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ARE HEALTH BEHAVIOUR AND PSYCHOLOGICAL WELL-BEING TAKING INTO ACCOUNT IN OLDER PEOPLE´S CARE AND SERVICE PLANNING IN HOME CARE?

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THESIS
Abstract

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Abstract

The aim of this study is to depict the overall contents of older home care clients' electronic care- and service plans based on the Finnish Care Classification. In addition, the aim is to evaluate how the clients' health behaviour and psychological balance have been considered in these care- and service plans. The topic is relevant in Finland and in many other countries, because structured nursing documentation is essential in everyday care giving as well as planning and assessing the care. The care- and service plan is crucial to in-home care; because all the care should be based on this plan which is made in co-operation with the client.

The study is a quantitative study. A quantitative study is a formal, systematic process to create numerical information about the subject that was studied. A quantitative method was chosen for this study because the research questions could be answered with this method. (Bloomfield J & Fisher MJ 2019.) In this study, document analysis (Anttila 1996) was chosen as one of the research methods because the aim of the study was to conduct a descriptive retrospective narrative from documentary material (Grove et al. 2013, Kankkunen & Vehviläinen-Julkunen 2013).

The information was gathered from 80 care-and service plans and 79% of the care-and service plans were made by women. Clients were between the age of approximately 65 and 90 years of age. Mainly the care -and service plans were done for women, who were over 70 years of age.

In care-and service plans (N=80) there were a total of 1213 documentations in FinCC-classifications, which included 596 in clients' needs (FiCND) and 617 in nursing interventions (FiCNI). Daily activities were the most documented component (21,9 %). Clients' needs (FiCND) or nursing interventions (FiCNI) that were included most in care and service plans were "Planning the continued treatment" in 77 of the care-and service plans and "Supporting the patient´s coping" in 74 care-and service plans. Health behaviour was the second least included category with 0,1% of total inclusion in the care-and service plans; this means that it was included in one plan. Respiration was included in four care-and service plans which means that it was included in 0,3% of the plans. In addition, there were no inclusion for the component Life Cycle.

As the results show the care- and service plans in home care are focused on physical issues and far less often psychological or health promotion. One of the reasons they are not so well documented could be that the issues are more difficult to address; there might be a chance that you as a home care professional cannot see all the issues related to health promotion or psychological issues.

Keywords
older people, home care, care and service plan, health behaviour, psychological balance, nursing documentation, quantitative study, document analysis

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1. INTRODUCTION

Population getting older is a global phenomenon. Many older people wish to spend their pension years active and healthy and for them to attain this there should be created a society where older people can have a healthy and active life through participating for example in social gatherings. The factors that might prevent older people living a healthy life and these include different psychological and socially acclaimed problems which occur with old age in addition to different diseases. (Arai, H. et al 2012.)

In Finland there will be lot more older people in the following decades, and this is one of the reasons why government is involved in many different projects to evolve home care and add digital services to older people. There is for example "The description of the enterprise architecture - The "Home care for older people will be developed and informal care enhanced in all age groups" (I&O) key project" which provides information about digital services. This project has been developing different services for older people so that the services are more equal as well as better coordinated. There is digital architecture which focuses on describing digital services for older people. (Silius-Miettinen, Noro, Lähesmaa & Vuokko 2018.)

One of the digital solutions is electronic nursing documentation. The documentation in nursing is always relevant and nursing and documentation in older people´s home care is a relevant subject when the number of nurses is mandated by law and discussion about the quality of older people´s care given. Documentation of care and service plans summarize the planning process of older home care clients´. Care and service plan combines the needs, goals, planned interventions and predicted outcomes of older clients and it also aims to guide the realization of care and support needed to ensure older persons independent living at home (Charalambous & Goldberg 2016; deCarvalho et al 2017).

The documentation practices and forms of care and service plans vary nationally, in Finland, and internationally, and raise questions about the comprehensiveness and consistency of the care and service plans for older people (Bökberg et al 2015; Charalambous & Goldberg 2016; Turjamaa, Hartikainen, Kangasniemi & Pietilä 2015).

This study is significant because in the future more and more people are going to be clients in older people´s home care and the importance of the documentation is getting even more significant because there might be 10 different nurses working with one client in one week. Client safety can be compromised if the needed information about daily care or care plans are not up to date. People over 70 have expressed that they worry about their own coping and their nutrition might get worse and also their physical ability to function may decrease if they can´t go outside. Because of the restrictions in the society many older people have now a void in their lives because they don´t have their daily activities available. (Rissanen et al 2020.)

At the same time, previous study indicates that in many countries older people have a better life satisfaction than the younger generations and this may be explained in part by the fact that nowadays older people have a better potential for recovery, adaptation and also psychological growth. These are important factors when talking about well-being in older people´s lives. (World health organization 2015.)

2. OLDER PEOPLE'S WELL-BEING AND DOCUMENTATION OF CARE AND SERVICE PLAN IN HOME CARE

2.1 Older people´s well-being and need for care and services.

In Finland there is a little over one million people who are over 65-years of age. Almost one million of them lives their lives un-assisted and different kinds of health- or social services are being provided to about 150 000 people. Regular services provided in home are being carried out to 95 000 people and about 50 000 people are living or staying in places where the care is being given around the clock. (Ministry of Social Affairs and Health 2017.)

Most of Finnish older people do not need constant social- or healthcare services. Many illnesses, for example dementia and different physical or psychological restrictions will increase with age and this is the reason why the eldest people will need more services. Most people who are over 90-years of age have some kinds of restrictions in their performance in everyday life. These restrictions however are not distributed equally; people who are less educated, who have been in manual labour and have smaller incomes have more restrictions which affect their everyday lives. (Ministry of Social Affairs and Health 2017.)

Currently, ageing can be looked at as a rewarding period of life with an emphasis on older people's healthy aging including aspects of well-being (World health organization 2015). Well-being of the older people has been described in a variety of ways, such as life satisfaction, social relationships and economic position. People under 80-years of age are feeling healthier, and they have less restrictions in their everyday lives than the prior generation at the same age. (Ministry of Social Affairs and Health 2017.)

According to a previous study, there are many older people who are dissatisfied with their lives. In this study, being female increased the likelihood of life satisfaction by 1.42 times. Higher education levels also had significant positive effect on the life satisfaction. Older people who reported daily walking more than 15 minutes were found to have greater satisfaction with life compared to people who didn´t walk daily. A good physical status also had a significant relation to life satisfaction. (Zeinalhajlou, Alizadeh, Sahebihagh, Mohammadpoorasl & Matlabi 2020.)

When the number of social interactions decrease, people get less social support in their lives and loneliness can be a reason for a lower life satisfaction. On the other hand, having social support in life has a positive effect on life satisfaction. In addition, the study showed that having friends has a correlation with satisfaction with life among older people. (Zeinalhajlou et al 2020.)

It is common for older people to have many diseases and other also different geriatric issues. In home care health-care professionals should be aware of features of geriatric syndromes, which include for example depression and urinary incontinence. It was stated in a previous study that the medical educational system doesn´t have these requirements and this is why geriatric specialists are urgently needed. It has also been recognized that to reduce the length of hospital visits, there should be multidisciplinary work done among healthcare- and other welfare providers so that older people´s staying in their homes can be promoted. (Arai et al 2012.)

Older people may have psychological changes when they go through an environmental change and this can cause their disease symptoms to get worse and. This is one of the reasons that in older peoples´ care it should be remembered that treatment should be planned with a holistic view of an older person´s life. This may delay the older person from entering assisted living because their functions have been assessed holistically, so that all of their aspects of life have been taken into consideration. (Arai et al 2012)

Read, Grundy & Foverskov (2016) argue in their study that that poorer social economic position is linked to poorer subjective well-being and feeling of health. Social economic position had various impacts in the findings; associations were weaker among the oldest groups of people. Gender on the other hand seemed not to have an impact on social economic position related to subjective health- and well-being. Most of the 71 studies indicated some association between social economic position and subjective feelings of health and overall well-being. (Read, Grundy & Foverskov 2016.)

In addition, the status of the person´s occupation resulted in better comparative self-rated health. Overall, the association between the person´s life quality and education more important in physical aspects than in the psychological aspects studied. Only one study stated that better income was in closely related to psychological but not with physical aspects of life quality. (Read et al 2016.)

Dow (2015) states that well-being has focused on the factors related to psychological health and well-being. In this research it has been shown that the social activities and networks improve older people ´s well-being. In this report 10 older women were interviewed, and they said that having support and being able to support others gave them a sense of belonging. This study concerning older people in home care found that their quality of life and positive feelings about their moving to a residential care unit if needed, were improved by being physically able to do different activities, not feeling depressed, and having family and psychological support. (Dow 2015).

2.1.1 Health behaviour among older people

Health issues among older people are mainly caused by chronic illnesses and many of them could be prevented or delayed by focusing on health behaviour. Supportive surroundings can also improve their health-related issues and their personal growth can continue to grow. But unhealthy behaviour is a general problem among older people and the health care systems can be poorly aligned for the needs of older people. (World health organization 2015.)

A previous study shows that the rates of poor self-rated health was higher with older people who were non-alcohol drinkers compared to people who drank alcohol. Also, in previous study it was shown that the highest incidence of poor self-rated health was with people who had quit drinking alcohol. On the other hand, the older people who reported quitting drinking, reported improvement in self-rated health within ten years after the study was conducted. (Frisher et al 2015; de Oliveira & Holdsworth 2015.)

Furthermore, a study was made involving almost 20 000 over 50 year olds were taking part in a study between the years 1995 to 2012. This study examined the effect of cognitive impairment related to health behaviour among older people. People with some kind of cognitive impairment without dementia were more likely not to take part in vigorous physical activity. These parameters were not significantly related to smoking or alcohol drinking. The study concluded that these parameters were risk factors for older people being physically inactive. It was shown that vigorous physical activity was decreased by 16 % when having dementia or cognitive impairment without dementia. It was also shown in the study that people with dementia were more likely to be smoking cigarettes at the time of the study than people without dementia. (Sung-wan & Xiaoling 2020.)

In Finland, older people between the ages of 65 and 84 who smoke daily are about total of 7% who smoke daily. In the last decade smoking among the adult population in Finland has been decreasing but this development seems to have ended in the year 2018. Quitting smoking can help to deal with stress and it also improves the quality and quantity of sleep. If a person is having anxiety or depressive thoughts, quitting smoking can relieve these symptoms often in a 6-month period as efficiently as medication. (Finnish institute for health and welfare 2018b; Finnish institute for health and welfare 2020g.)

For older people in Finland the most common issue with substance abuse is with alcohol consumption. Clinical symptoms are for example mood changes, depression, delirium, sleeping problems, neglecting daily functions and recurring accidents. Overall, when older people have excessive alcohol use, the symptoms and social issues are similar to the younger population. (Koponen & Leinonen 2019.)

Alcohol abuse and it´s damages are higher with older people because older people are usually smaller than the younger population, so an equal amount of alcohol used can cause higher alcohol levels in blood and it can also cause problem for example in liver or stomach. Because older people´s organ

systems are generally weaker than the younger population, they are also more sensitive to the intoxicating effect of alcohol. (Koponen & Leinonen 2019.)

With older people, problematic usage of alcohol can be because they have had problems with alcohol when they were younger. If the problematic usage of alcohol has started at an older age, it is usually related to relevant losses, for example losing a spouse. It has been noted that using for example AUDIT or laboratory tests with older people, works well for mapping out the problem. (Koponen & Leinonen 2019.)

Among older people, 6% of the causes of death were caused by alcohol related issues in the year 2013 between the ages of 65-74 in Finland. In the last decade alcohol related deaths have almost doubled in Finland. There are many negative health factors that can shorten the lifespan of older people and alcohol can almost triple the risk of dying. (Äijö 2015.) The current generation of older people uses more alcohol than the generations before them, and alcohol can cause problems with sleeping. Many older people have problems with sleeping, and the reason which can´t be solved for that is a problematic use of alcohol. (Alanen & Leinonen 2014.)

2.1.2 Older peoples´ psychological well-being

Older peoples' psychological well-being consists of psychological well-being and this includes social activities. Approximately 16 to 30 % of over 65-year old Finnish people suffer from some kind of psychological disorder. Usually the disorders are the same as middle-aged people suffer from, but often there are also some physical symptoms involved. The most common problems are mood-disorders, anxiety, psychosis and psychological disorders which are caused by organic reasons for example urinary infection. It is important that people over 65-year of age can get in to help fast when the symptoms appear, because they can lose their physical and social performance. When figuring out the psychiatric symptoms and somatic issues, an evaluation of the persons overall situation in life needs to be taken into consideration, for example social contacts and living conditions. (Koponen & Leinonen 2019.)

When older people are depressed, they have certain symptoms and they are the following: talking about somatic issues, loss of appetite, losing weight, psychomotor changes, punishment- and poverty delusions and self-destructiveness. When people grow older loneliness and different lack of senses can cause symptoms including being delusional. When older people get into treatment early and they get proper treatment, their prognosis is as good as younger people. (Koponen & Leinonen 2019.)

Almost all psychiatric diseases involve problems with sleeping and for example psychosis often start with insomnia. When older people are depressed their daily ability to function decreases and psychosis symptoms occur more than with the younger population. (Alanen & Leinonen 2014.)

It is recognized that the role of health professionals varies when identifying depression among older people. Dow's research (2015) examined different risk factors and use of services over the course of one year in older peoples' home care and how these impacted depression. This study showed the important role the home care organizers and healthcare workers play in observing depression in older people living at home. It was also shown in these studies that awareness of depression among the healthcare workers increased when they routinely used the "Cornell scale" for accessing depression and dementia. (Dow 2015.)

According to Chipps et al. (2015), almost 83% of the participants reported a fair sense of well-being, and the rest of the participants a poor sense of well-being. There were only 5 participants who reported severe psychological stress and it was also shown in the results that men showed more psychological stress than women. The participants who reported that they were psychologically well, had higher levels of social connections and more social support, which is widely associated with psychological well-being. Participants who felt that they were psychologically well also reported more that they were able to confide in their children and grandchildren. (Chipps & Jarvis 2015.)

There has been made a study regarding the EASYCare Standard 2020, which is being used as a instrument for older peoples´ point of view identifying health related issues, wellbeing and also functional independence. This study was made to determine whether this instrument can be used as a self-assessment tool, and if it will give comparable results to assessments done by professionals. The study had 100 participants who all lived in their own homes. There were 20 participants who had symptoms of depression and all the participants were relatively independent. It was shown in the study that self-assessment scores were consistent with the same- and other tools used by professionals. In this study it was shown that there is a possibility to use self-assessment tools in everyday practice with older people who don´t have dementia. (Tobis et al 2018.)

Anxiety has similar frequency rates as depression, but there are fewer studies that focus on anxiety. One study suggests that anxiety might have a bigger influence on the quality of life than depression, but further studies should be done about the subject because of the small sample size in the study. (Dow 2015.)

Loneliness has also been studied and there has been studies that aimed to determine the prevalence of loneliness and possible elements related to this issue among older people. There has also been made a prior study about using brochures containing self-help information about easing the feeling of loneliness in a community for older people. In this study the loneliness factor was measured by a straightforward question about how often the older people felt loneliness. 7% of the respondents reported that they have felt severe loneliness, and 31,5% said that they felt lonely sometimes. Social networks were identified as important for easing feeling loneliness, and in addition living alone and poorer self-evaluation of health situations were seen to be associated with more loneliness. (Dow 2015.)

A previous study also showed the connection between feeling lonely and experiencing health problems. This study had a sample of 332 older people and 52% of the people answered were found to have either some loneliness or severe loneliness. There was as association between loneliness and lower physical and psychological health scores. (Dow 2015.)

Psychological health has an impact on a person's well-being and in a study of interviews with older people in multiple countries, it was revealed four themes were identified which impacted their well-being: social distancing and feeling lonely, social worth, self-determination and the feeling of being safe. There were positive and negative components of psychological health influencing well-being of older people related to these four categories. Loneliness was identified to have an impact on their psychological well-being; lack of social networks, no family and not being connected to society caused the feeling of social isolation. Loneliness was seen as a negative experience which had an impact on psychological health well-being. This feeling also sometimes caused the fear of being alone. The positive impacts on well-being as coming from a on feeling of being cared for, getting attention from close relatives and other significant people and basic interaction with other people was also a factor to contributing to psychological and emotional well-being. (Moyle et al 2010.)

One of the participants specifically expressed the attention they get from their children to be important when thinking about psychological health well-being. In a previous study (Moyle et al 2010.) it was mentioned that "the love and attention my husband and I get from the children is very important to me."

2.2 Older people´s home care in Finland

In Finland very elderly and people who have many different needs are being taken care of in their own homes. Between the years 2016 to 2018 the daily client amount for caregivers increased by 4000. In May of 2018 there were about 51 700 people in home care. (Finnish institute for health and welfare 2020d.) R

The national goal in Finland is that older people can continue to live in their own homes for as long as it is possible, even for the rest of their lives. When people are in need of care, they will get it in their home or else in a home-like environment. Many times, the care and other services brought to an older people´s home is a combination of different service providers. (Finnish institute for health and welfare 2020d.)

The Social Welfare Act states that a person has the right to get different services in their home which includes housing, personal care, and other basic needs in everyday life. Home care is being provided to people who can´t cope in everyday life on their own but are not in need for an around the clock assisted living. In the year 2015 there were about 95 000 people in Finland who got services to their home provided by home care or by a caregiver who is part of their family. Older people are entitled to live their lives in their own communities and when making care- or service plans they should be

part of stating the goals, select what they are interested in in activity wise, how they are implemented and they should also have right to assess their own performance. It is also stated in the Elderly Services Act that older people needs should to be included in the process when there are some decisions made regarding their services. (Elderly Services Act 28.12.2012/980, Ministry of Social Affairs and Health 2017, Social Welfare Act 30.12.2014/1301.)

Home care means services that are being provided at peoples´ homes when they are in the need of these kinds of services because of their overall state, and these services are stated in the Social Welfare Act (20§) and Health Care Act (25§). The Health Care Act states that home care is done based on the client´s care and service plan. (Health Care Act 30.12.2010/1326, Social Welfare Act 30.12.2014/1301.)

Older people can be home care´s client only when their health condition has been evaluated and after that the client and their home care workers can do their care- and service plan in co-operation with the client. There are different ways a person can qualify for a performance evaluation; sometimes people seek help for themselves, sometimes their relatives seek help, sometimes social- or healthcare professionals bring the issue forward and sometimes neighbours report their concern to professionals. (Elderly Services Act 28.12.2012/980 980; Ministry of Social Affairs and Health 2017; Ministry of Social Affairs and Health 2020b.)

There are different aspects in older people´s life that can be included to a client's care- and service plan and the following also support the client's possibility to live at their home including home care, support services for home care, the support coming from their loved ones, and voluntary workers and technological solutions. (Finnish institute for health and welfare 2020d.)

Other services that can be provided to older people when living in their home include assistive equipment, daytime activity, and alteration work in the home by physiotherapy providers, rehabilitation professionals, doctors, memory nurses and social worker´s services and palliative care. (Finnish institute for health and welfare 2020d.)

There are also supportive services which are being used to reinforce the personal care provided by home care. These services are usually the first services provided to older people to assist their living at home and these services include meal services, cleaning services, clothes care, aid with going to the shops and running errands and transport services. (Ministry of Social Affairs and Health 2020b.)

There are differences in ways European countries utilizes services to people with dementia and in Finland there are more people taken care of at their own homes when they have dementia compared to some other countries where there are more places where there is around the clock care given. Also the following facts differ in different European countries, which may affect the way the care system has been utilized: the political system and the fact that the sense of obligation towards a family member with dementia was more pronounced in some of the countries but in Finland the feeling was not so apparent. (Bökberg et al 2015.)

2.3 Care- and service plan as a part of planning the services in home care

According to the Elderly Services Act the older person´s need for services needs to be addressed in a way that their involvement is being supported. The requirement of being part of their own care´s planning means they should be involved in the planning process. When older people and their loved ones are being included in the planning of their care, the life history of the person is being taken more into consideration in the care itself. In home care older people are being included in the planning more than in care facilities where care is being provided around the clock. (Elderly Services Act 28.12.2012/980, Erhola, Alastalo & Kehusmaa 2017.)

In home care over 80 % of clients who had maximum mild dementia symptoms felt like they were included in the planning of their own care. The clients stated that they had less opportunities to be included in the planning if their dementia symptoms were more dominant and when dementia got severe the clients were not taking part or were not included in the planning of their services or care, this part-taking was assessed by their loved ones or care takers. (Erhola et al 2017.)

It is stated in the Elderly Services Act that the client and / or his or her legal guardian should have a mutual understanding when the plan is being done. The client's needs, interests and opinions should be the number one priority when making the care- and service plan and the right of self-determination should also be taken into consideration while making the plan. The client must have a chance to participate and have a say in planning and implementing the plan. The thoughts and wishes of an older people must be heard while making the care-and service plan so that there can be an overall view of the person's life situation, goals, strengths and challenges. (Elderly Services Act 28.12.2012/980.)

It is important for an older person that they can be involved in the planning of their services and care. It is also important that the service entity can adapt to their needs and wishes. When the service entity is being tailored to meet the client's needs, the services can be more cost efficient and of higher quality. The client is always essential when making their care- and service plan, because they are the experts of their own lives. (Finnish institute for health and welfare 2020f; Päivärinta & Haverinen 2002.)

The ASLA study was conducted by the Finnish Institute for Health and Welfare in the fall of 2015. There were 2940 participants who were clients in home care across the country of Finland and they were asked about their experiences of the quality of the care they have received. The results show that people who are clients of home care participate more in the planning of their care than people who are living in places where they receive care around the clock. (Kehusmaa, Vainio & Alastalo 2016.)

People who were clients of home care answered that 80% of them participate in the planning of their care always or most of the time. Most of the respondents replied that they receive enough information

about their care. Almost 90% of the respondents living at home and getting services from home care feel that they get enough information about the care they are receiving. (Kehusmaa et al 2016.)

Studies have been made that suggest that shows how much care- and service plan can have variations in their documentation and also in their coverage of different aspects of a client´s life. Many of these documentations are focusing on planned actions instead of evaluation of needs. Psychological balance´s documentation has been minor, even though it is one of the aspects included in the evaluation that should be included in the care-and service plan. (Puustinen 2018.)

A good care- and service plan is a summary of a person´s personal situation and the services they need. The plan includes the person´s rehabilitation and service needs, the goals planned with the person and also the actions to take so the goals planned can be accomplished. There also needs to be follow up with the client, the documentation of the experience of the actions and the effects of the actions needs to be assessed continuously in nursing documentation. When a person takes part in the preparation of their own care- and service plan, older people have a chance to make, execute and also assess the plan. When person takes part in the process the right to get treated with dignity and respect as it is stated in the ethical principles which guide the work done with older people is more likely to be carried out. (Päivärinta & Haverinen 2002.)

When assessing the life situation and performance the state and environment of the person´s living conditions must be observed, and it is recommended that the plan is done in a place which is familiar to the client. It is extremely important that a person with dementia symptoms have their rights considered when making a plan for them. When a person has dementia, also their loved ones should be included in the process of making a care- or service plan. There must always be an opportunity for that the person can to invite someone near to them to accompany them in making the plan. When the plan is made together with the client and possibly with their loved ones there is less of a chance to have misunderstandings when it comes to the person´s care and other services. (Päivärinta & Haverinen 2002.)

2.4 Structured nursing documentation based on FinCC Classification

According to the Decree of the Ministry of Social Affairs and Health about client documents (298/2009) the client document needs to have the following information so that the patients care and follow up can be secured; organization of client´s care, planning, and implementation in a way that the documentation is clear and understandable. The documentation must provide the information about how the care has been provided, and whether happen something special happened during the care, and what kinds of solutions have been made during the time in care. Also, the people who have been part of the persons care must be able to be identified if needed. (Liljamo, Kinnunen & Ensio 2012.)

Nursing documentation in Finland has been studied and the following are for example the publications made on the subject in the last 6 years. In 2012 the National Institute for Health and Welfare published

a final report of the findings by the experts on advancing nursing and multi-professional documentation practices and guidelines – recommendations and suggested measures. This expert working group working with this report focused on three themes: making the national documentation model easier, publishing recommendations for standardising client records and improving documentation practises. (Nykänen & Junttila 2012.)

In 2014 National Institute for Health and Welfare published the results of a systematic literature review called "Structuring of the electronic client record: methods, assessment practices and impacts". In the review it stated that the impacts of structured documentation have not been studied much from the professional's point of view. It also shows that in Finland documentation practices require training and management support for it to be successfully used. Currently, there is only little evidence of the impacts of structured documentation. (Hyppönen, Vuokko, Doupi & Mäkelä-Bengs 2014.)

In 2016 the National Institute for Health and Welfare published preliminary report called Development of a Health and Care Plan 2016. This publication reports the results of a preliminary study of a health and care plan in 2015-16. 77% of the people who answered were healthcare professionals, and 57% of all the people who answered said that they are using health and care plan in their work, although some of them called it in a different name. (Mäkelä-Bengs, Virkkunen & Vuokko 2016.)

The systematic documentation of client's health information means that the care is being described in the client documentation system. Care processes are the following: defining the need for care, planning the care and assessing the care given. Nursing documentation includes terms, structured core information and documentations filling this information. (Liljamo et al 2012.)

Electronic documentation consists of different information groups- and sets and includes structured information. These information sets are categorized in different information groups based on the actions and steps in the care process. These information groups are displayed by headlines which can be used in multi professional cooperation and it also helps to find certain information in the medical files if needed. (Liljamo et al 2012.)

In healthcare, there are different structures in documentation. When the documentation is done in informal format, the information can be divided and structured with different topics and views. Different codes, classifications and terms can be used in documentation when they are jointly agreed on. All the information needed in a client's care have been defined in structured info contents. This means that all the information documented needs to be filed in the field specifically designed for that. When the information is structured, it means that the data can be identified and it can be dealt with in a digital way. (Finnish institute for health and welfare 2018a.)

This healthcare structure improves client's treatments quality when it is done by the care standards. When the information is up-to-date and consistent it supports client safety. There is also less confusion with interpretation between the client and health care professionals when the data is in structured

form. For the future reference, the data can be collected automatically for example through statistics and registry information. (Finnish institute for health and welfare 2018a.)

The use of structured nursing documentation can provide high-quality multi-professional care, because it has continuity and it also can have a positive effect on client safety. There have been some critical responses related to use of classifications because the information is hierarchical, and it may seem to serve more administrative need than client ´s needs. (Saranto et al 2014.)

FinCC is short for Finnish Care Classification system (FinCC) and the current version is 3.0. The system is a collection of three national classification systems: the Finnish classification of nursing diagnoses (FiCND), the Finnish classification of nursing interventions (FiCNI) and the Finnish classification of nursing outcomes (FiCNO). (Liljamo et al 2012.)

FiCND and FiCNI are being used for nurse documentation and the purpose of FiCNO is to estimate the outcome of the care process with three different outcomes: improved, stabilized and deteriorated. In FiCND and FiCNI there are a total of 545 categories when sub and main categories are combined. The classification system has been updated based on "feedback, evaluation, comments and suggestions from users in the healthcare field in 2010". The study was conducted by the National Institute for Health and Welfare, the FinCC group of experts and the Department of Health and Social Management of the University of Eastern Finland. (Liljamo et al 2012.)

In 2011 Finland started to use Kanta, where residence can see their health care information and Kanta needs structured documentation for it to work. FinCC uses structured documentation and by this the data written with the help of FinCC can be transferred to Kanta. (Liljamo et al 2012.)

Based on these facts, more knowledge is needed to understand how the clients' health behaviour and psychological balance have been taken into account in documentation. This information is significant to improve care planning and documentation in home care that can promote older people living in their own home. (Liljamo et al 2012.)

3. AIM OF THE STUDY

The aim of this study is to depict the overall contents of older home care clients' electronic care- and service plans based on the Finnish Care Classification. In addition, the aim is to evaluate how the clients' health behaviour and psychological balance have been considered in these care- and service plans. The topic is relevant in Finland and in many other countries, because structured nursing documentation is essential in everyday care giving as well for planning and assessing the care. The care- and service plan is crucial for home care; because all the care should be based on this plan which is made in co-operation with the client.

The aim of the study in general is to collect information about older people´s home care with respect to the different variables mentioned above. Nursing documentation is an important and efficient way of gathering this information. When this information is analysed there will be evidence-based results about this important and relevant topic.

The specific research questions are the following:
1) What are the contents of care and service plans according to the FinCC Classification?
2) How has the client´s psychological balance and health behaviour been taken in consideration in the care- and service plans?

4. METHODS

4.1 Document analysis as a quantitative method

The study was a quantitative study. Quantitative study is a formal, systematic process to create numerical information about the subject that was studied. For example, in nursing research quantitative study could be effectiveness of treatment. Whenever a nursing study is made, it needs to be based on evidence which has been defined to be the combination of research, clinical experience, local information and the client s´ experiences in the delivery of care and healthcare services. (McIntosh-Scott, Mason, Mason-Whitehead & Coyle (edit) 2014; Grove, Gray & Burns 2015, 30-31.)

In a quantitative study there are different ways to gather information, such as questionnaires. (Ingham-Broomfield, Rebecca 2014.) With a quantitative method the person doing the study can gather more numerical information and this data collected can be used to make infographics about the data gathered and analysed. The idea with the data collected is to find patterns within the material and analyse this information gathered. When doing a quantitative study, the person doing the study needs to be very observant and careful so the study stays reliable and valid. (Valli 2015.)

The quantitative method was chosen for my study because the research questions could be answered with this method. Quantitative research creates data which is in numerical form and it has a high impact in nursing and healthcare because it can used to measure different parameters in an objective way. (Bloomfield J & Fisher MJ 2019.) In this study, document analysis (Anttila 1996) was chosen as one of the research methods because the aim of the study was to produce a descriptive and retrospective information from documentary material (Grove et al. 2013; Kankkunen & Vehviläinen-Julkunen 2013).

4.2 Research environment

The research was carried out in a town belonging to the province of North Savo. Home care services are based on a care and service plan drawn up by the client, relatives and home care professionals,

which is updated if necessary, but at least once a year. The focus of this study was the care and service plans for older home care clients. The organization involved in the study has about 800 regular home care clients, who are considered older people and, in the organization, working practical nurses, registered nurses, public health nurses and home care service managers.

4.3 Material and data collection

This study is a part of a wider study that will be carried out at the University of Eastern Finland. First, the ethical approval was received by the Research Ethics Committee (date 15.12.2015, Dnro 453). After that, the permission from the research organisation was obtained. The data in this study were the care and service plans for older home care clients of the organization participating in the research. Daily documentation for nursing were limited to the exclusion of the research. The documented care and service plans were stored in an electronic medical records system.

Home care professionals were instructed to choose care and service plans for one or two of their clients according to the research. So, sampling of care and service plans was conducted as a convenience sample (Grove et al 2013). The care and service plan should be agreeable to be documented by the home care professional himself and made for an older client. A more accurate age limit was not used, and it was not seen to be justified in the context of the data. Professionals were requested to print care and service plans and delete all personal and identification information from them before participating in a monthly meeting where the material was collected.

Data were collected during autumn 2017 in association with the home care service manager. The researcher provided the home care service manager detailed information about the data collection method and criteria for the data selection. After that, the manager informed home care professionals via email and asked them to bring their clients' care and service plans to the home care professional's next meeting. The home care professionals brought the care and service plans and before that, the care and service plans were anonymized. The final data comprised of care and service plans for older home care clients (N=80).

4.4 Data analysis

The numerical material can be shown in two forms, which differ from each other. Firstly, the information can be seen in raw figures and for example in percentages and after that the data is shown more visually as in histograms or in different graphics. (Ingham-Broomfield 2014.)

In the first phase, I read all the 80 care and service plans to understand what the material consists of. There were very different care-and service plans; some were very detailed and others had a few components included. Not all care-and service plans had a follow up attached to them. Care-and

service plans used FinCC-titles in use and all the different components used in the plan were documented separately.

I did not go through the open text areas thoroughly, because the information I was looking for was the numerical data. I only looked at the open text areas, and to see if there was some evaluation or the client's wishes or goals added to the documentation, or if there was any open text at all in the care- and service plan.

I analysed the different components by using a structured menu (based on FinnCC classification) in care and service plans, and by quantitative methods using frequencies and percentages using the statistical tools Microsoft Excel by Microsoft for Windows (version 20.0).

I made two different Excel documents to gather information. First, I made an Excel table where I gathered background information such as age and sex of the older people. The numerical information is also in percentages in this table (Table 1). I did not use them as variables when analysing the data, because 79% of the care-and service plans were done for women and only 6% of the care-and service plans were made for people under 70 years of age.

In the first Excel data set, I also gathered information about the documentation of the care-and service plan such as how many of the plans had an evaluation added to them, and in how many care plans was there a documented goal of the older person in hand or how many plans had false documentation in them. I also included data about in how many evaluations the client's voice was visible and in how many care-and service plans included planned actions for the care-and service plan. To this Excel data set I also added more detailed information about how many men and how many women had different components added to their care-and service plans and how many care- and service plans had an action ended without a reason like for example "the situation has improved".

The third step was for me to make a structured table of all 17 components of the FinCC (Liljamo et al 2012) (Table 2). In this table I separated FiCND and FiCNI categories in each of the 17 component and also counted the total sum of documentation of each 17 components. In this table I also provided the numerical values in percentages. The information is shown in this table is from the most frequently documented component to the least documented component.

I also constructed more detailed tables of all 17 components so it could be shown how many different components and categories were used in care-and service plans (Table 3, Table 4 & APPENDIX 1: Table of data gathered). In Appendix 1 the numerical information can be seen in a more structured and in informative form. I added the information about all components in the Finnish classification of nursing diagnoses (FiCND), and the Finnish classification of nursing interventions (FiCNI). In these tables there are no percentages used because the information would be too fragmented because most of the categories were used only once or twice.

After these steps I started to analyse the results gathered in Excel tables and the following paragraphs show the results I found from the material. In the following paragraph I will present the numerical data gathered.

5. RESULTS

5.1 Demographic and contents of older home clients' care and service plans

The information was gathered from 80 care- and service plans and 79% of the care- and service plans were made for women. Clients were between the age of approximately 65 and 90 years of age. (Table 1.) Mainly the care- and service plans were done for women, who were over 70 years of age. The client´s own voice was documented in 42 of the care-and service plans and four of them had the client´s own personal goals for the treatment documented such as the client could be able to turn in bed by themselves and they could have better balance while they are sitting down. Evaluation of the planned actions was included in 43 of the care-and service plans. In evaluation or daily documentation had 54 plans which had client´s own voice and opinions documented.

In 62 of the care-and service plans all components were included in the plan (the Finnish classification of nursing diagnoses (FiCND) and the Finnish classification of nursing interventions (FiCN) and in 19 women clients had documentation corrected in their care-and service plans; they were for example related to old care and service plans and were not relevant anymore. There were also 3 care-and service plans which had activities ended but they were missing the reason for these actions.

TABLE 1.

Demographic details of 80 care- and service plans

Demographics of care- and service plans	*n*	*%*
Gender		
Female	63	79
Male	17	21
Age		
Under 65	1	1
65 – 70	4	5
71 – 80	18	23
81 - 89	45	56
Over 90	12	15

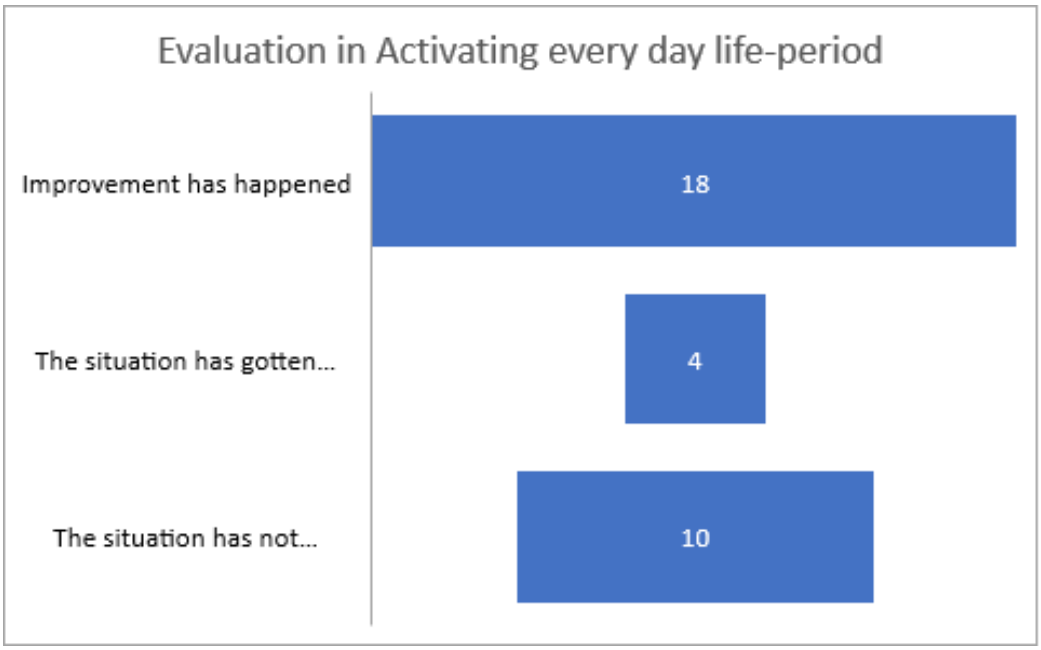
Activating every-day support-period was a specific time period where the workers concentrated on certain daily activities. Evaluation of this period was mentioned in 32 of the care and service plans

and 18 people were evaluations showed that their activity has improved, 10 people were evaluated so that there had been no change and 4 had been evaluated so that their condition had gotten worse during this period. Supporting the client ´s coping was mentioned in so many care and service plans because the clients in home care have, according to these care and service plans studied, weakened coping.

All of the 80 care and service plans should have had an "Evaluation of Actions"-component and that component should have included an "Activating everyday life-period" because that was supposed to be included in all 80 care and service plans, according to older people´s home care in the area. Chart 1 shows information about the evaluation in Activating everyday life-period in the 32 care and service plans where the evaluation was included.

CHART 1.

Evaluation in Activating everyday life-period.



5.2 Documented clients' needs and nursing interventions.

In care and service plans (N=80) there were a total of 1213 documentations in FinCC-classifications, which included 596 in clients' needs (FiCND) and 617 in nursing interventions (FiCNI) (Table 2). Daily activities were the most documented component (21,9 %). Clients' needs (FiCND) or nursing interventions (FiCNI) that were included most in care and service plans were "Planning the continued treatment" in 77 of the care-and service plans and "Supporting the patient´s coping" in 74 care-and service plans. "Patient´s weakened coping ability" was in 68 care-and service plans. "Actions encouraging activity" was included in 67 care and-service plans and washing and hygiene was added to both Need for care/subclass and Actions in nursing/subclass 66 times in the Daily activities-component.

Health behaviour was the second least included category with 0,1% of total inclusion in the care-and service plans; this means that it was included in one plan. Respiration was included in four care-and service plans which means that it was included in 0,3% of the plans. The fourth least included category was Metabolic which was added in 12 care- and service plans which means that it was included in 0,9% of the plans. In addition, there was not any inclusion of the component Life Cycle, this component includes for example palliative care.

TABLE 2.

The overview of documented nursing diagnoses (FiCND) and nursing interventions (FiCNI) in client's care and service plans (n=80).

	FiCND	**FiCNI**	**Total**	**Total %**
Component	**n**	**n**	**n**	**n of 1213**
Daily activities	150	115	265	21,9
Coping	107	78	185	15,3
Coordination of care	95	84	179	14,6
Medication	32	116	148	12,2
Activity	66	81	147	12,1
Nutrition	27	48	78	6,4
Circulation	24	24	48	4,0
Safety	27	10	37	3,1
Secretion	12	23	35	2,9
Skin integrity	19	8	27	2,2
Psychological balance	11	8	19	1,6
Sensory and neurological functions	8	9	17	1,4
Fluid balance	8	6	14	1,0
Metabolic	6	6	12	0,9
Respiration	3	1	4	0,3
Health behaviour	1	0	1	0,1
Life cycle	0	0	0	0,0
Total	*596*	*617*	*1213*	*100 %*

5.3 Documented clients' health behaviour and psychological balance

Health behaviour was mentioned in 1 care and service plan, and once in Actions in nursing/main title (FiCNI) and the main title was Guidance that promotes health. Health behaviour had no documentation in Need for care/main title (FiCND), Need for care/subclass or Actions in nursing /subclass. The overall percentage of Health behaviour inclusion in the 80 care-and service plans was 0,1%.

TABLE 3.

FinCC component, Health behaviour, and its FiCND and FiCNI main categories and subcategories.

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Factors that affect health	0	Smoking habits	0	*Observing the way of life*	0	Follow-up of nutrition habits	0
		Substance use habits	0			Follow-up of exercise habits	0
		Other addiction	0			Follow-up of substance use habits	0
		Nutrition habits	0		0	Follow-up of smoking habits	0
		Exercising habits	0			Follow-up of other addictions	0
		Living conditions which may harm health	0			Follow-up of living conditions	0
Change in the commitment to the care	0	Difficulty in self-assessment ability	0	*Guidance that promotes health*	1		
		Deviating the careplan	0	*Promoting the commitment to the care*	0	Making a care-contract	0
		Refusal of treatment	0			Inclusion in planning and taking part of their care	0
Need for information about health behaviour	0						

Psychological balance was documented in 10 care and service plans. Psychological balance had 11 mentions in total because in one care and service plan this component was mentioned twice. Need for care/main title (FiCND) was mentioned four times; once Fearfulness and three times Change in mood was included in the care-and service plan.

Need for care/subclass was mentioned in 7 care-and service plans; Hallucinations and Delusional were both included in one care and service plan, Anxiety was included twice, and Depression was included

in 3 care-and service plans. Change in mood was mentioned in three care-and service plans and subcategory in all of the three of them was depression.

Actions in nursing/main title (FiCNI) was included in the care-and service plans four times; 3 times Observation of psychological state and once Guidance to improve psychological balance. Actions in nursing/subclasses was also included in four care-and service plans; Observation of mood was included once, Conversation with primary nurse was included twice and Affirmation of sense of reality was included also once. Two of the 80 care and service plans it was mentioned that the client had been diagnosed with depression but neither of these plans had Psychological balance included in them.

TABLE 4.

FinCC component, Psychological balance, and its FiCND and FiCNI main categories and subcategories.

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Change in self-image	0	Change in body image	0	*Observation of psychological state*	3	Recognizing disturbance in perception	0
		Self-esteem disorder	0			Recognising behavioural disorders	0
		Eating disorder	0			Obervation of mood	1
		Anxiety	2	*Therapeutic relationship work*	0	Conversation with primary-nurse	2
Fearfulness	1					Preventing self-harm behaviour	0
Change in the mood	3	Euphoria	0			Increasing understanding and awareness	0
		Mania	0			Affirmation of sense of reality	1
		Apathy	0			Listening to the patient's reality	0
		Depression	3	*Use of different care-and therapeutic methods*	0	Individual treatments and therapies	0

Change in behaviour	0	Aggressiveness	0			Group treatments and therapies	0
		Violence	0			Creative treatments and therapies	0
		Self-harm	0	*Isolation*	0	Interaction and mood observation when in isolation	0
		Repetitive compulsive functions	0			Psychological conversation after isolation	0
		restlessness	0	*Guidance to improve psychological balance*	1		
		Change in personality	0				
disruption of the sense of reality	0	Hallucinations	1				
		Delusions	1				
		Fragmentation	0				
		Incoherence	0				

6. DISCUSSION

6.1 Coverage of documentation

This study provided knowledge about documentation focusing on daily activities, which was the most documented component. In addition, the documentation provided a narrow view of client's health behavior and psychological balance. Moreover, some of the contents of the components were narrowly documented and therefore, the client's perspective was unclear.

The results show that" Taking part in the care-and service plan" was mostly documented in "Planning the continued treatment" under the "Coordination of care" instead of "Health behaviour" and "Inclusion in planning and taking part of their care". More specifically the following categories were used: "Need for information about patient´s rights" and "Need for continued treatment" instead of "Inclusion in planning and taking part of their care".

The FinCC categories have other similarities also which were noticed while analysing the material. Nutritional issues were mostly included in the "Daily activities"-category under "Need for help with feeding" 34 and "Assistance in feeding" 5. Nutrition was on the other hand included in 32 of the care-

and service plans and mostly these two main categories were not included in the same care-and service plans.

Life cycle-category was not included in any of the care-and service plans. Maybe talking about sexuality is also one of the things that might feel uncomfortable for the care providers and it also could lead into assumptions that older people don´t need to talk about issues related to sexuality even though they still might be sexually active.

In Finland older people´s sex lives have been studied in 1992, 1999 and 2007 in FINSEX-study. The subject is more relevant now than ever since a large percentage of the population is entering old age, and recent studies show that continuity in active sexuality has positive health effects. The study shows that sexual interest and sexual activity remain the same with people who live in relationship and most of the responders feel that their relationships and sexual lives are satisfactory. Healthcare personnel should be prepared to give sexual counselling to older people, and they should not be uncomfortable about this subject. Studies have shown that nurses and doctors have positive attitudes towards sexual activity among older people, but these attitudes won´t necessarily lead changes in practices mostly because of strict ruling in older people´s living facilities. (Kontula 2009.)

Not one of the care-and service plans included palliative care. All of the care and service plans had at least three different FiCND or FiCNI categories documented. "Actions encouraging activity" was not included in all care and service plans even though home care had activating every-day support-period and because of that it should have been added to all care-and service plans.

6.2 Narrow view of client's health behaviour and psychological balance

As the results show, psychological balance and health behaviour is not taken into consideration enough in home care. It was stated in one study that the confidence of the health professionals working with people with depression increased when they were provided with education about the subject. The symptoms of depression can sometimes go unnoticed or the health professional doesn´t have enough confidence to talk about the symptoms with the older person or/and their family members. (Dow 2015.) All sleeping related issues are not included in the "Psychological balance" but in the "Activity"-category. Commonly sleeping issues are being treated as an issue that is related to a person´s psychological balance. Sleeping disorder was mentioned in one care-and service plan.

Because there was no mention of people smoking or drinking alcohol or using medication falsely, it seems to me that the home care professionals have a lack of confidence to bring these issues to the table so to say. However, based on an earlier study this is an issue that should be taken to the managers of health care facilities as well as schools for social- and health care studies because there are people who have depressive thoughts, and they have a problem with cigarettes or alcohol consumption; someone just needs to talk to them about it. A study conducted in 2015 shows that the confidence to talk about the subject increases with education. (Dow 2015.)

Most of the clients whose care-and service plans were in the data collected were women, so this could explain the lack of smoking in the care- and service plans because fewer women tend to smoke in this age group than men. (Finnish institute for health and welfare 2018b.)

As recognized earlier (Moyle et al 2010), older people also feel that also the government should take some responsibility of older people´s feeling of loneliness and social distancing, because this is affecting their psychological health and can cause depression. This can also affect the physical health and will cause costs when older people are admitted into hospitals to be taken care of. (Moyle et al 2010.)

The question in the study topic is "Are health behaviour and psychological well-being taking into account in older people's care – and service planning in home care?" and unfortunately, there was not to be found a specific answer to this question based on the material and results in this study. A more specific answer to this question is that electronic care and service plans can support these is mentioned in the question but there should be more counselling to home care professionals on how to get the most from the care and service plan made with their clients and also there should be more courses for nurses and other workers on how to talk for example about substance use and psychological well-being. Without these aspects taken into consideration the care and service plans cannot be used to their fullest potential.

6.3 Issues affecting older people´s home care in the future

COVID-19 started to affect people´s lives in March of 2020 when Finland was put in a state of emergency and people over 70 years of age were put in a quarantine-like conditions. They were supposed to stay mostly in their own homes, and they were not allowed to meet loved ones who they didn´t live with or have physical contact with them. If it was necessary for these people to go to stores and pharmacies, they were advised to do so when there were few people as possible outside. Most of the people who have died of COVID-19, have been over 70-years old and they have also had some chronic illness. (Ministry of social affairs and health 2020a; Finnish institute for health and welfare 2020b; Finnish government 2020 & Rissanen et al 2020.)

Older people are in a risk group for many reasons and because of this their social distancing is important, but it will affect the way they will cope in their everyday lives and their overall coping and their ability to function and state of health will decrease. This means that the number of new clients in social and health services might increase if for example their state and care of chronic illnesses is not at the same level as it was before the epidemic. Before the epidemic the assessment for need of services needed to be done in seven days but this rule was changed so that the assessment for non-urgent clients will be delayed. The situation with older people might change drastically in a short period of time and this epidemic may have caused a delay because of the change in the seven-day rule. (Rissanen et al 2020.)

In home care there has been re-organizing going on because of the epidemic and some new digital health services has been added to their everyday routines. In home care, remote appointments have been increasing, but there is a worry about whether the remote service is giving out a real image of the older people´s situation. There is also the issue that not everyone is capable of using these services because they might not have the equipment and there are some areas in Finland where the connection is not good enough yet. (Rissanen et al 2020.)

Approximately 600 000 Finns use alcohol so much that their risk for harmful effects has increased. Epidemic and restrictions may cause people who use a moderate amount of alcohol to start using more alcohol, and they also may be at the risk of harmful effects. People who have been able to end their alcohol use may end up starting to drink alcohol again because of the exceptional situation in Finland. Even people who don´t have chronic diseases may have harmful effects if they use alcohol more than advised. The harmful effects amplify if the person has other risk factors like smoking or they are overweight. (Finnish institute for health and welfare 2020a; Finnish institute for health and welfare 2020c.)

People who are substance users, can be vulnerable when it comes to coronavirus because many of them have also chronic diseases for example issues with their respiratory system, kidney- liver or circulation diseases. Many of the over 50-year-old´s who are in opioid replacement therapy have chronic diseases and this puts them in the risk category. (A-Klinikkasäätiö 2020.)

Smoking increases the risk of having a serious case of coronavirus because it causes damage in the lung tissue and weakens the defence mechanisms on the mucous membrane. These are the main reasons why a respiratory virus can enter a smoker's system. Electronic cigarettes affect the lungs and also nicotine products used orally can increase the infection risk if hands are not being washed after every use. Older people who smoke are in the high-risk category when talking about coronavirus. (Finnish institute for health and welfare 2020g.)

The psychological symptoms for older people have increased the need for peer support in peer support phonelines. When older people are less in contact with their next of kin, it affects the psychological well-being. When Uusimaa was being quarantined from the rest of the country, many families were able to meet each other less often than usual. Even the older people, who are in good condition, were not able to go to their summer cottages and this might have had some effect on their psychological well-being. When there are fewer social contacts, the risk of having psychological health related symptoms increases and the need for conversation help also increases. (Rissanen et al 2020.)

A study was conducted in April of 2020 in Finland that shows that people in Finland had approximately 75% less social contacts that normally. Adults had approximately 2,5 contacts a day during the week of the study. In the category of people between 70-79 of age, they had half of the social contacts compared to people who were in work life. With regard to "Skin contacts" (hugs, kisses e.g.) people had with approximately 0,78 people in a day. There were no differences between the sexes. (Finnish institute for health and welfare 2020e.)

Older people who have many social contacts and the opportunity to maintain their physical functional abilities are feeling better during the state of emergency. However, the older people who did not have many social contacts may lose their functional abilities and also their quality of life might become worse. The increasing of psychological health issues among older people causes worry at this time. (Rissanen et al 2020.)

6.4 Ethical considerations

The ethical aspect needs always to be taken in consideration when doing a research. In this study, the approval of The Research Ethics Committee was received (date 15.12.2015, Dnro 453), and after that, the permission from the research organisation was obtained. When making a study, you always need to make sure you protect your subjects´ privacy and human rights overall. There are ethical guidelines which set standards for doing a study for example the privacy of all the participants is extremely important when conducting a research. Especially in medical research there should always be extremely high ethical standards because the researchers are dealing with peoples´ personal information. (Grove et al 2015, 93-100; Ingham-Broomfield 2014.)

The subjects´ privacy has been taken into consideration while making this study; the ages and sexes of the people whose care-and service plans have not been specified but the basic information is very vaguely shown in the study. The data which have been selected for this study comes from a larger group of care and-service plans and the names and more detailed basic information have not even been given to me at any point. The geographic area where the data is gathered from, is large and also the information for the place where the data was gathered is also only vaguely alluded to in my study.

Study ethics should be shown in the study in the research section and should include methodology and in the research results, and attestation that the researcher is fulfilling the criteria set for research. Research should also bring something new to the field of study. The researcher must also be honest and specific when doing the research and presenting the results of the study. (Gerrish & Lathlean 2015; Vilkka 2015.)

These study ethic-related issues mentioned in the last paragraph have all been taken into consideration when doing my research and these components have been on my mind all the way throughout the study. Firstly, when thinking about the subject and making the subject more defined and when I presented the results, I was as honest and specific as possible.

In this study I have followed the science community's operational guidelines which are integrity, meticulousness and accuracy doing research, recording the results, presenting them and also in the evaluation of research results. I have also used ethically sustainable and responsible ways to gather information and researching- and evaluation methods. I have also been open about the ways of doing

my study and conducting the results. I have also used references appropriately so that I have given respect to other researchers and their work. Overall I have followed the study ethical principles and legislation guiding research work. (Medical research act 488/1999; TENK 2012).

6.5 Reliability and validity of the study

This study follows the principles of conducting a research; I have made sure that I have integrity and accuracy when conducting my study, analysing the data, presenting and also evaluating the results. I have made a plan that I have followed even before I have started to conduct my study as I have also done during my work when doing the study. I have also cited correctly any information that I have used as a reference in this study. (TENK 2012.)

It has been stated by Leavy (2017) that there are many ways of processing the reliability and validity of a study. For this study, it has been decided that reliability and validity will be observed throughout the study process, starting from planning the study. The validity of the study was improved by careful planning and making sure that all the variables were carefully thought through (Vilkka 2015; Leavy 2017).

The study process is in detailed form in the study plan and in all the stages of the study process the objectivity and thoroughness have been important issues. There were many conversations about the topic, study questions, process as a whole and also the findings with the supervisor of the study and by this the reliability has been consistent through the whole process. The study was brought together by a person who has never worked in older people´s home care, so there were no assumptions of the content of care-and service plans, but an overall understanding of social and healthcare documentation was possessed by the researcher.

Because the care and service plans are written by people there might be some randomized errors, but not so much that it would affect the results. The 80 care-and service plans were a random collection from previously gathered material and this gave the data more anonymity. It must be remembered that the information gathered was not made for a study purposes but to make a care-and service plan for an existing clients in older people´s home care and this is the reason why the researcher should be somewhat critical towards the information gathered. But in this study the material; care-and service plans, answered the questions asked in the study questions and this is also a critical for the study validity to be fulfilled. (Bowen 2009; Validity and Reliability 2019; Vilkka 2015.)

An advantage from the validity and reliability point of view in a document analysis is that the researcher did not have any impact on the 80 care-and service plans used in the study. This increases the objectivity and reliability of the study. Adding more quantitative methods to the study, shows more detailed information of the study. The researcher gathered information into a table which consisted of all FinCC-components and sub-categories, and the results can be found in these tables and this also includes the validity of the structure in the study conducted. If the study questions wouldn´t

have been so well structured, the information would have been too fractured when all the sub-categories were included in the tables. The researcher has reported the analysing process as precise as possible so the results and information gathered would be consistent. (Bowen 2009; Grove et al 2013; Grove et al 2015).

7. CONCLUSIONS

In conclusion it can be stated that there are many aspects in the care and service plans in older clients' home care that should be improved and further developed in the future. FinCC is a broad entity and not all categories have been used in the care-and service plans.

As the results show the care- and service plans in home care are focused on physical issues and not so much on psychological or health promotion. One of the reasons these issues are not so well documented could be that the issues are more difficult to address, and it might be the case that you as a home care professional can´t see all the issues related to health promotion or psychological issues. People have a nurse visit them perhaps 3 times a day and if they have issues with substance use, they can easily hide the evidence so to speak if they don´t have severe dementia. Substance use is a subject that should be generally emphasized in the studies to become a social-or healthcare worker. Also, health and social services´ managers should be able to prep their workers to bring up even the hardest subjects with their clients.

Smoking is also one of the things that should be studied more among older people so that there could be some evidence-based information to give out to older people. There is information available for all but for older people this should definitely be more present in their lives. And just like with other health behavioural issues there should be more education for the professionals and students alike of how to talk about these issues with their clients.

Some of the medication for insomnia or depression were only mentioned in the Medication section; but other than that, there was no mention of the issue anywhere else in the care-and service plan. When there should be more specific education provided for healthcare workers, and there should also be education on how to properly use FinnCC as a tool in their work. These would also be an interesting study topics: How well do the workers know how to use FinnCC? Have they been given time to learn how to use it? How much time do they need to make a care-and service plan?

There should also be a study done about how often the professionals talk with their clients about psychological health related issues or health behaviour related issues; because it seems that according to these finding in my studies, there should be more discussion of both of these issues mentioned.

The lack of Health behaviour added into the care and service plans show that this is something that should be taken into consideration when thinking about training and education for the workers so that these subjects will be talked about. The same is also true with the Life-cycle category; it was not

added even once in the care-and service plans. These issues should also be studied more but perhaps from the nurse's perspective. Why aren´t these subjects are not talked about more with their clients and clients in home care generally?

The Finnish institute for health and welfare has conducted a two year follow up study about how the coronavirus epidemic has affected socially to the people who socially marginalized and how their services have changed because of the epidemic. This is an interesting study that should be followed during the next two years. The coronavirus epidemic and its effects on older people is also one of the things that should be studied more, especially because it can have negative effects on older people´s psychological health and their health behaviour. (Finnish institute for health and welfare 2021.)

The overall conclusion I think is that the results of this study were a bit shocking because the care-and service plans were lacking so much potentially important information about the older people who have home care. As I stated there should be different kinds of studies made about the subject in Finland and these issues should be more present in studies of people studying to be in the healthcare field in the future.

I included information about the pandemic in the discussion part of the study, because although it may have not been part of the material in study, but it will surely be part of making the care-and service plans for older people in the home care in the future. It should be taken into consideration when making another study about home care, or older people, psychological balance or health behaviour, or any of these subjects combined.

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APPENDIX 1: TABLE OF DATA GATHERED

Activity in 69 care- and service plans (76 mentions in total)

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Change in activity	53	Weakened activity	8	**Follow up of the activity**	1		
		Small amount of pastime	1	**Actions encouraging activity**	67	Game play	0
		Hyperactivity	0			Organizing stimulation	2
		Tiredness	0			Functional rehabilitation	1
		Weak tolerance of extertion	0			Taking care of exercirses	7
		Limitation of moving	1			Patient positioning which maintains functionality	0
		Weakness of physical strength	2	**Guidance related to ativity**	2		
Need for information about activity	0			**Limiting the activity**	0		
Sleeping disorder	1	Excessive amount of sleep	0	**Encouraging activity of sleep and wakefulness**	1		
		Low amount of sleep	0	**Follow-up of sleep and wakefulness**	0		
		Change in the daily rhythm	0	**Guidance related to sleep and wakefulness**	0		
Need for information about sleeping disorder	0						

Secrecration in 11 care- and service plans

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Dysfunction related to secretion	3	Fecal incontinence	0	**Observation of bowel functions**	2	Monitoring the amount or quality of feces	0
		Constipation	0			Monitoring the bowel sounds	0
		Diarrhea	0	**Treatment of bowel functions**	0	Treatment of diarrhea	0
		Problem with defecation	0			Treatment of constipation	1
		Flatulence	0			Emptying the bowel	0
		Haematochezia	0			Treatment of a stoma	1
		Soiling	0	**Guidance related to bowel functions**	0		
Dysfunction related to urinating	4			**Observation of urinating**	3	Monitoring the amount or quality of urine	1
		Urinary Incontinence	2			Observation of the frequency of urinating	0
		Residual urine	2			Measuring the residual urine	0
		Retention of urine	1	**Maintaining the functions of the kidneys and urinary tract**	0	Implementation of indwelling catheter treatment	0
		Quiken need to urinate	0			Training the bladder	0
		Reduced urinary excretion	0			Throwaway catheterization	0
		Increased urinary excretion	0			Washing the bladder or urinary tract	0
		Hematuria	0			Treatment of urinary fistula	0
		Enuresis	0			Treatment of urinary incontinence	1
Weakened function of the kidneys	0			**Guidance related to urinating**	2		
Bleeding	0			**Guidance related to stoma**	0		

Other dysfunction related to secretion	0		**Prevention and treatment of nausea or vomiting**				
Nausea and vomiting	0		**Guidance related to prevention and treatment of nausea**	0			
Drain secrecration	0		**Take care of other secretion related issue**	0	Taking care of the functioning of nasogastric tube	0
The need for information about sercrecration	0				The quality and quantity of secretion in nasogastric tube	0
					Drain treatment	0
					Observation of sweating	0
					Observation and treatment of bleeding	0
					The quality and quantity of amniotic fluid	0
			Guidance of other secretion related issue	0		
			Dialysis	0		
			Guidance related to dialysis	0		

Coping in 65 care- and service plan (84 mentions in total)

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Patient´s weakened coping ability	68	Change in the ability to make decisions	0	**Evaluation of the patient´s coping ability**	2		
		Change in the ability to focus	0	**Supporting the patient´s coping**	74		
		Lack of initiative	0	**Using family nursing methods**	0	Family therapy	0
		Learning difficulty	0			Family conversation	0

		Change in the ability to adapt	0			Taking the children of the patient in to consideration	0
		Paramnesia	1	**Guidance related to coping**	1		
Family´s weakened coping ability	0			**Psychological support**	0		
The support related to coping	15	Need for psychological support	0	**The support and guidance related to communication**	0	Recognizing the thinking- and speaking disabilities	0
		Fear of dying	0			Using interpreter services	0
		Sorrow	0	**Supporting social interaction**	1		
		Feeling of guilt	0				
Communicational problem	0						
Change in social contact	0	Social distancing	0				
		Problem with working in a group	0				
		Problem with being alone	0				
		Need of intimacy	0				
		Need of privacy	0				

Fluid balance in 7 care- and service plan (8 mentions in total)

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Risk of liquid balance disorder	0	Thirst	0	**Observation of liquid balance**	0	Counting the liquid balance	0
		Water drunkenness	0			Observing the swelling	6
Change in the fluid volume	1	Swelling	7	**Ensure hydration**	0	Giving liquid orally	0
		Dehydration	0			Intravenous hydration	0

			Giving blood derivative	0	
			Guidance related to hydration	0	
			Limitation of the amount of liquid	0	
			Assist in fluid removal	0	

Coordination of care in 59 care- and service plans (98 mentions in total)

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Need for professional services	0			**Coordinating professional services**	0		
Need for information about patient´s rights	48			**Giving out information about patient´s rights**	5		
Need for information about examination, procedure or sample.	0			**Performing examination, procedure or sample**	1		
Need for continued treatment	47			**Preparing and guiding patient to examination, procedure or sample**	0		
Instructions about continued treatment	0			**Observing after examination, procedure or sample**	0		
				Planning the continued treatment	77		
				Guidance related to continued treatment	1		

Medication in 76 care- and service plans (86 mentions in total)

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**

Risk of using medication	1	Simultaneous use of medication	0	**Observing the effect of medication**	13	Observing the side effects and reactions to medication	0
		Unsuitable medication	0	**Guidance in medication**	11	Written guidance of medication	0
		Risk of intoxication	0			Oral guidance of medication	1
		Medication allergy	0			Guidance for medication via phone	0
		Negativity towards medication	0	**Deviate in medication**	0		
		Side effect of medication	0	**Administrating medication**	49	Orally taken medication	14
		Combined influence of medication	0			Administrating an injection	6
Need for assistance in medication	1	Need for assistance when taking medication	19			Rectal medication	1
		Need for assistance when allocating medication	7			Giving inhalation	5
Need for information of medication	4					Putting on an medication plaster	7
						Vaginal medication	2
						Administrating a medicational infusion	0
						Epidural medication	0
						Medication directly in the abdominal cavity	0
						Using ointment	0
						Administrating drops	6
						Administrating spray	0
						Surface anaesthetic	0

						Administrating medication via medication pump	1
				Giving medication without consent	**0**		
				Take care of dose distribution	**0**		
				Implement cytostatic treatment	**0**		
				Vaccination	**0**		

Nutrition in 32 care- and service plans

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Change in nutrition	12	lack of appetite	2	**Observation of nutrition**	9	Making a nutritional chart	2
		problems swallowing	0			Weight control	9
		malabsorption	0			Height control	0
		problem with eating	0			BMI charting	0
		reflux	0	**Making sure of food intake**	20	Follow-up of feeding	1
		difficulty sucking	0			Special diet	0
Need for special diet	0	need for supplements	0			Tube feeding	0
		need to restrict supplements	0			Intravenous nutrition	0
		food allergy	0			Giving supplements	2
Increased need for nutrition	3					Serving favourite foods	0
Decreased need for nutrition	0			**Making sure of age appropriate nutrition**	2	Assisting in breast feeding	0
Need for information about nutrition	10					Assisting in babies bottle feeding	0
				Giving supplements	**0**		

				Restricting the amount of nutrition	**0**	fasting	0
						Serving low calorie diet	0
				Guidance related to nutrition	**3**		

Respiration in 3 care- and service plans

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Respiratory insufficiency	0	dyspnoea	3	**monitoring respiration**	1	monitoring the quality and quantity of respiration	0
		hyperventilation	0			PEF-follow up	0
		cough	0			cough observation	0
		blocked respiration	0	**the amount and quality of respiratory secretions**	0	mucus observation	0
		change in respiratory frequency	0			sputum observation	0
aspiration risk	0			**support for the function of lungs and respiration**	0	administrating oxygen	0
mucus	0					breathing exercises	0
Need for information about respiration	0					drainage therapy of lungs	0
						suction of mucus	0
						patient positioning that helps respiration	0
						positive pressure blowing	0
						treating tracheostomy	0
						respiratory treatment with other aid	0
						humidification of breathing air	0
						intubation	0

						extubating	0
				guidance related to respiration treatment	**0**		

Circulation in 24 care- and service plans

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
circulatory disorder	0	change in blood pressure	24	**monitoring circulation**	0	Follow-up of blood pressure, pulse and rhythm	24
		change in heart rhythm	0			Follow-up of peripheral circulation	0
change in body temperature	0	hypothermia	0			Follow-up of oxygen saturation	0
		fever	0			Follow-up of the color and warmth of skin	0
need for information about circulation	0			**maintaining circulation**	0	patient positioning to maintain circulation	0
						equipment to maintain circulation	0
				Maintaining bodily temperature balance	0	Follow-up of temperature	0
						Maintaining temperature	0
						reduction of temperature	0
						improving temperature	0
				Guidance related to circulation	0		
				resuscitation	**0**		
				reviving a newborn	**0**		

Metabolic in 6 care- and service plans

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**

Hormonal changes	0			**follow-up and treatment of changes in metabolic**	0	**follow-up and treatment of blood sugar**	6
change in metabolic	0	change in blood sugar levels	6			**follow-up and treatment of yellowness**	0
		yellowness	0	**follow-up and treatment of hormonal changes**	0		
immunological changes	0	weakened immunity	0	**follow-up and treatment of immunological changes**	0	recognizing the risk of infection	0
		hyper sensitivity	0			implement insulation	0
Need for information about metabolic	0					implement infection isolation	0
				guidance related to infection	0		
				guidance related to metabolic	0		

Safety in 27 care- and service plans (28 mentions in total)

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Risk of an accident	2	fall risk	0	**organizing a safe environment**	2		
		risk of falling down	5	**inner and outer ratification of safety**	4	being present	0
		escapee	0			holding in one´s lap	0
feeling insecure	20					appeasement	0
infectious disease carrier	0					scrollercare	0
the danger of hurting someone else	0					setting boundaries	0
the danger of hurting themselves	0					request for executive assistance	0
need for information about safety	0			**restriction of patient´s self-determination**	0	taking possession of patients belonging or inspecting them	0

						restricting and observing the patient's movements	0
						restricting and observing patients' communications	0
						adherence	0
				taking in to account the injury risk	4		

Daily activities in 70 care- and service plans (149 mentions in total)

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
Deficiency of physical ability to function	0	Need for help with hygiene related issues	66	**Supporting self-motivation**	0	Assisting with hygiene and getting dressed	66
		Need for help with putting clothes on	7			with dental-or oral care	4
		Need for help with eating	34			Assisting with eating	5
		Need for help with movement	7			Assisting with movement	8
		Need for help with toilet functions	10			Assisting with toilet functions	8
		Need for help with running errands	0			Assisting with running errands	0
Need for information about supporting self-motivation	0			**Organizing assistive devices to support daily activities**	19		
Need for assistive device	26			**Guidance with the use of assistive devices**	4		

				Guidance related to daily activities	1		

Sensory and neurological functions in 6 care- and service plans (7 mentions in total)

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
change in sensory functions	0	change in hearing	1	**perceiving the changes in the sense of hearing**	1	removing a mechanical obstacle from auditory canal	0
		change in the sense of taste	0	**guidance related to the sense of hearing**	0		
		change in the sense of smell	0	**perceiving the changes in the eyesight**	2		
		change in eyesight	2	**guidance in the use of eyesight**	0		
		change in the sense of touch	0	**perceiving the changes in the sense of touch**	0		
		change in balance	0	**guidance related to the sense of touch**	0		
		stimulus sensitivity	0	**changes in the sense of touch related to procedures**	0		
need for information about sensory functions	0			**perceiving the changes in the sense of balance**	0		
acute pain	1	chest pain	0	**guidance related to maintaining balance**	0		
		headache	0	**perceiving the changes in tasting or smelling**	0		
		inflammation pain	0	**guidance related to a sense of smell- or taste**	0		
		pain related to a procedure	0	**arrange an assistive device related to sensory functions**	0		

		traumatic pain	0	**guidance for assistive device related to sensory functions**	0		
chronic pain	4	pain related to tissue damage	0	**consideration of stimulus sensitivity**	0		
		neuropathic pain	0	**follow-up of pain**	3	measuring the intensity of pain	0
		idiopathic pain	0			evaluation of pain	0
		cancer pain	0	**pain treatment**	2		
need for information about pain	0			**guidance related to pain treatment**	1		
neurological changes	0	change in the level of consciousness	0	**observing level of consciousness**	0	defining level of consciousness	0
		tremble	0			observation of pupillas	0
		rigidity	0	**follow-up of neurological symptoms**	0	testing for motor response	0
		aphasia	0			testing for muscle force	0
		sensation deficiency	0			testing for sensory disturbance	0
		dizziness	0			check-up of face mimics	0
		seizure	0			follow-up of coordination and limb force	0
need of information about neurological changes	0					follow-up of speech	0
						follow-up of orientation	0
						follow-up of a field of vision deficiency	0
						follow-up of dizziness	0
						follow-up of stiffness	0
						follow-up after an epileptic seizure	0
				guidance related to neurological functions	0		

Skin integrity in 16 care- and service plans (18 mentions in total)

Need for care/main title (FiCND)	**n**	**Need for care/subclass**	**n**	**Actions in nursing/main title (FiCNI)**	**n**	**Actions in nursing /subclass**	**n**
change in the integrity of skin	6	skin breakage	1	**follow-up and treatment of skin integrity**	7	taking care of the skin surrounding cannula	0
		risk of skin breakage	4			taking care of the root of an external fixation device	0
		infection of the cannula extraction point	0			taking care of the skin surrounding a stoma	0
		skin damage caused by an external fixation device	0	**guidance related to skin care**	0		
		rash	1	**follow-up and treatment of a rash**	1	giving a treatment bath	0
change in the integrity of mucous membrane	0					applying a compress	0
acute wound	1	surgical wound	1			pensing of a rash	0
		skin graft	0			putting lotion to a rash	0
		skin uptake	0			light therapy to a rash	0
chronic wound	0	leg ulcer	0			Applying bands	0
		pressure wound	1	**guidance related to a rash**	0		
		infected wound	1	**follow-up and treatment of mucus membrane**	**0**		
		diabetic foot wound	1	**guidance related to mouth and mucus membrane**	**0**		
traumatic wound	1	burn	0				
		frostbite	0				
the need for information about tissue integrity	1						

Life cycle in 0 care-and service plans

Need for care/main title (FiCND)	n	Need for care/subclass	n	Actions in nursing/main title (FiCNI)	n	Actions in nursing /subclass	n
Sexual health	0			**Guidance related to sexual health**	0		
Need for information about sexual health	0			**Guidance related to reproductive health**	0	Advice on contraception	0
Reproductive health	0					Genetic counselling	0
Need for information about reproductive health	0			**Guidance during pregnancy**	0	Antenatal classes	0
Pregnancy	0			**Pregnancy follow-up**	0	Treatment of the termination of pregnancy	0
Need for information about pregnancy	0			**Tend to childbirth**	0		
Child birth	0			**Follow-up after childbirth**	0		
Need for information about child birth	0			**Guidance with breastfeeding**	0		
Difficulties with breast feeding	0	Difficulties with breastfeeding	0	**Follow-up and tending to a newborn**	0		
Need for information about breast feeding	0	Lactation	0	**Follow-up and tending to age-appropriate growth and development**	0		
Growth and development of a newborn	0			**Palliative care**	0		
Need for information about growth and development of a newborn	0			**Supporting the loved ones of a dying patient**	0		
Age-appropriate growth and development	0			**Tending to a dying patient**	0		

Need for information about age-appropriate growth and development

Need for palliative care