THE RESIDENT ASSESSMENT INDEX IN HOME CARE

Anneli Lariviere

Bachelor's thesis
October 2012
Degree Programme in Nursing

TAMPEREEN AMMATTIKORKEAKOULU
Tampere University of Applied Sciences

ABSTRACT

Tampereen ammattikorkeakoulu
Tampere University of Applied Sciences
Degree programme in Nursing
Option of Medical-Surgical

LARIVIERE ANNELI:
The Resident Assessment Index in Home Care

Bachelor's thesis 28 pages, appendices 7 pages
October 2012

The Resident Assessment Index (RAI) is an internationally created and used tool for nursing and clinical assessment and a computer program system consisting of three parts. There are multiple versions of RAI created for different health care settings. This Bachelor's thesis focused on RAI-Home Care (RAI-HC).

The purpose of this Bachelor's thesis was to explore and describe home care nurses' perceptions and experiences of the Resident Assessment Index Home Care (RAI-HC) and to help the working life contact find ways to improve their use of RAI-HC, and in turn improve quality of client care. The objective of the thesis is to increase knowledge regarding RAI-HC in practice and improve nursing assessment and practice, benefiting both the clients and nurses.

A qualitative approach was chosen due to the focus of the thesis being on experiences of home care nurses regarding RAI-HC. Semi-structured interviews were conducted with eight home care nurses in the spring of 2012. All nurses were experienced in home care and the use of RAI-HC. Data was analysed using qualitative content analysis.

Through analysis of the interviews, three categories were created: positive experiences or aspects of RAI-HC, negative experiences or aspects of RAI-HC, and suggestions for improvement. The results show that need for open discussion in the workplace regarding the use of RAI-HC should be encouraged. Further studies could be made in other municipalities or other health care settings regarding nurses' experiences of RAI and their suggestions for developing the use of RAI in a way that serves all members of the health care profession, as well as the clients and patients they focus on. An international study could also be interesting and beneficial; how have nurses or health care professionals in other countries experienced RAI and solved issues they may have had regarding its use.

Key words: home care, RAI, resident assessment index, nursing

TIIVISTELMÄ

Tampereen ammattikorkeakoulu
Tampere University of Applied Sciences
Hoitotyön koulutusohjelma
Sisätauti-kirurgisen hoidon suuntautumisvaihtoehto

LARIVIERE ANNELI:
The Resident Assessment Index (RAI) kotihoidossa

Opinnäytetyö 28 sivua, liitteet 7 sivua
Lokakuu 2012

The Resident Assessment Index (RAI) on kansainvälisesti luotu ja käytetty työväline ja tietokonejärjestelmä hoitoa ja kliinisen arviontia varten, joka koostuu kolmesta alueesta. On olemassa eri versioita RAI:sta, jotka ovat luotu eri terveydenhuollon osa-alueita palvelemaan. Tämä opinnäytetyö keskittyi kotihoidon RAI:hin: RAI-HC.

Opinnäytetyön tarkoitus oli tutkia ja selittää kotihoidon hoitajien kokemuksia RAI:sta ja edesauttaa työelämäkontaktia edistämään RAI-käyttöään parantaen hoidon laatua. Opinnäytetyön tavoitteena oli lisätä tietoa RAI:n käytöstä käytännön tasolla ja parantaa hoidon suunnittelua ja arviointia asiakkaiden ja hoitajien hyödyksi.

Kvaltatiivinen meneltelmä valittiin, sillä opinnäytetyö tarkasteli kotihoidon hoitajien kokemuksia RAI-HC:stä. Teemahaastetteluihin osallistui kahdeksan kotihoidon hoitajaa keväällä 2012. Kaikki hoitajat olivat kokeneita kotihoidossa ja RAI:n käytössä ja haastatteluista kerätyt tiedot analysoitiin sisällö-analyysimenetelmällä.

Haastattelujen analysoinnin myötä, kolme kategoriaa kehittyi: positiivisia kokemuksia tai ominaisuuksia RAI-HC:stä, negatiivisia kokemuksia tai ominaisuuksia RAI-HC:stä sekä ehdotuksia RAI-HC:n parantamisesta. Tulokset osoittavat, että vapaakeskustelu RAI-HC:n käytöstä työpaikalla on tarpeellista ja sitä kuuluisi rohkaistaa. Jatkossa muita tutkimuksia voisi tehdä muilla paikkakunnilla tai terveydenhuollon osa-alueilla liittyen hoitajien kokemuksiin ja heidän ehdotuksistaan RAI:n kehittämisestä tavalla, jotta siitä olisi hyötyä kaikille terveydenhuollon ammattilaisille sekä heidän hoidossaan olevia asiakkaita ja potilaita. Myös kansainvälinen tutkimus voisi olla sekä mielenkiintoinen että hyödyllinen, miten hoitajat ja terveydenhuollon ammattilaiset muissa maissa ovat kokeneet ja ratkaisseet ongelmia liittyen RAI:n käyttöön.

Avainsanat: kotihoito, RAI, resident assessment index, sairaanhoito

CONTENTS

ABBREVIATIONS AND TERMS

RAI	Resident Assessment Index
RAI-HC	Resident Assessment Index Home Care
MDS	Minimum Data Set
CAPs	Clinical Assessment Protocols
LPN	Licensed practical nurse
MDT	Multi-disciplinary team
RN	Registered nurse

1 INTRODUCTION

The Resident Assessment Index (RAI) is a tool for nursing and clinical assessment and a computer program system consisting of three parts. The first part is the survey which is filled out by the nurse with the possible cooperation of the client and their family. This is called the Minimum Data Set (MDS). The different versions of RAI have different MDS, as well as their own handbooks. The handbook which is integrated into the computer program is the second part of RAI; it is used to standardize the answers given in the MDS. Lastly, the information is input into the computer program RAI and the guidelines are created for planning care according to the meters set (Finne-Soveri, Björkgren, Vähäkangas, Noro, 2006 24-27).

There are different versions of RAI for different health care settings. The following are the different variations: RAI-AC (acute care), RAI-AL (assisted living), RAI-HC (home care), RAI-LTC (long term care), RAI-MH (mental health), RAI-PAC (post-acute care), and RAI-PC (palliative care) (Finne-Soveri et al 2006, 25).

The goal of RAI is to help nurses to recognize certain areas of the client's care that need extra attention to create individualized goals for nursing interventions. The RAI process can, within regular intervals, be repeated to see if the interventions have helped (Finne-Soveri et al 2006, 26). It was created in the United States of America in the late 1980s as a way to follow the quality of care in long-term care facilities (Finne-Soveri et al 2006, 24).

This Bachelor's thesis was done with the cooperation of a small Finnish town's (population approximately 32 000) home care sector. Home care can be defined as "a health service provided in the patient's place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability" (Mosby's Dictionary of Medicine, Nursing and Health Professions 2009, 886). The key issue of the thesis was to explore and describe, through qualitative methods, the home care nurses' perceptions and experiences of RAI-HC, and help the working life contact improve their use of RAI-HC thus improving client care.

2 THE RESIDENT ASSESSMENT INDEX

2.1 The history of RAI

RAI was created in the United States of America in the 1980's as a way to follow the quality of care provided in long-term care facilities (Finne-Soveri et al 2006, 24). As the long-term care facility version of RAI gained popularity as a useful and trustworthy assessment tool worldwide, development of the other versions of RAI began. RAI-HC was released in 1994 (Interrai©: Instruments: Home Care, 2012).

Since 1990 Interrai© has been the developer and holder of the rights to RAI. Interrai© is an international non-profit organization of researchers. (Interrai©: Who We Are, 2012.) RAI is currently used in multiple continents around the world. In addition to Finland, some countries using the RAI-HC system include: the United States of America, Canada, Italy, Switzerland, Hong Kong, Japan, Australia, and New Zealand. (Interrai©: Instruments: Home Care, 2012).

2.2 RAI in Finland

RAI-HC has been used in Finland since 2003. As of June 2010, 43 municipalities in Finland were using RAI-HC, serving a total of 22 539 home care clients. The RAI-HC software is provided by Oy RAISoft Ltd. (RAIsoft: RAI-järjestelmänkäyttö Suomessa, 2012.)

The working life partner of this thesis was one of the first municipalities in the country to use RAI in home care, giving them 9 years of experience at the time the interviews were conducted.

2.3 RAI in practice

RAI-HC is used by filling out the MDS-HC questionnaire. The questionnaire reviews all aspects of the client's care and current condition, such as key areas of function,

health, social aspects, and use of services (Appendix 1). The assessment can also lead to identifying problem areas or risks, which link to the Clinical Assessment Protocols (CAPs). CAPs are general guidelines for further care and assessment. (Interrai© Home Care Assessment Form and User's Manual 9.1, 1-2, 2009.) In this thesis, the client is the recipient of care (Meleis 2007, 467). The evaluation is done by the nurse who knows the client best, the client's primary nurse, meaning the nurse who has the primary responsibility to plan, evaluate and care for the patient (Blackwell's Nursing Dictionary 2005, 479).

The data is collected by interviewing the client, observing the client, interviewing the client's family members if possible, observing the client's family members, asking colleagues who have also cared for the client, and consulting documents. The data is usually collected over three days' time, unless otherwise specified. The data is collected when the client is taken into the home care sector, specified intervals, or when the client's condition changes dramatically (Finne-Soveri et al 2006, 31).

In home care in Finland, the RAI-HC consists of MDS-HC (Minimum Data Set for Home Care) version 2.0, the Home Care Handbook, and the CAPs-system (Clinical Assessment Protocols), which is a list of clients' own health resources or risk areas used in planning care. 'Risks' means "a hazard; the possibility of harm" as defined in the Blackwell's Nursing Dictionary (2005, 527). 'Resources' means "the capability in dealing with a situation or in meeting difficulties" as defined in the Webster's dictionary (1994, 1221).

The working life partner of the thesis conducts RAI for each of their clients every six months. The primary nurse of each client is responsible for completing RAI. The results of RAI are then used to assess the needs and risks of the clients.

The home care sector aims to complete the RAI of each new client within two weeks to one month, to use RAI to assist in the creation of the service care plan. RAI is also completed if the client's health, home situation, or other factors change dramatically, e.g. a quick decline in ability to function independently at home.

3 PURPOSE

3.1 The purpose

The purpose of this Bachelor's thesis was to explore and describe the nurses' perceptions and experiences of RAI-HC and help the working life contact find ways to improve their use of RAI-HC, and in turn improve quality of client care. The data collected may possibly be of use to other home care sectors.

3.2 Research questions

The research questions of the Bachelor's thesis were:

1. How useful do home care nurses' experience RAI-HC as a tool for assessing and planning client care?

2. What are the nurses' suggestions for improving the use of RAI-HC?

The objective of the thesis was to increase knowledge regarding RAI-HC in practice and improve nursing assessment and practice, benefiting both the clients and nurses.

4 METHODOLOGY

4.1 Qualitative approach

A qualitative approach was chosen due to the focus of the thesis being on experiences of the home care nurses regarding RAI-HC (Polit & Beck 2008, 71). The basis for qualitative research is not to generalize the topic to other subjects or settings, but to deeply investigate phenomenon or experiences so as to increase knowledge or develop a more patient-focused practice (Thomas & Magilvy 2011, 152).

4.2 Data collection method

The data was collected through semi-structured interviews. The interview questions were based upon existing literature (Doran et al 2009; 165-174; Polit & Beck 2008, 394; Kraft & Scott 2007, 30-31; Nichols & Willis 2004, 6-11), as well as the interviewer's own interest in the topic (Appendix 2). Interviewees were recruited by the home care manager and were volunteers.

All interviews were conducted in the spring of 2012. Eight home care nurses were interviewed, of which three of the participants were public health nurses; five were licensed practical nurses (LPN). The nurses interviewed had experience in home care ranging between 12-27 years. All participants had nine years of experience using RAI and had all received education regarding RAI through the place of work.

The interviews were conducted in a private room at the home care office to ensure a peaceful environment and promote confidentiality of the interviews. The interviews lasted from 10 to 30 minutes and were recorded, then later transcribed verbatim. The language of the interviews was Finnish, as all participants were native Finns.

4.3 Ethical considerations

The ethics of the thesis were considered by obtaining permission from the Leader of Elderly Care Services of the city in question to interview up to 10 home care nurses or until data saturation was achieved (Polit & Beck 2008, 70-71). The interviews were conducted during working hours with permission from the home care sector's manager. All participants were volunteers. Participants were given beforehand a letter regarding the research topic and asked to sign a letter of informed consent (Appendix 3).

4.4 Qualitative content analysis

The interviews were analysed using qualitative content analysis as described by Elo and Kyngäs (2008, 107-115). The data was read through carefully multiple times, and all sentences related to the two research questions were underlined. The units of analysis were sentences or statements made by the participants. The units were translated from Finnish to English and given headings. The headings were then grouped together into three categories: positive experiences or aspects of RAI-HC, negative experiences or aspects of RAI-HC, and suggestions for improvement (Appendix 4).

5 RESULTS

5.1 Positive experiences and aspects of RAI-HC

While opinions regarding the usefulness of RAI-HC were divided, positive experiences and aspects were mentioned nonetheless. RAI being a part of the nursing care for many years was reflected in the interviews.

> "Siis on niin jännä juttu toi RAI:kin sillai, et kun sä tiedät sen joutuvas kuiteskin täyttään, niin on niinku asioita, johon sä niinkun joudut kiinnittään huomiota, et jos ajattelis, et jos sitä RAI:ta ei olisi olemassakaan - että tottakai hoitotyössä joutuu kiinnittään huomiota - mut kiinnittäiskö ihan niinku samalla lailla?"
>
> It's an interesting thing with RAI, because you know you have to fill it out eventually, there are things you have to notice. So if you think that RAI didn't exist - of course in nursing you pay attention to things - but would you pay attention to them in the same way?

The benefit of RAI-HC seemed easy for participants to reflect through the comparison of RAI-HC not existing at all. Long-term use of RAI-HC has become a part of home care nursing assessments and it encourages, in its own way, nurses to take an individualistic and holistic view of the client. The holistic assessment was seen as a positive and good reminder of the client's life situation.

The ability to compare a client's current and previous situation, using RAI-HC assessments, helped the nurses to draw conclusions to whether goals were being achieved in the client care. Following the CAPs, the nurses could see the direct outcomes of their work and make new goals or adjustments to the nursing and care plans. The example of following CAPs to follow risks or declines in function was also made, using a decline of memory.

> "No, pystytään seuraamaan esimerkiksi RAI:n tuottamia CAPs:iä. Eli jos tuota, tulee ilmi vaikka muistihäiriöepäily, tartutaan siihen ja tutkitaan"
>
> Well, we can follow, for example, RAI's produced CAPs, and if we see that a memory illness could be suspected, we catch on to it and investigate it.

The working life partner's home care sector uses a multi-disciplinary team (MDT) consisting of a physician, social worker, and client care counselor, to chart the client's needs and create a care and service plan to best support the client at home. According to the interviewed nurses, this MDT relies on RAI-HC results, because they lack regular interactions with the clients unlike nurses. However, the MDT is responsible for making care and service plans and must make decisions based on client needs. RAI-HC has become invaluable resource in this.

When a new client joins the health care sector of this thesis, the nurses make general visits and try to gather as much information on the client and their needs as possible. The goal is to complete the RAI-HC assessment within two weeks to one month of joining, and for the MDT to have a meeting with the client and family if possible, to create an individual care and service plan based on the client's needs.

Adjustments to the care and service plan can be made later in regards to changing situations, risks, or improvements in the client's life. When nurses evaluate a patient's situation and come to the decision that a client needs additional care or help in certain areas, or perhaps the situation has improved and they do not need as much help anymore; the nurses can use RAI-HC to justify increasing or reducing client times to the MDT.

> "Me [hoitajat] niinku niitä käytetään siis sillai, et jos jollekin esimerkiks niinku…tavallaan, et ollaan esimerkiks sitä mieltä, et voitais vähentää käyntejä, niin kyllähän sitä vois perustella sillai, että RAI on näin hyvä, siis että RAI:n mukaan sä oot, niinku kykenevä näitä tekeen tai päinvastoin, et kun tarttis lisätä [käyntejä]."
>
> We [nurses] use RAI so that if, for example, we need to justify reducing visits, we can say that because the RAI is so good, that according to RAI, you [the client] can manage doing this, or then the opposite when we need to increase [visits].

RAI-HC is held in high regards when a home care client's health or situation declines in a way that home care services cannot support the client enough for them to continue living at home. This is when RAI-HC, according to the data, is extremely respected and useful in helping the client to be placed into full-time institutionalized care that will help meet their needs.

These aspects being taken into account, nurses felt that RAI-HC served home care clients and the MDT very well in their municipality. In addition to the clients and MDT gaining from RAI-HC, the nurses felt it was a good tool to validate their work and show their achievements.

> ”Et jotain millä me pystyttäis osoittaan sitä sitten, että me ollaan tärkeitä. Kyllä mä uskon, et toisaalta päättäjät sen tietääkin, mut et se, et kun sitä tarvitaan todella sitä dokumenttia siihen, että näin on.”
>
> Something we can show that we are important with. I do believe that the decision makers know it, but that, that we need documentation that it is indeed so.

Using RAI-HC results to justify the need for more or less nurses was also spoken of. The management of the home care sector could adjust the amounts of employees in home care teams based on how labor-intensive clients in particular areas were. The only drawback to this though, is the fact that there is about a six month delay to RAI-HC assessments. The management was also seen to benefit from RAI-HC when making national or municipal comparisons to the condition of clients in home care for community-based decisions and statistical purposes.

5.2 Negative experiences or aspects of RAI-HC

While there are positive aspects of RAI-HC, many negative aspects were found as well. In regards to RAI-HC itself as a tool or the software, it being foreign was experienced negatively. The Finnish home care system was felt to be different enough from other countries that using a translated and generalized program didn’t give the right impression or suit Finnish home care circumstances.

Another negative aspect was considered to be the lack of attention to preventive health care measures. It was brought to attention that only a few questions focused on disease prevention, for example has the client had mammogram screenings or influenza vaccines. More focus on disease prevention was missed, since it is an important part of health care and community care today.

The questions were described as “tricky”, or unclear. Differences in how questions were interpreted were considered adverse, skewing the results of the assessment all together.

> ”Jos laitetaan kaks eri hoitajaa tekeen samasta ihmisestä erilliset RAI:t, niin tasan tarkkaan sieltä tulee erilaiset tulokset.”
>
> If you take two nurses and have them make separate RAI assessments about the same person, the results will most definitely be different.

It was stressed that to complete an accurate RAI-HC assessment, it was essential for the questions to be answered correctly, meaning the basis of the questions and evaluation criteria have to be understood and respected. Insecurity of answering the questions wrong and not conveying an accurate evaluation of the client were apparent.

> “Onks se niinkun hirveen, tiedätkö, semmonen haastava? Pelätäänkö siinä, kun sä teet sitä RAI:ta, et sä teet jotain väärin; sä töppäät jonkun ihmisen mahdollisuuden päästä johkin hoitoon, koska se ei pitäis olla niin.”
>
> Is it like, you know, a big challenge? Are they scared that when you do the RAI and you do something wrong, that you’re going to ruin someone’s chance to get into (fulltime) care somewhere, because it shouldn’t be so.

The stress and challenge of making time for RAI-HC assessments was another evident issue for nurses. When asked the amount of time each RAI assessment took, the answers varied. The question was unintentionally understood in two ways: the time it took in total to gather data, or the time it took to fill out the assessment on the computer. Thus, the answers varied between 3 days to 30 minutes. It was hard to define the time used, as it was felt each RAI assessment was as individual as the client.

The nurses felt the opportunities to take the time to make the RAI-HC assessments with thought was limited, and if time were to unexpectedly come up, the RAI-HC assessments require planning and having cared for the client in the past three days, that it might not always be possible to do it.

> “Mut siis sillai et oikeesti ne vaan sitten, et sehän on se, et kun asiakastyötä ei voi jättää tekemättä niin kyllähän se on ne muut mistä sitten joustetaan niinku että, että tota noin niin, niin sitten ne niinku ruuhkaantuu ja sit sulla on ne.”

> But really all that it is, is that you can't leave client care undone, so it's everything else that you have to be flexible about, and so it gets backed up and you have them [RAI-HC assessments to do].

RAI-HC was described as a nuisance for taking time from the work day to complete. The use of RAI-HC results were also in the nurses' opinions not used to their desired potential due to lack of time. Many wished the results of clients' RAI-HC assessments could be discussed in weekly meetings amongst the home care nursing team, and they could together plan practical goals based on RAI-HC. This was according to the interviews attempted, but failed due to lack of time for nursing meetings.

There was a general consensus that RAI-HC was not used as well as it could be for and by the nurses. It was not felt to fulfill the nursing work in comparison to the amount of time and effort it took to complete. Did the reason lie in RAI-HC itself, or the attitudes of the nursing staff? In addition to taking time and effort to complete, the information was seen by some as being redundant to the nurses. The primary nurse cares for the client and regularly follows and evaluates their care without using RAI-HC, so that the information from a biannual RAI-HC assessment is rarely new or surprising.

5.3 Suggestions for improvement

While there are both positive and negative experiences and aspects of RAI-HC according to the participants, suggestions were made to improve the use and improve the attitudes regarding it. Essentially, taking RAI-HC into practical and regular use was desired.

As mentioned before, the nurses had attempted before to have meetings in which clients' RAI-HC assessments be discussed and practical goals could be made. This idea failed for the most part, apparently due to time constrictions. The desire for these meetings still remained and naturally, it was suggested that these meetings regarding RAI-HC be attempted again. While some of the nursing goals may be obvious, it was still felt that pondering them or saying them out loud would be beneficial to all participating in the client's care.

In regards to the previously mentioned issue of insecurity when making a RAI-HC assessment and the differences of views or understanding the questions, pair work with a colleague was considered a constructive idea. Through working together, there could be less insecurity and more affirmation as to the results being accurate. Some already admitted to consulting a colleague when in doubt, or working in an RN-LPN pair to complete a RAI-HC assessment.

While the basic education regarding RAI-HC was considered good, suggestions for more education were made. The basic education was criticized as being overwhelming with a lot of information in a short amount of time, making it hard to grasp all aspects of RAI-HC. Further education to deepen the knowledge and increase the ability to analyze and use the results of RAI-HC was requested.

Another suggestion regarding education was small group lessons where, for example, a team could go through a client's RAI-HC assessment together and reflect and think about the questions and answers together. This kind of small group lesson would hopefully serve as a way to learn more and decrease the threshold for completing RAI-HC assessments independently or in pairs.

Motivation from managers was also considered important and underestimated when it comes to RAI-HC. It was suggested that managers now and then give feedback regarding the use of RAI-HC, for example, by informing the home care nursing teams of how the municipality was doing in comparison to surrounding municipalities. Using the RAI-HC system as a tool for feedback and as a motivator meant a lot. In general more activity from the managers was sought.

> "Niin tuoda sitä esille, että kyllä se näkyy, että meillä on raskasta, raskashoitosia asiakkaita. Ja kuitenkin saadaan pidettyä kotona. -- Ja palautetta että sitä on tehty. Sieltäpäin se täytyy se motivointi ja semmonen tietty kannustus tulla. "
>
> And to bring it up that it shows that we have hard, laborious clients. And yet, we can keep them at home. – And feedback that we have done it. That's the direction that the motivation and a certain kind of encouragement need to come from.

6 CONCLUSION AND DISCUSSION

The purpose of the thesis was to investigate the experiences and perceptions of home care nurses regarding RAI-HC and to find suggestions to improve the use of RAI-HC by the working life partner. Eight home care nurses were interviewed and the interviews were transcribed verbatim and analyzed using qualitative content analysis.

The units of analysis were sentences or statements chosen from the transcribed interviews in regards to the research questions of the thesis. These units of analysis were given headings and the headings were placed into categories. Three categories arose from the analysis: positive experiences or aspects of RAI-HC, negative experiences or aspects of RAI-HC, and suggestions for the improvement of use of RAI-HC.

Positive experiences were related to the holistic and individualistic nature of the RAI-HC assessment and the benefit it is to the MDT and home care client when making and adjusting client care and service plans. The nurses felt RAI-HC was an important tool when decisions regarding client placement from home care to institutionalized care were necessary. Nurses also felt they benefited from RAI-HC when justifying their work load and accomplishments. Home care management also reaped benefits from the data collected from RAI-HC.

Negative experiences were related to RAI-HC being foreign and international, making the use in a Finnish health care setting a challenge. The questions were deemed “tricky” and hard to understand, creating insecurity. The assessment was thought to take too much time, and prove only to have redundant information for the nurses themselves. The feeling of RAI-HC serving others more than nurses was apparent. The hope for it to be used in a way that benefits also the nurses making the assessments was clear.

Suggestions for improving the use were to have meetings between the home care teams, in which clients’ RAI-HC assessments would be discussed and common practical goals would be made. A deeper education in regards to the use and clarification of questions, as well as the use of the results was suggested. Small group lessons were also thought to be a good practical idea to learn more and decrease the threshold regarding RAI-HC. Wishes for the home care management to be more active in motivating personnel using RAI-HC were felt to be necessary.

This study has shown the importance of open discussion in the work place regarding the development of the use of RAI-HC. The nurses' feeling that RAI-HC is a tool that serves others more than themselves is unfortunate, especially since it is an assessment tool meant for all health care professionals.

The limitations of the study are the author's inexperience in conducting studies and the lack of similar studies. The trustworthiness of the data was assisted by the years of experience the participants had using RAI-HC and generally their long career experiences in home care.

Further studies could be made in other municipalities or other health care settings regarding nurses' or other health care professional's experiences of RAI. Active discussion and suggestions for developing use of RAI should be encouraged in all health care settings using it. Ways for the use of RAI to serve all members of the health care profession, as well as the clients and patients they focus on, is essential. A more international study could also be interesting and beneficial; how have nurses or health care professionals in other countries experienced RAI and solved issues they may have had regarding its use.

REFERENCES

Blackwell's Nursing Dictionary 2005. 2. ed. Blackwell Publishing.

Doran D.M., Hirdes J., Blais R., Ross Baker G., Pickard J., & Jantzi M. 2009. The nature of safety problems among Canadian home care clients: evidence from the RAI-HC reporting system. Journal of Nursing Management 17 (2). 165-174.

Elo S. and Kyngäs H. 2008. The Qualitative Content Analysis Process. Journal of Advanced Nursing 62 (1). 107-115.

Finne-Soveri H., Björkgren M., Vähäkangas P. & Noro A. 2006. Kotihoidon asiakasrakenne ja hoidon laatu. RAI-järjestelmä vertailukehittämisessä. Stakes (Terveyden ja hyvinvoinnin laitos).

Interrai©: Instruments: Home Care. Read 04.10.2012 http://www.interrai.org/index.php?id=94

Interrai©: Who We Are. Read 04.10.2012 http://www.interrai.org/index.php?id=2

Interrai© Home Care Assessment Form and User's Manual 9.1. Sample copy. Read 4.10.2012 https://catalog.interrai.org/samples/interRAI_HC_Manual_SAMPLE.pdf

Meleis, A. 2007. Theoretical Nursing Development & Progress, 4. ed. Lippincott Williams and Wilkins.

Mosby's Dictionary of Medicine, Nursing and Health Professions 2009. 8. ed. Mosby Elsevier

Nichols CL. and Willis LA. 2004. Innovations in Long-term Care. The paired RAI/MDS Specialist Model: improving outcomes in Veterans Affairs nursing home care units. Journal of Gerontological Nursing 30 (10). 6-11.

Polit D. and Beck C. 2008. Nursing Research Generating and Assessing Evidence for Nursing Practice. 8. ed. Lippincott Williams and Wilkins.

RAIsoft: Vanhusten kotihoidon ohjelmisto. Read 04.10.2012 http://www.raisoft.com/index.php?p=286

RAIsoft: RAI-järjestelmän käyttö Suomessa. Read 04.10.2012 http://www.raisoft.com/index.php?p=448

Thomas E. & Magilvy J. 2011. Qualitative Rigor or Research Validity in Qualitative Research. Journal for Specialists in Pediatric Nursing 16 (2011). 151-155.

Webster's Encyclopedic Unabridged Dictionary of the English Language. 1994. Gramercy Books.

APPENDICES

Appendix 1. The Areas of the MDS-questionnaire

Background of the client	Personal information and marital status The information of the home health care unit and evaluation The client's willingness for cooperation and possibly a legal guardian
Intellectual skill	Memory Ability to make decisions Symptoms of acute confusion
Communication	Hearing Comprehension/Being understood
Vision	
Mental Health	Depression and anxiety Behavioural symptoms
Social activities	Participation Isolation
Informal support network	Mapping those participating in care and their actions Observing the burden caring has placed on them
Level of capacity	Instrumental Activities of Daily Living (IADL) Activities of Daily Living (ADL)
Level of continence	Continence of urine and feces Possible aids in use
Diagnosed illnesses	

Health status and preventative measures	Mapping of health status Mapping of preventative measures Symptoms causing discomfort or medical procedures Balance and falling Lifestyle Self-assessment of health status Abuse
Nutrition and fluid balance	Height and weight Nutrition Swallowing
Oral health and dental care	
Skin	Skin condition, wounds Nursing interventions
Environment	The home as an environment for activity Needs for change in living arrangements
Services	Use of health care staff Use of services Use of aids (e.g. for movement) Use of acute care services or hospitals Goals of care that are met Changes in health status Financial status
Medications	Medicines Physicians evaluation of medicines in use and their need Compliance

(Finne-Soveri et al, 2006, 30).

Appendix 2. Interview questions

Mikä on koulutustaustasi? (sh, lh jne)
What is your educational background? (RN, LPN, etc)

Miten kauan olet ollut hoitoalalla? Kotihoidossa?
How long have you been in the health care industry? In home care?

Miten kauan olet käyttänyt RAI-järjestelmää?
How long have you used RAI?

Oletko saanut koulutusta RAI:n käyttöön (työpaikan kautta)?

- Koetko, että saamasi koulutus oli riittävä?
- Missä opit käyttämään RAI:n? (sairaalassa, laitoksessa, kotihoidossa?)
- Onko työpaikalla nimetty RAI-vastaavaa?
- Keneltä voit kysyä jos tulee ongelmia RAI:n täyttämisessä?

Have you received education for the use of RAI (through the workplace)?

- Do you feel as though the education was sufficient?
- Where did you learn to use RAI? (hospital, institution, home care?)
- Is there a named RAI-contact? (Nichols & Willis, 2004.)
- Who can you ask if there are problems with filling out RAI?

Missä tilanteessä täytät RAI:n?

- Miten usein käytät RAI:n?
- Miten paljon aikaa siihen menee?
- Helpottaisiko parityöskentely RAI:n käyttöä? (Nichols & Willis, 2004.)

In what situations do you fill out RAI?

- How often do you use RAI?
- How much time does it take?
- Would pair work make RAI easier?

Ketä RAI mielestäsi palvelee?

- Mihin RAI:n tietoja käytetään?

Who does RAI serve?

- How is the information from RAI used?

Miten hyödyllisenä koet RAI:n?

- Käytätkö RAI:sta saatuja tietoja asiakkaiden hoidon arvioinnissa ja suunnittelussa?

How useful do you think RAI is?

- Do you use information from RAI in the evaluation and planning of client care?

Miten RAI näkyy arjessa?

How can RAI be seen in everyday life?

Edistääkö RAI:

- potilasturvallisuutta? (Doran et al, 2009.)
- Omahoitajuusmallia?

Does RAI promote:

- Patient safety?
- Primary nursing models?

Mitä on hyvää RAI:n käytössä?
What is good in the use of RAI?

Mitä on kehitettävää RAI:n käytössä?
What needs improvement in the use of RAI?

Mitä koet haasteellisena RAI:ssa?

What do you find challenging in the use of RAI?

Jos lisää koulutusta kaivataan, mitkä olisi sellaisia asioita mistä haluaisivat enemmän tietoa/taitoa? Minkälaista koulutusta?

If more education is wanted, what would be the educational areas for knowledge/skills? What kind of education?

Appendix 3. Informed consent letter

Hyvä hoitaja!

Pyydän Teitä osallistumaan opinnäytetyöhöni, jonka tarkoituksena on tutkia kotihoidon hoitajien kokemuksia RAI:sta.

Osallistumisenne tähän opinnäytetyöhön on täysin vapaaehtoista. Voitte kieltäytyä osallistumasta tai keskeyttää osallistumisenne syytä ilmoittamatta milloin tahansa. Opinnäytetyölle on myönnetty lupa --- kaupungin vanhustyön johtajalta. Opinnäytetyön yheistyötahona kotihoidossa toimii kotihoidon ohjaaja ---.

Opinnäytetyö aineisto kerätään haastattelemalla 6-10 kotihoidon hoitajaa. Haastettelu luvallanne nauhoitetaan ja se kestää korkeintaan tunnin. Haastattelu tapahtuu kotihoidon toimiston neuvotteluhuoneessa työajalla.

Opinnäytetyön valmistuttua aineisto hävitetään asianmukaisesti. Aineisto on ainoastaan opinnäytetyön tekijän käytössä. Aineisto säilytetään sanasanalla suojattuina tiedoistoina, kirjallinen aineisto lukitussa tilassa.

Teiltä pyydetään kirjallinen suostumus opinnäytetyöhön osallistumisesta. Opinnäytetyön tulokset käsitellään luottamuksellisesti ja nimettöminä, opinnäytetyön raportista ei yksittäistä vastaajaa pysty tunnistamaan. Opinnäytetyöt ovat luettavissa elektronisessa Theseus-tietokannassa, ellei --- Kaupungin kanssa ole muuta sovittu. Yksi kappale opinnäytetyöstä toimitetaan --- kaupungin kotihoidon tomistoon.

Mikäli Teillä on kysyttävää tai haluatte lisää tietoja opinnäytetyöstäni, vastaan mielelläni.

Anneli Lariviere
Sairaanhoitajaopiskelija (AMK)
Tampereen ammattikorkeakoulu

SUOSTUMUS

The Resident Assessment Instrument as a Tool for Practice (RAI käytännön työkaluna)

Olen saanut sekä kirjallista että suullista tietoa opinnäytetyöstä, jonka tarkoituksena tutkia kotihoidon hoitajien kokemuksia RAI:sta. Minulla on ollut mahdollisuus esittää opinnäytetyön tekijälle kysymyksiä.

Ymmärrän, että osallistuminen on vapaaehtoista ja että minulla on oikeus kieltäytyä siitä milloin tahansa syytä ilmoittamatta. Ymmärrän myös, että tiedot käsitellään luottamuksellisesti.

Paikka ja aika

_____ ___ . ___ . ___

Suostun osallistumaan opinnäytetyöhön:

Suostumuksen vastaanottaja:

_____ _____

Haastateltavan allekirjoitus

Opinnäytetyön tekijän allekirjoitus

Appendix 4. Examples of qualitative content analysis

”Et jotain millä me pystyttäis osoittaan sitä sitten, että me ollaan tärkeitä. Kyllä mä uskon, et toisaalta päättäjät sen tietääkin, mut et se, et kun sitä tarvitaan todella sitä dokumenttia siihen, että näin on.”

Something we can show that we are important with. I believe that the decision makers know it but that we need documentation that it is so.

- ➔ **Proof of nurses' importance**
- ➔ **VALIDATION OF NURSES → POSITIVE ASPECTS OF RAI-HC**

”Jos laitetaan kaks eri hoitajaa tekeen samasta ihmisestä erilliset RAI:t, niin tasan tarkkaan sielt tulee erilaiset tulokset.”

If you put two nurses to make RAI about the same person, the results will be different.

- ➔ **Understood differently**
- ➔ **DIFFERENCES IN VIEWS/UNCLEAR QUESTIONS → NEGATIVE ASPECTS OF RAI-HC**

”Niin tuoda sitä esille, että kyllä se näkyy, että meillä on raskasta, raskashoitosia asiakkaita. Ja kuitenkin saadaan pidettyä kotona. -- Ja palautetta että sitä on tehty. Sieltäpäin se täytyy se motivointi ja semmonen tietty kannustus tulla.”

Bring up that it shows that we have hard, laborious clients. And yet, we can keep them at home. – And feedback that we have done it. That's the direction that the motivation and a certain kind of encouragement need to come from.

- ➔ **Motivation/feedback from managers**
- ➔ **SUGGESTIONS FOR IMPROVEMENT → SUGGESTIONS FOR IMPROVEMENT OF USE OF RAI-HC**