in their daily lives and what they are willing to do, and to work collaboratively with them (Hayashi et al. 2011, Raiche et al. 2012). Furthermore, the professionals mentioned family in the context of the perspective of helping clients with daily living. Family as a resource for maintaining social relationships was not emphasized. However, in line with results from the literature (Jopp et al. 2008, Coleman et al. 2011), older clients' social partnerships were noted as an important dimension of quality of life and psychological well-being, including social relationships and the elements of daily living.

The interviewed clients were unsatisfied with home care services due to the rushed and quick nature of visits and the fragmented practice of multi-professional care. They felt that the nature of home care was fragmented, and employees were from different organisations, such as municipal and private service providers or associations. Employee turnover was high, and employees were thus unfamiliar with their clients. Both clients and professionals also explained care and services as scattered care consisting of several unfamiliar employees. They described that a one-to-one relationship was confidential and good, but this had not been experienced in relation to the multi-professional group. From the clients' perspective, the multi-professional group was described as an unsafe environment with many unfamiliar employees, and, for nurses, it represented poor collaboration and unclear

responsibility roles. The fragmented role differentiation in the multi-professional group was based on expert-orientation and focusing on limited tasks (Belanger & Rodriguez 2008, Eloranta et al. 2008a), which has also been reported in previous studies. This results in a risk of losing the holistic overview of the client's situation.

The clients also felt that professionals made decisions and performed care-related actions on their behalf; the clients felt it was important to them. 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. Moreover, clients are also sometimes seen as passive care recipients (Outhoorn et al. 2007), and thus, their perceptions are ignored (Hammar et al. 2009, Hayashi et al. 2011, Salguero et al. 2011). On the other hand, high-quality home care services are not solely dependent on the ability of professionals to assess and support client's resources and needs, but are also related to the policy and home care services provided at a municipality level (Forma 2011, Janlöv et al. 2011). This requires professionals' expertise to include ethics in referring to values and rules. In caring for older clients, professionals face ethical challenges when having to negotiate between the conflict of professional standards and the clients' will (Tanner 2006, Jakobsen & Sørlie 2010, Juthberg et al. 2010), coercive care and clients' autonomy, integrity, their needs and organizational resources (Lindblad et al. 2010, Zhang et al. 2011). Coincidentally, circumstances and demands may conflict with the professionals' moral values.

In summary, it was evident, that professionals' working methods in daily care were based on an illness-centered approach that focuses only on clients' physical needs and abilities. In contrast, the social and psychological resources have been taken less into consideration. Additionally, on the organizational level of home care services, there has been continuous discussion about the form of providing home care services for older clients. Current home care services have been provided in collaboration with the private and third sectors. It is noteworthy that there is a need for discussion about providing home care services with different participants. One reason justifying this discussion is the improvement of client-centred approach in daily care.

6.1.4 Client-driven approach in future home care services

The results showed elements that promote older clients living at home based on clients' individual skills and abilities as highlighted by home care services. One essential question concerns the factors that contribute to older clients' living at home. As populations are ageing, it is evident that organisationally-driven and passive home care is causing increasing public health and financial concerns (Hammar et al. 2008, National institute for health and welfare 2010). Additionally, because of their availability, home care based on available services cannot respond to the challenges provided by care that promotes clients' living at home for as long as possible. Caring for clients in their own homes takes place in a different context to hospitals and is one that requires a different approach (Karlsson et al. 2009, McGarry 2009, Juthberg et al. 2010).

An interesting finding in this study was that both older home care clients and home care professionals were very positive and interested in the study and supported the development of home care when they had the possibility to tell their opinions about the aspects of home care that should be developed. The professionals assessed realistically their own working methods and the organization of home care services as a whole. The results of this study also indicate that especially professionals realistically assessed their current working methods as task-oriented, routine-like and based on a philosophy of 'doing on behalf of clients'. Their descriptions were completely opposite to the perspective of current structure of home care and views of home care which support clients' living at home. For example, one interesting difference was found with medication: in the case of the current structure of home care, medication was dominant and its importance was stressed by

clients and professionals. In the context of promoting remaining at home for as long as possible, medication was not mentioned at all.

The professionals reported that the focus of daily care was on everyday activities was based on clients' physical needs. They characterised the care as repeating similar activities from day to day, home to home and client to client. Work was mechanical, performance-based and standardized. The results of this study are similar to those indicated by previous studies, where task orientation, illness-centred approach and being solely focused on clients' physical resources have been found to characterise professionals' work with older people (Hayashi et al. 2011, Salguero et al. 2011). Both clients and professionals saw meaningful and inspirational activities as the most important elements for promoting clients' living at home. In accordance with previous studies by Eloranta et al. (2010) and Jopp et al. (2008), acknowledging the importance of daily life among clients, focusing on meaningful activities and social relationships, and clients' individual resources are important to their overall quality of life and psychological well-being. Additionally, both groups highly valued resource-based home care, including elements of encouraging and supporting everyday activities (Janssen et al. 2012, Raiche et al. 2012).

In general, both clients and professionals found clients' resources crucial for their living at home. Resources referred to a client-driven approach, where clients' own abilities to manage everyday life are taken into account and supported by home care. The clients found that the first step needed for promoting their living at home was having the same professionals care for them continuously. This personal relationship is then what enables professionals to take into account the individual resources and habits of the clients (such as eating and individual schedules). As professionals reported, despite some clients' dementia diagnoses, most clients could participate at least partially in their everyday activities. The fact is that there is a need for 'cognitive impairment-sensitive' care and services; even in the case of clients diagnosed with a memory disorder, the target is to maintain their living at home for as long as possible. Care and decision making by professionals could be enriched by exploring and documenting preoccupations with, key relationships in and wishes for the everyday care of clients with dementia (Burt et al. 2012.)

This study showed that there is an urgent need to develop an older clients' care planning system based on a comprehensive approach. It is evident that care planning designed from the professionals' viewpoint is limited as it is to an illness-centred approach that focuses only on clients' physical needs and resources and is causing increasing public health and financial concerns. Individually designed care plans highlighting clients' individual resources and opinions were described as a way to promote living at home for as long as possible. However, the current content of care was organisation driven where the clients' opinions seemed to be missing (Outhoorn et al. 2007).

One essential question concerns the documentation practices and standards for older clients' home care services and documentation as a whole. It seems that the detailed classification-based documentation is not flexible, and it hides the comprehensive picture of the clients' situations. It could be possible that the structure of care and service plans is based on the Finnish Care Classification's direct documentation for an instrument-oriented approach. It has been noted in various research contexts that it is common to document using illness-centred terminology and scattered information (Saranto & Kinnunen 2009, Gjevjon & Hellesø 2009, Carrington & Effken 2011). Therefore, rather than requiring professionals to write what are they doing, they are guided to observe clients' individual needs and resources. It is unfortunate that the FinnCC classification categorizes based on medical diagnosis and nursing problems, with no emphasis on home care settings. A major challenge for the future is to develop clearer documentation and component terminology based on the clients' individual needs and standards of care and practice. On the other hand, there could be a risk with more standardised and systematic documentation if it is used only to confirm standardised approaches that do not describe the comprehensive view of clients' needs and resources. In addition, standardized form of documentation has been

criticized due to its classification-based form. In the documentation of transforming individuals into clients, professionals collect and assess information about the clients in order to classify them and put them into predetermined categories of needs and available services (Janlöv et al. 2011, Miller 2011). Based on findings, home care would benefit by context-sensitive software with a focus on the special needs of older clients and their resources.

In conclusion, both clients and professionals found developmental aspects of home care services which plug into elements that promote older clients' living at home for as long as possible. The main contents of the different elements can be condensed into an individually designed care plan, referring to home care in which clients' resources are recognized, and different meaningful and inspirational activities are provided. According to the professionals and clients, living at home for as long as possible requires a care relationship that is founded on reciprocity and a safe care context. Client's individual resources are significant dimensions in overall quality of life and psychological well-being. Both clients and professionals highly valued resource-based home care, including elements of encouraging and supporting everyday activities. The professionals' descriptions were more work-related, such as that daily work with clients should include elements of rehabilitative nursing. The clients' descriptions consisted of meaningful actions and individual habits.

6.2 TRUSTWORTHINESS OF THE RESEARCH

The trustworthiness of a study can be assessed by examing the study design, and by evaluating the analytical process and the results (Tong et al. 2007). In order to guarantee the trustworthiness of the research, a combination of several methods were used (Burns & Grove 2009, Topping 2010). The combination was used to ensure deep understanding and comprehensive evidence of the research topic. In addition, synthesis of the results helps to catch up more complete and contextualized overall picture of the phenomenon being studied (Polit & Beck 2006).

The trustworthiness of methodological choices is linked to the number of publications and the methods used in previous studies. Qualitative approaches were used because of the low number of previous studies regarding recognizing older clients' resources from the perspective of the reality in daily care. Older people's own points of view were also missing. In this study, the knowledge of older clients' resources in home care services were achieved by using international scientific literature and the viewpoints of older people themselves, clients and home care professionals, including retrospective knowledge (previous literature, care and service plans), perceptions (focus group interviews) and observing the reality (video-based stimulated recall interviews).

The trustworthiness of the use of different data and results concern the process of literature review and interviews. The reliability of the systematic literature review was ensured by following the review protocol (Bearman et al. 2012), including clear definition of research questions, following search strategy, definition of inclusion and exclusion criteria, the evaluation of the quality of selected original studies, and the repeatability of the analysis (Whittemore 2007). The literature searches focused on the relevant databases corresponding to the research question of the review. Resource is a complex and multidimensional concept and it is possible that it has been used as a synonym for, e.g., the concept of the quality of life and psychological well-being. Therefore, aiming to improve reliability, the keywords in each database were identified in collaboration with the research group and an information specialist (Bettany-Saltikov 2010), and manual searches were conducted. The use of pretested keywords in the first search ensured a valid search strategy to identify relevant studies and minimize selection bias. The literature review was conducted in collaboration and agreement with research group (Bettany-Saltikov 2010). The quality of research articles was evaluated by using a method-specific evaluation form,

created for this review and based on previous instruments. The evaluation form was pretested and found suitable for evaluating research with different designs. The evaluation form was considered relevant to identify the quality of original articles in the review (see Original article I). The review findings were assumed to be reliable due to the quality of the data and the precision of the data analysis.

The trustworthiness of interviews as a data collection method concerns the selection of the participants, interview methods, conducting analysis and researchers' roles. Trustworthiness was ensured by recruiting participants with experience of the research topic (Maltby et al. 2010). The older people who participated in this study were clients of home care services with regular daily home visits. In addition, they were willing and committed to provide information on their experiences. Despite their diagnoses of Mild or Moderate Stage Dementia, interviews were closely linked to the older people's daily living at home and focused on the research questions. As research participants, the home care professionals were experienced in working with older people and were familiar with working at clients' private homes.

In this study, two different interview methods were used to find out about not only participants' perceptions and experiences, but also their realization in daily home care. The purpose of the focus group interviews was to obtain home care professionals' views of the collective topic (Barbour 2010), and to produce multidimensional and cumulative descriptions. Using focus group interviews as a data collection method, this study was successful in obtaining multidimensional descriptions and diverse views about the resources of older people and clients (Paharoo 2007). The focus group data were complex because of conversation and different opinions among the home care professionals (Curtis & Redmond 2007). Thus, significant attention needed to be paid to the professionals' expressions of their conceptions, although individual interviews might have provided deeper insights (Barbour 2010). As a way of guaranteeing confidentiality, home care service managers, home care nurses and practical nurses in the focus group study were dealt with in separate groups according to their titles. Homogeneity is discussed by researchers (McLafferty 2004, Kitzinger 2006), who recommend that focus groups should be homogeneous in terms of age, status, class, occupation and other characteristics, as such factors influence how participants interact with each other. In addition, researchers have been recommended to aim for homogeneity within each group to capitalize on people's shared experiences (McLafferty 2004). However, it can also be occasionally beneficial to bring together diverse specialists in order to gain multidimensional aspects of the topic (Kitzinger 2006).

It was suitable to use video-based stimulated recall interviews, as this is a method to catch reality in daily home visits. Watching videotaped situations activated memories and brought up occasions in participants' thoughts and subjective reactions based on the home visits. The method enabled the researcher and participants to observe the home care from a realistic point of view (Caldwell & Atwall 2005, Carayon et al. 2014). In practise, videotaping was conducted in older clients' homes during practical nurses' home visits. At the beginning of each home visit, the researcher ensured participants' awareness of video recording, and encouraged them to act as naturally as possible in order to catch authentic situations. Although the clients and practical nurses were aware of the video recording, they later explained that they felt this had not influenced their behaviour. This is in line with previous studies (Mollo & Falzon 2008, Carayon et al. 2014).

Home care professionals' focus groups and video-stimulated recall interviews were carried out during working hours, which possibly decreased the total time spent on the interviews. The place for interviews was carefully selected in order to ensure privacy. Older home care clients' video-based stimulated recall interviews were conducted at clients' own homes to ensure clients' possibility to think about their views in familiar environment.

Interview themes were created based on the results of the systematic literature review (see Original Article I). Themes were used in focus group interviews and in the video-based

stimulated recall interviews to ensure comparability of the results. Themes were operationalized to catch situations concerning older clients' resources in daily life. During the development of themes, the contents remained the same and thus, ensured logical focus on research topic.

The data were analysed by one researcher, but discussed and confirmed by the research group (Hsieh & Shannon 2005, Gibbs 2007). The findings do not represent the views of all participants in older clients' home care on national and international level. Nevertheless, based on a systematic literature review, the results are useful in other similar situations (Rebar et al. 2011), because understanding older people's resources at home can also help realize their potential in other similar contexts.

All interviews were conducted by the same researcher, which improves the reliability of this study (Burns & Grove 2009). The researcher had previous work experience as a home care nurse, and thus had empirical understanding of the phenomenon. Based on her previous carrier, she was familiar with some of the home care professionals. However, participants reported that they experienced a relaxed and confidential relationship with the familiar researcher and thus enjoyed their participation.

The trustworthiness of the use of care and service plans also concerned the selection and analysis of the plans. The selected care and service plans represent care documentation of all older clients over 75 years but were limited to one urban region in Finland during July 2010. On the other hand, in many countries, the form of care and service plans encompasses elements of the international Clinical Care Classification System (CCC). Hence, generalization is possible to environments using the same software. In order to grasp the complexity of the content of care and service plans, thematic content analysis (Hsieh & Shannon 2005) and quantitative methods (Sandelowski et al. 2007) were used. The contents of care and service plans were formulated according to the standardized documentation, including an open-ended section for goals, interventions and expected outcomes of the care and service process. The standardized forms of documentation as well as illogical documentation of particular components were a risk that might have led to restricted and poor expressions and thus produce limited knowledge of the research topic. However, the documentation was conducted systematically and all plans were filled out. Thematic content analysis was suitable to condense structured but fragmented data and to quantify confirmed results.

In conclusion, this study has some limitations that also need to be taken into account. Despite the use of different data and methods, the combination of collected data was not systematically conducted. However, a synthesis of separate results was made to answer the research questions. Furthermore, because of the local nature of the empirical data, no generalizations on the conclusions can be drawn.

7 Conclusions

The study provided new information on older home care clients' and home care professionals' multidimensional awareness concerning older people's resources. However, there was a gap between awareness and practice in daily care from the perspective of taking into account clients' resources. Furthermore, this study produced new information by using different methods, which enabled investigating resources of older clients from a realistic point of view.

7.1 CONCLUSIONS OF THE MAIN RESULTS

The following conclusions were made:

1. The results of this study indicate that home care professionals have knowledge about older people's resources. It is evident that home care professionals considered resources significant in older peoples' daily lives as a whole.

2. It is notable that professionals' descriptions about existing home care clients' resources were reduced to mainly include physical needs. The recognition of clients' situations is incomplete and does not address the subject of their individual needs and resources. Therefore, as professionals, nothing should be considered as self-evident, and every client's aspects should be perceived individually.

3. The current planning for older clients' care is classification-based with an instrument-oriented approach where there is a lack of acknowledgement of clients' individual needs and resources. In addition, classification-based documentation seems to be inflexible and hides the full picture of the client's situation.

4. Current home care is organisationally-driven and the context of care is mainly routine-like help in everyday activities, based on doing things on behalf of clients and ignoring their personal perspectives, individual needs and resources.

5. In order to be able to promote clients' living at home, home care services need to be provided based on individually designed and delivered care and services that takes into account clients' resources and perspectives of meaningful activities.

7.2 SUGGESTIONS FOR NURSING PRACTICE, EDUCATION AND FUTURE RESEARCH

This study emphasized recommendations for promoting older clients' living at home through comprehensive home care services. This strengthens the knowledge of practitioners, managers, educators and policy-makers by contributing information to older clients' home care services, nursing practice and education.

Suggestions for nursing practice:

1. In order to promote older home care clients' living at home for as long as possible, home care professionals need to be able to recognize older clients' individual needs. In order to be able to recognize older clients' needs and resources, there is a need for a regular use of assessment tools in identifying clients' individual resources based on a comprehensive approach.

2. Older clients' resources have to be assessed from the client's point of view, and their own perspectives must be taken into account when planning care and services.

3. The development of nursing documentation as a whole requires home care professionals to be able to design clients' care and services individually. More comprehensive electronic documentation systems must be developed so that clients' individual needs and resources can be faithfully documented.

4. In order to be able to promote clients' living at home, home care services need to be provided as individually designed care which takes into account clients' resources and perspectives of meaningful and inspirational activities as well as social relationships.

5. In daily care, working with a 'doing things with clients' rather than a 'doing things on behalf of clients' philosophy is needed.

6. There is a need for dialogue at the organisational level in collaboration with clients and professionals, including discussion on aspects of developing home care services to answer to clients' needs and resources.

Suggestions for education:

1. Teaching approaches should be based on the phenomenon of older people as active participants of the society living healthy lives.

2. Home care professionals need more ongoing education on how to recognize and to put into use many different potential resources of their clients.

3. There needs to be continuous collaboration between educators and home care professionals in order to develop education to interweave knowledge and skills. In this collaboration, the preconditions, roles and responsibilities of all participants have to be clarified. The collaboration should be strengthened by offering shared further education to all participants.

4. The education should develop educational methods which strengthen the skills of social and healthcare students and home care professionals in real-life contexts so that they are able to recognize and promote clients' living at home while taking into account individual resources.

Suggestions for further research:

1. Further research is needed to develop assessments tools to clarify older clients' resources. This information is crucial to developing methods that allow for early interventions to slow down the decline of these resources.

2. There is a need for evaluating the impacts of interventions targeted at clients' resource-based daily care to create a model for delivering client-driven home care services based on clients' resources.

3. It is worth conducting further research on the production of resource-based home care services for older clients from diverse perspectives of participants, including managers and management as well as advocates of society.

4. Future research should focus on developing clearer documentation and component terminology based on clients' individual needs and resources.

5. In order to obtain more generalized information about current older clients' home care, it is significant to study older clients' home care services more widely on the national level.

6. There is a need to study both older home care clients and family members, such as caregivers, together. Understanding on caregivers' views of clients' resources is needed to allocate home care services as comprehensively as possible.

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Riitta Turjamaa

Older People's Individual Resources and Reality in Home Care

This study focuses on the recognition and realization of older people's resources in home care services from the perspectives of clients and home care professionals. Based on interviews, participants were well-aware of older peoples' resources. However, results from document data and videotaped situations indicated a gap between awareness and daily practice. In order to be able to promote older home clients' living at home, home care services must take into account clients' resources and their perspectives of meaningful and inspirational activities.

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