

Anne Vesterinen & Hannele Niiniö (eds.)

Development Project as Driving Change in Elderly Care



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Development Project as Driving Change in Elderly Care

LAUREA UNIVERSITY OF APPLIED SCIENCES, TIKKURILA UNIT
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To The Reader

Economic growth, the reformation of the economic structure and long-term competitiveness all depend on high-quality know-how. This in turn requires the strengthening of basic research, in addition to new, creative and applied research that is connected to regional working life and companies. Universities of applied sciences have taken a notable place in this field that is close to practical working life. The research, development and innovation activities that are carried out by universities of applied sciences can be described as user-oriented, student-based and working life centered. In the latest development plan for education and research, it is pointed out that universities of applied sciences support regional vitality. This is done by strengthening the universities' research, development and innovation activities by developing, in particular, demand-based and user-based innovation activities and well-being services.

Laurea's focus areas for the years 2010-2015 are service innovation and design, expertise in nursing and coping at home, security, safety and social responsibility, in addition to student entrepreneurship. These focus areas, which have been agreed on with the Ministry of Education and Culture, can be seen in all of Laurea's processes. This new publication collects the results of some developments that have been made in the focus area of expertise in nursing and coping at home. Traditionally, Laurea has been an expert in this demanding field both in terms of education and long-span research, development and innovation. At the same time, this publication highlights Laurea's method of combining its students' learning processes with high-quality projects.

The contents of this publication touch on one of the most significant challenges of our time: that is, aging societies and public healthcare. This is also a global issue. In order to solve this problem, a new kind of activeness, in addition to multidisciplinary networking, is needed from various experts. Solving these complex issues reflects on the reorganization of the research and innovation structure and innovation environments, in addition to their mutual networking locally, nationally and internationally. Also, research, development and innovation activities have been a way of networking for Laurea. With its research and development projects, Laurea has been on the frontline to provide new possibilities for experts in a particular field to meet others in a vast international context.

On behalf of Laurea University of Applied Sciences, I would like to thank the authors of this publication for their valuable work. I believe that this publication will have an important role in creating new networks and developing the best expertise possible in this important field.

Maarit Fränti
Vice President

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Introduction

The Driving Change in Welfare Services for the Aged project publication describes the proven results gained during the course of the project. All the project results are available at: www.muutosvoimaa-hanke.fi. The development project was carried out in co-operation with the cities of Vantaa and Espoo, Aalto University School of Economics, as well as Laurea University of Applied Sciences' Tikkurila unit from February 1st 2008 to April 30th 2011. The project constituted a part of the European Social Fund's Leverage from the EU 2007-2013 Continental Finland's structural fund's operational program number 3. The project—under the administration of The Ministry of Education and Culture—was funded by the European Social Fund, Uusimaa ELY Centre (Centre for Economic Development, Transport and the Environment), as well as the cities of Espoo and Vantaa.

The goal of the project was to develop the structure and operations of Espoo and Vantaa's community services for the elderly in such a way that the share of institutional care in services for the elderly diminishes and that as many senior citizens as possible can live at their own homes also in the future. In Espoo, around 50 health and social services employees participated in the project. Of Vantaa's entire personnel in community services for the elderly—which encompass home care, service houses, and rehabilitative daily activities—around 70 employees participated in the development work. Both cities developed network competency and network management, promoted by the networking-based operating method especially devised for the project. In addition, Vantaa's development areas consisted of the city's aging policy strategy and development of elderly work methods, operating procedures, work processes, and personnel's competencies. The researchers, principal lecturers and senior lecturers of Laurea's Tikkurila unit and Aalto University School of Economics, as well as representatives of the cities of Vantaa and Espoo had responsible roles in the project. Furthermore, Laurea Tikkurila students' learning was integrated in the project in accordance with Laurea University of Applied Sciences' LbD model. The LbD (Learning by Developing) model means developing learning in R&D and innovation projects of genuine working life.

The project was divided into subprojects, and subproject-specific evaluation plans were devised in the beginning. The development work emphasized network-based work and research approach. The articles in this publication primarily describe the results of co-operation on development. The results are described as development of networks, network competency, good practices, and employees' vocational competency. In addition, the publication includes two articles, one of which considers and evaluates the significance of development from the perspective of strategic management, and the other describes students' perceptions of elderly work.

Naturally, this publication cannot list all the achievements of the project or everything about the development co-operation the parties involved in the project accomplished in the course of more than three years. Based on the feedback from the project actors, one essential achievement was the development approach implemented in the project: results were gained by working in networks and by developing both networks and network competency.

Development is fascinating and interesting, but also demanding. Our goal is that these articles arouse readers' interest in pondering and evaluating the significance of multiprofessional and goal-oriented co-operation and networking as a tool for development, especially when true change in working life is striven at.

We thank all the participants in the Driving Change in Welfare Services for the Aged project for their valuable input in co-operation on development work.

In Sipoo, on Father's Day 2012,

Anne Vesterinen and Hannele Niiniö (eds.)

Development project as strategic support for managing services for the elderly

Matti Lyytikäinen and Jaakko Valvanne

Abstract

This article describes the Driving Change in Welfare Services for the Aged project from the perspective of strategic management in two of the cities participating in the project: Espoo and Vantaa. The two cities had different starting points for the project. Likewise, the position of the project in overall development was different in the two cities. In both cities, the project was based on strategic objectives, but the results were different in Vantaa and Espoo: In Vantaa, the project objectives were achieved for the most part, whereas in Espoo, the achievements did not fully meet with expectations. This article analyzes the reasons for the successes and failures. In addition to city-specific interests, peer development and co-operation arose between the cities, and it continues after termination of the development project. At the end of the article, the lessons of the project are considered in more detail from the perspective of strategic management.

Situation in Espoo and Vantaa before beginning of the project

At the beginning of 2007, the City of Vantaa Health and Social Welfare department carried out a restructuring according to which local social and health centers were reorganized, and health and social welfare services for the elderly were concentrated in the Services for the Elderly and the Disabled result division. Before the restructuring took place, services were produced in seven different units: Home Care; Service Houses; Daily Activities for the Elderly; Social Work in regional social and health centers; health center's hospital operations in Katrina hospital, under the authority of the director of

health services; and round-the-clock care in the Special Services for the Elderly unit, also under the authority of the director of health services.

Even though services for the elderly had been coordinated on a department-specific basis, regional organization had led to the situation where service level, resourcing, and procedures differed from one region to another. Furthermore, both departments' own and external surveys (Haho & Saurén 2007, 58-65; Nykänen & Järvensivu 2007) showed that there was room for improvement in co-operation between different actors. Community services for the elderly were deemed to be close to social services, round-the-clock care and hospital services close to health services. Mutual trust and commitment to shared objectives were not highlighted in co-operation. The consequence was that services were not always customer-oriented and service chains for the elderly did not function flexibly.

When the Driving Change in Welfare Services for the Aged project started in late 2008, the City of Espoo had just finalized revising its aging policy, valid as of 2002. Earlier focus had been on the significance of services for the welfare of senior citizens with limited functional abilities. The age-policy discussions conducted during the renovation emphasized the following: supporting senior citizens' own resources, preventing health and social problems, and customer-orientation. Senior citizens in Espoo strongly emphasized regarding the aged as a resource and as fellow citizens, as well as the importance of quality of life. Besides national guidelines, Espoo's annual strategies and new research data, many introductory visits and partnering projects from 2005 to 2008 influenced the contents of the program.

The Health and Social Welfare Committee's visit in the fall of 2005 to Denmark to study how the country's elderly care had been arranged made trustees and leading officials willing to develop community care into a more rehabilitative direction and to transform long-term care into a more fulfilling, one-stop service. The national Kimppa project put the customer at the core, involved private service providers in development work, and encouraged interactive events. The project also generated a new kind of way to view the aging policy as part of the city strategy (Haho & Vääntinen 2007). The Reformed Elderly Care—Model for Others project proved without a doubt the necessity of enhancing productivity, and it strengthened the concept of the culture of activating care (Ryhänen et.al. 2007).

Espoo learned from other cities' work on developing services for the elderly. One of Espoo's objectives was to launch Senior trainer activities in accordance with Vantaa's model. Participating in the Active project was a natural continuation to the Ennalta ehkäisevät vanhuspalvelut (EEVA) (Preventive Services for the Elderly) project (Puranen et.al. 2007; Valvanne 2007).

In 2007, the Health and Social Welfare department started co-operation with Jönköping's Qulturum development unit (Landstinget i Jönköpings län 2011). In Jönköping, health care had for more than 15 years been developed according to the continuous quality-enhancement principles. They applied, among other things, an inclusive method to services for the elderly in order to make operations more customer-oriented. This was accomplished with the help of so-called OSAKE workshops (Rysti et.al. 2010).

Project interface with the cities' own development strategies

The City of Vantaa has a long tradition of strategy work. Nevertheless, when the project started, the city did not have an aging-policy strategy compliant with the quality recommendations for services for the aged. As part of the city's strategy-work development, Vantaa had devised a service strategy for the elderly as a pilot project in 2002. The compilation and contents of the service strategy focused on health and social welfare services as well as their concentration. On city-level, development of services for the elderly was dictated by one critical success factor of the Vantaa strategy: shared responsibility for a good old age. When the project began in 2008, the objective was to strengthen and establish co-operation between different departments on promoting welfare of the elderly. Another objective was that 92% of people aged 75 or over would live either at their own homes or in home-like circumstances. The project aimed to support realization of the above-mentioned objectives on both city-level and health- and social-welfare-level.

Espoo city council ratified the 2009-2015 aging policy in November 2008 (City of Espoo 2009). The vision of the program is "full life at an advanced age." The policy aims at reforming the operating and service culture. The starting point of service development is supporting self-governed aging, living, and housing. Essential preconditions for self-governed aging consist of accessible environment, sufficient access to information and services, and supported living at home. The preconditions for a functional service system are deemed to be: competent and motivated personnel and inclusive management. Moreover, process flexibility, continuous quality enhancement, productivity and cost-effectiveness, and customer-oriented service ideology all constitute important factors. Like Vantaa's service strategy, Espoo emphasizes multiple actors and joint responsibility (figure 1).

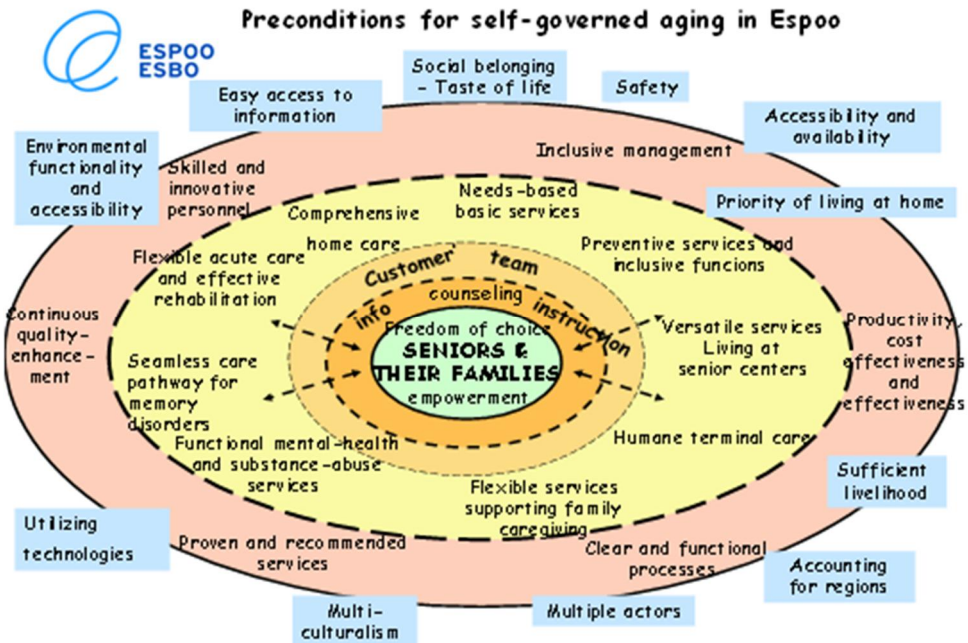


Figure 1: Preconditions for self-governed aging in Espoo. The starting point was senior citizens and their relatives and friends in Espoo. The fourth ellipse from the inside describes the integrated service system for the elderly and the fifth the preconditions for functioning of the service system. Items on the outer circle are general factors ensuring self-governed aging for the elderly

From 2008 to 2010, Espoo implemented the aging policy with the help of several projects. The subprojects of the Driving Change in Welfare Services for the Aged project were planned to support development, consistent with the aging policy.

Driving Change in Welfare Services for the Aged project as support for strategic management of services for the elderly

The 2008-2010 strategic objectives of Vantaa's services for the elderly were:

- safe living at one's own home for as long as possible
- developing acute care and rehabilitation for the aged
- shared responsibility for a good old age

The Driving Change in Welfare Services for the Aged project was a key development project that especially supported achievement of the first and third objectives. The Services for the Elderly and the Disabled balanced scorecard (BSC) listed all the objectives of the subprojects as well. Other projects were simultaneously going on, but the Driving Change in Welfare Services for the Aged project was the most important project striving to change operations.

Vantaa's 2010-2015 aging policy—devised as part of the project—dictates for years to come how services for the elderly are developed in Vantaa on both city level and at the Health and Social Welfare department.

The Driving Change in Welfare Services for the Aged project supported strategic management in Espoo in two ways. First, its subprojects each implemented Espoo's aging policy. Second, the project gives the participating supervisors a possibility to develop their own network-management skills. This also applied to the top management of services for the elderly and health services, since the necessity of networking skills was especially evident when developing care pathways. Committing employees by means of traditional hierarchical management style and changing procedures in processes involving myriad actors were not successful.

What was sought after?

As regards Vantaa's part, the goals of the Driving Change in Welfare Services for the Aged project were to reform and develop services for the elderly and the personnel's competency, to advance joint responsibility for the aged throughout the city, and to develop elderly-work networks. The Health and Social Welfare department chose the following service areas to be developed: home care, daily activities for the elderly, and supporting caregivers. The project also strove to advance doing things in a new way. The new organization needed to develop partnership networks, standardize procedures, and enhance the personnel's competency. Service development based on customer needs was an essential starting point. The project also supported creation of a novel approach.

Home care aimed to develop approaches and registration practices. Co-operation with health centers was an important development area. Before the project, daily activities for the elderly had been concentrated under the authority of just one supervisor. The project aimed to develop the contents of rehabilitative daily activities and so-called open daily activities that are implemented in co-operation with different actors. In Vantaa, establishing the trial senior citizens' welfare clinic operations was one of the project objectives. As regards support for caregivers, the discussion in Vantaa had mainly focused on the amount of family caregiver allowance. The project sought after new services for family-care recipients and forms of support for caregivers.

Co-operation between the city's different departments was central to developing both senior info and socio-cultural methods. Vantaa's aging policy was to be compiled by means of an extensive network-like approach where the council for the elderly and senior citizens in Vantaa play a major role. Senior trainer education, created at Laurea at an earlier stage, was integrated in the project. Thanks to the project, a natural connection arose between senior trainers' volunteer work and the City of Vantaa's service production. Senior trainers were also irreplaceable in other subprojects where they introduced the resident- and customer perspective into the development work.

As regards Espoo, the project objective was to develop networking and network-management competencies at Espoo's Health and Social Welfare department and its key networks. Networking partners consisted of services for the elderly, family and social services, services for the disabled, specialized care, purchased services, organizations, and volunteer work. Originally, there were four development areas: 1) developing co-operation between home care and services for the elderly; 2) developing SAP expert teams (later on, this subproject was named "developing geriatric teams"); 3) developing acute care pathways for the elderly; and 4) developing a network of mental-health services for the elderly. The last-mentioned subproject was not continued in 2010, because there were no preconditions for the network's long-term operations. In 2010, developing the acute care pathways was transferred to the HUS-coordinated SUTJAKE project ("flexible care pathways"). Instead of the acute care pathways project, in 2010 Espoo's third subproject was creating a comprehensive development network for services for the aged.

In addition to city-specific interests, Vantaa and Espoo strove for increased co-operation and peer development (figure 2).

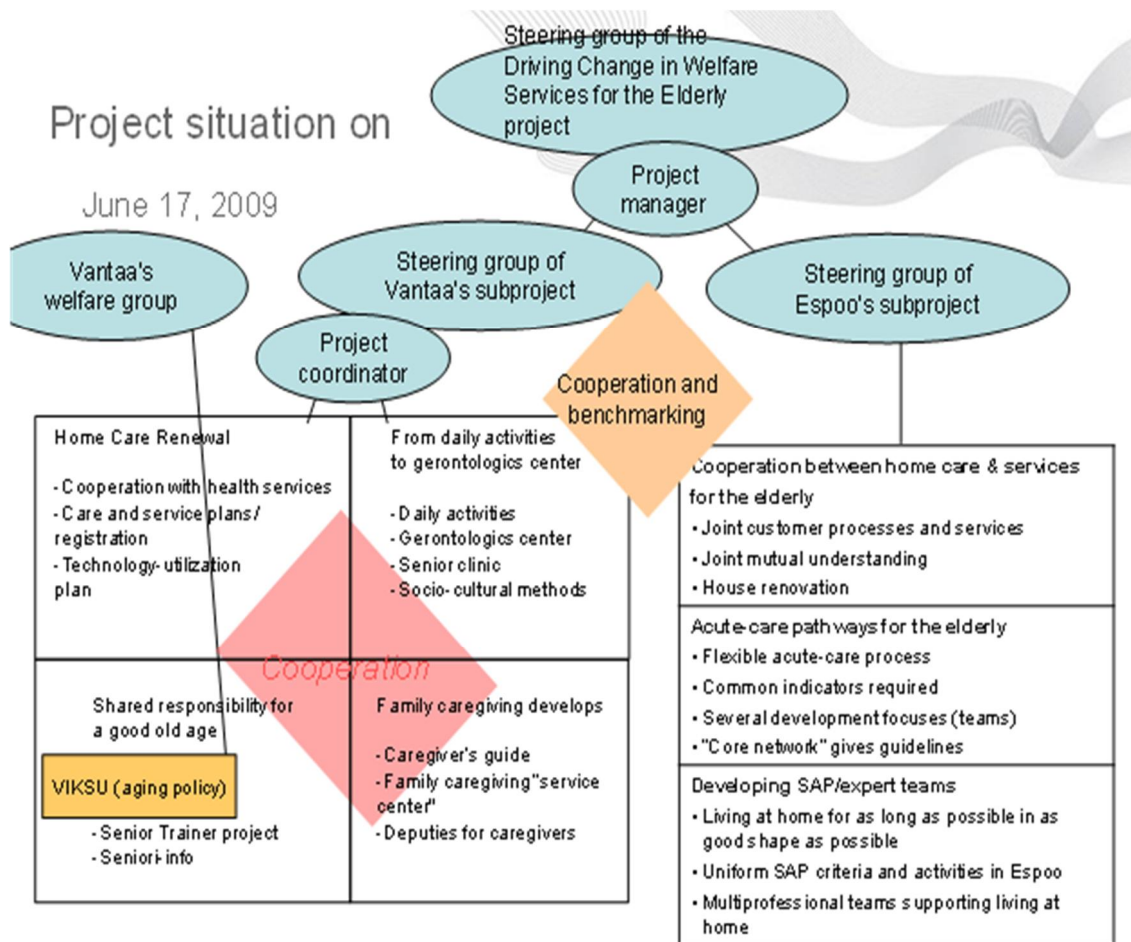


Figure 2: Organization of the Driving Change in Welfare Services for the Elderly project and situation of subprojects in 2009

What was accomplished?

As regards Vantaa's subproject, the project objectives were achieved. In the course of the development work, projects progressed at different paces. The project succeeded in both enhancing existing operations and creating new procedures. The concrete results of the projects are described elsewhere in this publication. Some of development measures implemented in the project were very close to ordinary operations, which is why it is for some parts difficult to say what the project's share is in reforming activities. Based on preliminary assessments, the project succeeded in not only developing operations but also creating a new approach. In addition, commitment to function-specific objectives improved.

Even though around 70 employees actively participated in Espoo's subprojects, the project results did not fully meet the expectations. Nevertheless, co-operation between home care and services for the elderly developed well and was established as a part of normal interaction already during the course of the project. Geriatric team operations had not begun by fall 2010, even though the kick-off schedule had been decided on. Developing acute care pathways for the elderly as a network got a good start, but stagnated in time. Developing a network of mental-health services for the elderly stopped after a couple of meetings. Likewise, creating a development network for services for the elderly stopped in the first leg of the journey.

In addition to city-specific interests, Vantaa and Espoo strove for increased co-operation and peer development. In 2009, the City of Espoo started senior trainer education after an Espoo employee had participated in a corresponding course given by the City of Vantaa. Numerous employees of services for the elderly in Espoo participated in the project seminars. In the course of the project, supervisors and employees at both Vantaa and Espoo home care became very willing to develop their operations by learning from one another. Joint home-care meetings between Espoo and Vantaa employees have taken place on a regular basis.

What went well and why?

From the perspective of strategic management, the most important result was compiling Vantaa's 2010–2015 aging policy (City of Vantaa 2010). The policy consists of the aging program and its implementation plan (VIKSU) that dictates the operations of all the city's departments and actors and the Health and Social Welfare's service-structure development program. The policy received positive feedback. The project enabled sufficient resources for compiling the policy. The chair of the council for the elderly participated in compiling the policy, and the senior trainers worked actively and brought the necessary resident- and customer perspective into the work. Aalto University's network researchers were also deeply involved in the preparation process and enabled the good end result.

The fact that the project results were for the most part included as objectives on Services for the Elderly and the Disabled's balanced scorecard promoted the achievement of project objectives on a general level. In addition, the people responsible for development were often also responsible for the operations in question. Furthermore, the fact that Vantaa had a fulltime project coordinator—who in general promoted the project coordination and progress, but could also support the subprojects when required—contributed to the success of the project. The input of Laurea University of Applied Sciences Tikkurila and Aalto University School of Economics in the project was great, both quantitatively and qualitatively, which facilitated the achievement of good results.

It is important to note that the majority of the new procedures generated by the project does not require additional resources, but can be implemented with existing resources by changing the contents of work and division of labor and by doing things in a novel way. One characteristic of Vantaa's project was that at first the subprojects developed operations from their own starting points, while the final solution could be found by "crossing borders." (Figure 3). One example of this is the caregiver centers proposed by the caregiver group early in the project whose functions were finally implemented as part of daily activities and that the subprojects in question developed together.

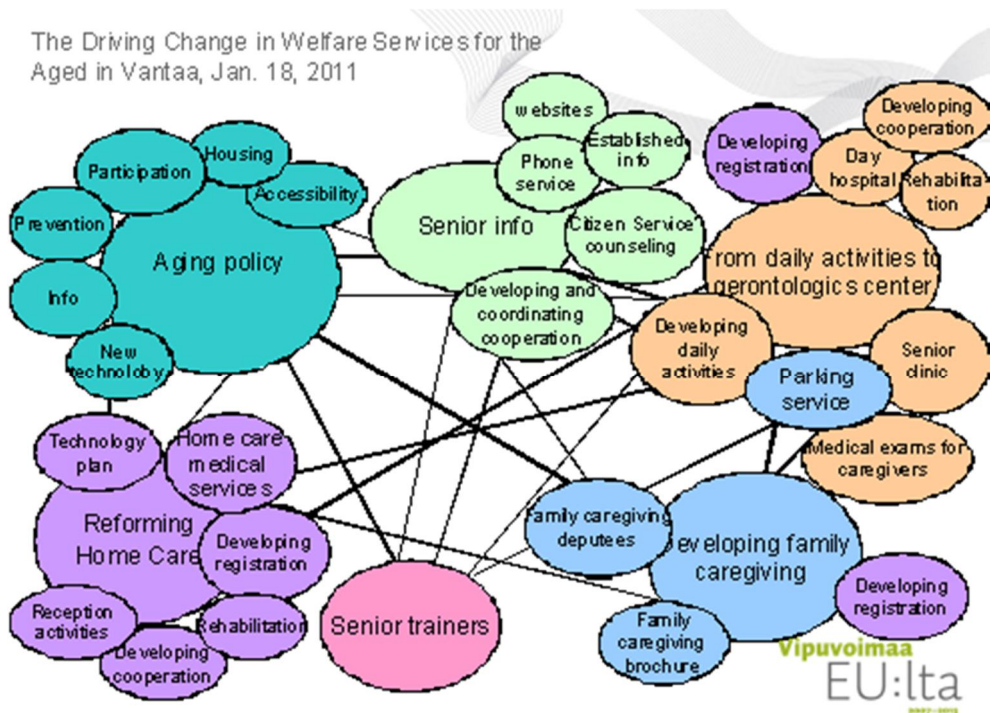


Figure 3: Situation of Vantaa's project in January 2011. The Supporting Family Caregiving project, in particular, has "crossed borders"

In Espoo, co-operation between home care and services for the disabled succeeded very well for a number of reasons. First, the managers of both home care and services for the disabled deemed development of co-operation to be not only necessary but also sensible. Second, also the middle management—direct supervisor level (home care counselors) and representatives of the personnel—were motivated to develop co-operation. This was due to, for instance, the fact that many customers considered challenging were common to both organizations. The third contributing factor was that the key actors that were committed to developing co-operation were found at a very

early stage. The fourth contributing factor is without doubt both managers' ability to motivate their troops to mutual networking. The fifth factor is that the contribution of the university experts was regarded as especially rewarding by this group. The experts' role was clear.

Where did failures occur and why?

In Vantaa, co-operation between home care and health centers did not develop according to the original objectives. At the beginning of the project, committing the top management of health services was not sufficiently focused on. In addition, putting it bluntly, one can say that co-operation between home care and health centers is of the kind that home care needs (medical services for home-care patients) whereas health centers do not (medical services for patients that cannot come to the health center). The health centers were simultaneously involved in two development projects of their own: the personal-doctor model and developing teamwork at health centers, which surely diminished the enthusiasm for co-operation. In hindsight, developing co-operation between health centers and home care should have been included as a part in developing health centers' teamwork.

In the Home Care Renewal and Family Caregiver Allowance projects development was started and realized slower than in the other groups. The likely reason is that the person responsible for developing home care retired and another person assumed these duties. Organizing family caregiving in Vantaa changed in the course of the project. After restructuring, the person responsible for development was no longer responsible for family caregiver allowance. Developing support for caregivers required co-operation with the other subprojects (daily activities, Senior Clinic), which also demanded more time.

In Espoo, planning the operations of SAP-expert teams, i.e., geriatric teamwork, progressed slowly in 2009. It was difficult to get all the necessary experts in the workshops at the same time. Moreover, the employees and management of services for the elderly and health-services profit centers had highly differing perspectives on how and in which direction SAP operations (clarify-assess-service counseling) should be developed. The group also included strong opinion-shapers whose commitment to the new approach created in the course of the subproject was questionable. Some of the experts were severely stressed about resources. In addition, key persons in practical management were under a heavy workload, which is why adopting the geriatric team model was transferred to the fall of 2010.

Developing acute care pathways for the elderly in co-operation between all the actors involved had already started in Espoo in 2008, and it was boosted by the inclusion of networking experts. After discussions with the experts, management of the subproject was changed: from traditional steering group management into networking in such a

way that a so-called core network headed and coordinated development work. There were, however, problems in making the new approach work. One of the problems was that the actors involved did not reach a consensus on who owns the acute-care pathway for the elderly. Likewise, consensus on the indicators measuring the flexibility of the care pathways was not reached to the extent that it would have been possible to regularly monitor them. The subproject demanded more time from the manager of the elderly care responsible for the subproject (JV), clear and regular flow of information toward all the actors, and support of the top managers of all the organizations involved, for example, in the form of a steering group. A crucial improvement would likely have been if a part-time or full-time project manager or project coordinator responsible for the progress of issues agreed and flow of information could have been assigned to the subproject.

Espoo's actors in health and social welfare and organizations met a couple of times for developing the network for mental-health services for the elderly. Nevertheless, such representatives of line management who had the possibility and power to influence implementation of issues agreed upon did not participate in these networking meetings. Therefore, the meetings were not continued. The aim was to create a network for developing services for senior citizens in Espoo in the course of 2010. The members and tasks of the network were outlined in the spring of 2010. Because no permanent director had been chosen for the position of director of services for the elderly by the fall, it was not deemed sensible to convene the network before the summer.

Lessons of the project

Development projects shall be an established part of developing cities' service systems. The projects shall support achievement of strategic objectives and vice versa; the project results shall also be included as objectives on balance scorecards. Quite often, ideas for development projects originate from other organizations and their objectives do not necessarily serve cities' development.

The number of development projects shall be limited. Ideas for projects easily arise from cities' own activities. They are also created by several bodies interested in cooperating with cities. Too many projects exhaust supervisors and employees and may take away too much time from basic duties.

It is crucial that top managers of health and social welfare be committed to strategically important projects. They must be kept up-to-date, preferably as active project participants, during the entire course of the project. If the person responsible for the operations under development is not an active participant in the project, he or she shall belong to the project's steering group so that establishing the results is ensured.

The roles of the project participants and external experts shall be clear, and it is worthwhile to repeatedly discuss these roles in the course of the project. A representative of the city shall oversee projects and subprojects related to developing the city's own operations. Representatives of the city shall mutually agree on who oversees what.

Organizing network management in care and service pathways involving myriad actors is challenging. In addition to the support and guidance by top managers, big projects shall have a project manager or another dedicated coordinator who thoroughly knows the practical work and has the stamina to ensure the progress of the subprojects.

When generating ideas for this project, the starting point was a five-year project. Financing was gained for a three-year project, which was good. A 3-year development project is sufficiently long.

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Authors

Matti Lyytikäinen

Lic.Med., Specialist, M.Sc.

Director of Services for the Elderly and the Disabled, City of Vantaa

Peltolantie 2D, 01700 Vantaa

matti.lyytikainen@vantaa.fi

Jaakko Valvanne

M.D., Ph.D., Professor of Geriatrics

School of Medicine, University of Tampere

Lääkärintie 1, 33014 Tampereen yliopisto

jaakko.valvanne@uta.fi

Essential development elements of networks and networking process

Timo Järvensivu, Katri Nykänen and Rika Rajala

Abstract

Networking is an integral part of producing services in the field of social and health care. Networks are needed especially when the aim is to produce holistic customer-oriented services. In this article, we describe briefly central elements and process of networking. Networking can be described as a process entailing four phases: identifying the challenge that requires a network, mapping the existing network, and inviting the required network to the first meeting(s); creating the common goal, and specifying how the network will function; working systematically towards the solution; spreading the solution the network has created and the network know-how it has gained during the process of networking. In the heart of good and successful networking there lies trust and commitment towards networking and the capability of the network to provide a solution to the challenge. Trust and commitment evolves during the networking process.

Introduction

Networking constitutes an essential part of everyday operations in the health and social services sector. Simultaneous increase in the number of customers and the growing demand for labor in the field pose challenges especially to provision of services for the elderly. The challenge can be partly met by promoting networking and partnering between the actors in the field. Networking boosts service development and efficiency, for instance, by curbing overlapping functions.

Networking is in demand, but the concept of networking has partly become stale due to abundant use: In other words, the importance of networking has frequently been emphasized, while operations have sometimes failed to change with words. Moreover, networking has been defined in several different ways; for instance, it has been used as a

synonym for teamwork, multiprofessional co-operation, and partnering. This multitude and blurriness of concepts have hindered the potentials and practices of networking.

In health and social services, networking can be hindered by a number of factors: lack of time for joint negotiations, the interests of different actors do not meet, the logics of hierarchy and network point to different directions, structures do not promote co-operation, or personal chemistries do not mix. Even though obstacles to co-operation may be powerful, they can be overcome with the help of long-term systematic networking.

A networking model differs from other operating models—such as hierarchies and markets—as regards the relationships between actors. Network relationships are based on trust and commitment (Podolny & Page 1999; Powell 1990). Network actors are, as a general rule, free to make their independent decisions, which means that it is not possible to direct operations by hierarchical authority or market-based purchase-and-sale operations. In networks, the strength and longevity of relationships are based on mutual trust and shared objectives. A well-functioning network can develop new innovations more flexibly than hierarchies and markets (Powell 1990). For example, developing new solutions in the Finnish health and social sector often fails because the municipal organizations'—that are responsible for arranging services—organizational boundaries prevent good co-operation. For the same reason, municipal organizations' ability to utilize the development potentials of, for instance, businesses, organizations and volunteers is often limited.

This article describes, in brief, the model for the basic elements of network management and networking process, resulting from the Driving Change in Welfare Services for the Aged project. A more detailed description is included in the Verkostojohtamisen opas ("Network management guide") that can be downloaded at: www.verkostojohtaminen.fi.

Network management enables trust and commitment

Network management can be briefly defined as measures that promote the functionality of the network (Järvensivu & Möller 2009). The network is functional when it creates added value to its actors. The functionality of the network can be promoted by focusing on mutual trust and commitment between the actors (Mandell 2001; Powell 1990; Kickert & Koppenjan 1997; Keast & Hampson 2007; McGuire 2002; Hunt & Morgan 1994). Trust and commitment enable information flow between the actors, which is essential for development. On the other hand, without open discussion and transfer of information, trust and commitment cannot arise. Thus, trust and commitment as well as information flow and functional development are elements that either boost or weaken each other.

Trust evolves through long-term and recurrent co-operation (Gulati 1995), which is why it is important to give every network member time enough to build trust. Parties that trust one another are willing to contribute input into co-operation on a long-term basis, they do not seek their own interest, and openly turn to their partners also in times of crisis. Furthermore, trust reduces friction in conflicts as well as the costs of finding new actors. (Gulati 1995.) When there is no trust, the parties are not prepared for open discussion, nor do they turn to one another to solve problems related to, for instance, a joint customer (Zand 1972; McEvily et.al. 2003).

Trust and commitment can be analyzed between not just people but also between teams, units, and organizations. Trust between different parties can only evolve when the parties know each other well enough. Trust and commitment between organizations can be anchored in co-operation routines such as agreed rules for co-operation, meeting practices, and ways of showing mutual respect. This anchoring can only strengthen or weaken through human action. Trust is also an individual characteristic (Gulati 1995). In networking one must account for the fact that some network members are by nature more trusting and some more suspicious.

Trust and commitment are both sensitive to exercise of power (Morgan & Hunt 1994). Exercise of power may even prevent commitment. Nevertheless, health and social services are in practice dictated by political exercise of power, and the municipal sector acts hierarchically. Since the health and social services sector includes these kinds of power structures, it is important to know when wielding of power is necessary and how it can be implemented so that it will not crumble trust and commitment. It is especially important to avoid too excessive exercise of power in such critical situations when fast decision-making is tempting but may in practice lead to lost trust and commitment between the actors. Since trust and commitment are built over a long time in co-operation between people and since this development process is sensitive to exercise of power, network management does not translate into short-term authoritative leadership but, above all, long-term work to enable good relationships between people. Management's core task in a network is enabling trust and commitment.

Networking as a process

Networking is not a one-off event, but a continuously developing interaction process where the partners' knowledge, competencies, and values are combined into common objectives and value-creating operations (e.g. Hakanen et.al. 2007). Trust is not born in the course of just one meeting; it is an iterative process. Trust born and shown in the process creates even more and deeper trust (Gulati 1995).

Networking process is characterized by the following four essential characteristics:

1. Identifying the network challenge, charting the existing network, and summoning the required network
2. Creating a common goal and specifying a joint operating method
3. Systematic networking in order to achieve and monitor goals
4. Spreading the results of networking and network competency

The phases can be distinguished from one another on the basis of the essential networking challenge depicting them. Success in a previous phase enables transfer to the next one and success in it too (Figure 1). Between the phases, one can also go back, as required.

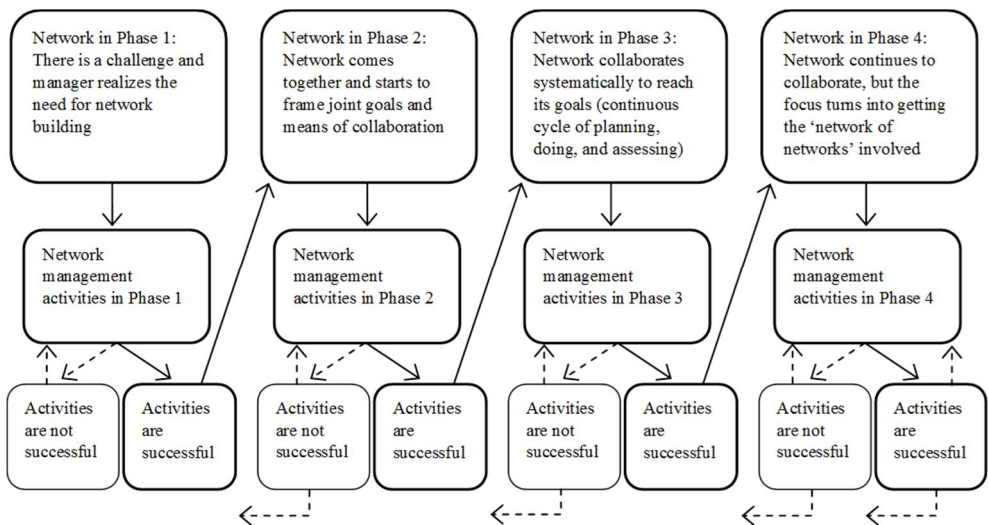


Figure 1: General model of network development through network management activities

In the first phase, network management is responsible for identifying the key network members and motivating them to solving the joint challenge. From the manager's perspective, this phase begins in practice by noticing a specific challenge and understanding that this challenge cannot or should not be solved alone: the network shall be summoned. At this point it is important to chart the network and its functioning, for example, by interviewing a sufficient number of key network actors. Based on the chart, the network manager can preliminarily plan the network's operating model: what the network aspires to, what the network structure is, how the network is coordinated and managed, what the participants' roles and responsibilities are, and how the network operations are monitored and developed. This phase is successfully completed when a

preliminary operating model for the network—which helps to solve the challenge—has been outlined and when the network has been summoned and motivated to joint discussion. The network manager is responsible for motivating the summoned people by explaining the importance of the challenge and the necessity of the network-type operating method.

At the beginning of networking, there already is a certain preliminary level of trust and commitment, based on the parties' attitudes toward one another, either as persons or organizations (Möllering et.al. 2004; Laaksonen et.al. 2008). When networking progresses, trust and commitment develop, and it is common that their levels vary from time to time. It is important to deepen the level of trust, since the initial trust is not yet sufficient to build commitment and create an atmosphere suitable for free and open discussion. Actual trust starts to evolve when the actors learn to know one another. It is important to provide time and space for discussion.

The aim of the second phase is to find common goals, agree on joint operating methods, and, when required, update the network members to correspond with the goals and operating methods. It is important not to start co-operation by directly finding solutions; one must begin by strengthening mutual familiarity, trust and commitment. At the beginning of networking, it is good to give the participants an opportunity to present themselves, their expectations, and their competencies. This makes it easier for the actors to get to know one another. Presentations are time-consuming if the network is big, but they are an important investment in building mutual trust between the network members.

When the network members get to know one another and their expectations, common matters can be handled in a more positive atmosphere. Sometimes the challenge to be solved by the network is of such nature that some of the actors join the co-operation filled with negative expectations. This, however, is not an obstacle to networking; on the contrary, it may even constitute an important reason to summon the network. Addressing negative attitudes can, at best, result in genuine co-operation, provided that the network is prepared to openly discuss even difficult matters. It does, however, take time to build this kind of openness. The network commits best to such objectives and operating methods that it has itself specified. This does not mean that the network must start defining a goal or operating method from a clean table, since the network goals are always defined in relation to the network members' expectations and in relation to the environment outside the network. Preliminary goals and operating methods have already been outlined in the first phase of networking.

Health and social services networks always operate within a municipal sector's hierarchical field. In this environment, defining the network objectives and operating methods always partly results from accounting for external objectives and operating methods. For instance, goals set by management or demands due to a municipality's

financial situation may set certain outlines that the network cannot ignore. Anyway, the network shall always have the final say in choosing and defining its more specific goals. Finding joint customers helps to promote finding common goals.

When specifying operating methods, it is worthwhile to keep in mind that network-type decision-making is by nature slower than hierarchical decision-making. It is important to create practices that enable open discussion on also such matters that are difficult to decide. Making decisions on difficult matters should not be progressed until the network has reached a sufficient level of understanding. As far as the operating method is concerned, it is important to list and agree on each actor's essential roles and responsibilities. When objectives and operating methods are agreed, it is worthwhile to once more revise the network members and ensure that the network has sufficient resources for the planned operations.

The third phase consists of long-term, systematic joint work that aims to achieving the jointly agreed objectives by means of jointly agreed operating methods. Work adheres to the common developmental cycle: planning operations, acting, assessing actions, and acting on the basis of the assessment (e.g. Joiner 1994; Lecklinin 1999). This cycle is repeated again and again until the final practical solution is successful or until it is agreed that a solution cannot be found. It is essential for networking that the entire network participates in all the phases of the developmental cycle described above. The network's commitment to development may weaken, for instance, if assessment is not carried out by the entire network, but an external actor—such as a separate management group—is responsible for the assessment and the resulting decision-making. It is important that the network itself assesses its own actions and makes decisions on its own operations. The network can, of course, seek outside support, but the network's long-term commitment requires that the network is empowered to make its own decisions.

During actual work, information flows within the network in very many ways: verbally and nonverbally, electronically and in paper form, in workshop discussions, and by e-mail. The importance of information flow should be self-evident in the network. Nevertheless, in practice a good flow of information is almost a universal and recurrent challenge in all networks. The network should continuously analyze its internal flow of information and be committed to developing it. Open and constructive discussion can be promoted with the help of inclusive approaches such as workshops. Successful network organization and successful discussion between network members also require systematic coordination of overall operations. In this context, coordination refers to planning and promoting meetings, workshops, information transfer and other co-operation-related measures as regards time and place. It is good to facilitate workshops to enable good discussion between the actors. The purpose of facilitation is not to prevent conflicts or prejudices from arising; it aims to promote constructive and fruitful handling of these conflicts and prejudices.

Co-operation deepens when the network learns together and when the time spent together, for instance, at workshops, affects the network members' actions also outside their time together. This demands that the network members implement the agreed measures in their own everyday life and transfer information from the network to their own backup troops and vice versa. Networking also emphasizes the importance of committing to independent activities outside workshops and other joint work.

Systematic networking requires monitoring and assessment of monitoring data. Monitoring shall cover all the objectives and operating methods set for the network (Figure 2).

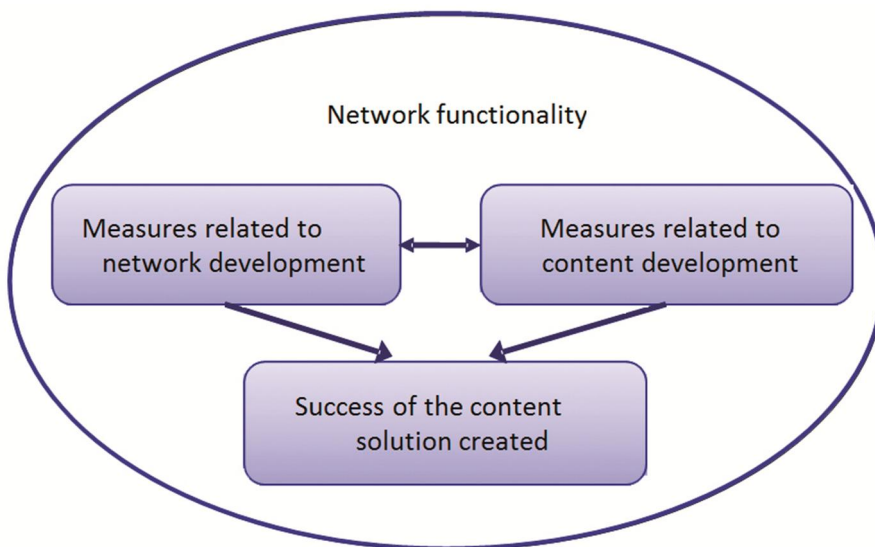


Figure 2: Network elements to be monitored

Successful networking measures and network functionality do not signify that the network has succeeded in all its goals. The success of the network depends on whether it can create a solution or solutions for the original challenge that was outlined in the first and second phases of the networking process. On the other hand, the network goal may also change along the way due to internal or external factors, which means that network success can also be assessed based on how successfully the network can—when required—reform its goals.

Monitoring shall include both qualitative methods and quantitative indicators. It makes sense to primarily utilize existing monitoring methods such as balanced scorecards devised for strategic monitoring. Separate questionnaires and interviews of actors can also be utilized as monitoring methods. At best, monitoring data can be acquired from

existing data systems, but monitoring of networking measures and network functionality is often a new thing for health and social services actors who have no data systems for monitoring these issues.

Successful monitoring does not merely depend on defining appropriate indicators and methods. At least as important is to set up a joint model for collecting and analyzing monitoring data. The monitoring data can be collected by a named team or an outside party, but it is important to include the network members in assessing the monitoring data as well as in the decision-making based on the assessment. Handling the assessment data together boosts mutual understanding of the network objectives and measures as well as success in them. This mutual understanding is a key element enabling trust and commitment.

When the network has created a solution for the original challenge, it can move on to the fourth phase and start spreading the results of its works on a wider basis (Figure 3). At this point, the network faces a new challenge related to trust and commitment: new actors should be made to trust the solutions developed by the network and to commit to adopting them.

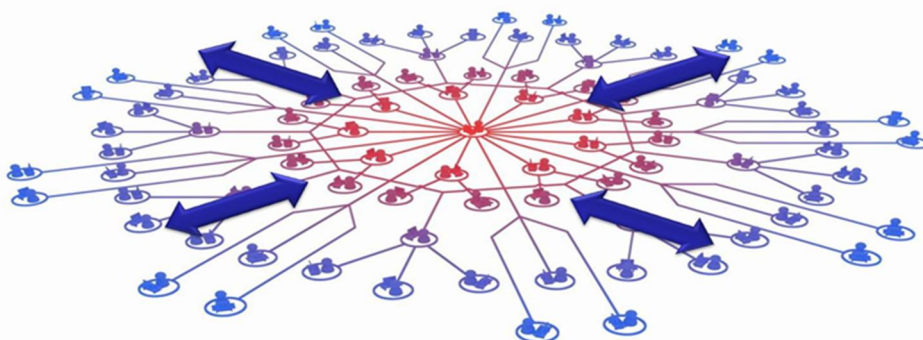


Figure 3: Network starts to spread and establish solutions into wider networks

It is important to note that even at this phase at issue is not "pushing" a ready solution to be used by others: Instead, it is essential to build with this wider network such mutual trust and commitment that ensures the solution's spreading and getting established. In other words, new actors must be empowered and included in spreading and establishing. This may also mean that when the solution spreads and becomes established, it may turn into various kinds of new solutions. In this stage, the network actually accepts a new challenge: spreading the solution. This challenge demands new goals, new operating methods, and a new systematic networking model. From this perspective, the network returns to the initial phase of the networking process.

The challenges of the fourth networking phase can be prepared for already from the beginning of the networking process, or permanent structures can be created for putting solutions into practice. For example, the director of health and social services can build in his/her department—or even cross-departmentally—a network structure where different public-sector or private-sector actors can bring their solutions for assessment and utilization. It is important to create into this kind of network in advance such mutual trust that promotes even fast adoption of new solutions. In addition to encouraging the network actors to share information about their own best practices, the culture of mutual trust encourages them to try and adopt solutions developed and found good by others.

Summary

We have described essential challenges of networking and network management and viewed the networking process. The process model we have described helps to identify the basic network development challenges and to direct networking measures in accordance with each actual networking situation. This process model is a simplified ideal model, progressing in stages, whose practical applications may vary to a significant extent.

At the core of networking lies trust evolving between the actors, which makes it possible for the network to create common goals and operating methods. In the courses of the process, mutual trust begins to promote commitment to joint objectives and operating methods. At best, a positive circle of trust and commitment is generated. This development is promoted by the foundation of co-operation, that is, systematic setting of goals and assessment workshops.

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Authors

Timo Järvensivu
D.Sc. (Econ.)
Research manager
Aalto University School of Economics
timo.jarvensivu@aalto.fi

Katri Nykänen
Ph.D. candidate
Researcher
Aalto University School of Economics
katri.nykanen@aalto.fi

Rika Rajala
Master of Social services
Student of Social Science
rika.rajala@kolumbus.fi

Developing a gerontological center in Vantaa

Päivi Keskinen, Anne Eskelinen and Timo Järvensivu

Abstract

The City of Vantaa has developed gerontological centers during the Driving Change in Welfare Services for the Aged project. In this article, three participants in this project describe the process and elements of the development and define the elements that have an effect on the process. The local network workshops formed a significant working method during the project. The City of Vantaa employees, members of different associations and organizations, researchers from Aalto University School of Economics and students and lecturers from Laurea University of Applied Sciences participated in these workshops and development work.

In this article, the writers describe the development process of a gerontological center in three aspects: The Learning by Developing model (LbD), management in practice and the four-step process of network management. There were challenges in the development work but the keys to solutions were found. The focus is the importance of the network and developing this network as a part of gerontological centers.

Introduction

The Development of the From Daily Activities to Gerontological Center project had its starting point in reforming daily activities. The aim was to find new developments for daily activities in customerships, developing the employees' competencies, multiprofessional network co-operation, and operating environment. As equal partners, the project consisted of representatives of the City of Vantaa, Aalto University School of Economics, Laurea University of Applied Sciences, and Vantaa associations and organizations. Joint network workshops—where operations were developed by including various bodies in planning—formed the framework for the project.

This article analyzes the development of a gerontological center from the perspectives of development-based learning (i.e., learning by developing, LbD), network management, and practical management. The aim is to present not only our essential observations about the challenges of developing daily activities and gerontological centers, but also to introduce preliminary conclusions for further considerations about learning by developing and network management theories.

Development was based on Laurea University of Applied Sciences' Learning by Developing (LbD) model. The starting point for LbD is that instruction progresses in R&D projects conducted together with the employment sector. Learning objectives are development and problem situations in authentic working life. Acting in projects is a guided and systematic process where each actor and organization has the possibility of developing new competency. The LbD model combines learning objectives and the basic task of a university of applied sciences, which consists of integration of pedagogical task, R&D, and regional development. (Pedagoginen strategia 2007, 5-8.) According to Rauhala (2009, 33), LbD entails a vision of the learning situation as a Dewey-ish educational thinking, according to which a learning situation is part of working life and society and not an isolated, artificial island.

In the LbD process, the individual and thus all the project actors are always in the learner's role. The process generates both individual and communal learning, as well as new knowledge based on partnering. At its best, all the parties' competencies enhance in the course of the project. Researched knowledge, skills-based knowledge, ethical knowledge, and empirical knowledge are interconnected by sharing and acting together. (Raij 2006, 22.)

The five dimensions of LbD consist of authenticity, partnership, empiricism, researchability, and creativity. Learning by Developing enables structuring of new knowledge-based information through individual and communal learning. (Pedagoginen strategia 2007, 7; Raij 2006, 27-28.)

Developing the gerontological center provided all the project actors with an authentic, genuine environment for learning and generating new competency. Empiricism was based on the actors' sharing of thoughts and perspectives during network workshops and development activities. Working was based on an approach where operations were based on joint work, interviews, feedback, and assessment. Creativity as part of joint working translated into different ways of implementing teamwork by utilizing methods and the possibility of "thinking aloud," the permission to introduce one's own, even unfinished, thoughts in the work of teams and workshops.

Gerontological center development process

The goal of the From Daily Activities to Gerontological Center project was to develop the gerontological center concept in Vantaa from 2008 to 2011. At the start of the project, the following objectives were set for development: defining the customership and service package of the gerontological center; strengthening the partnerships; choosing pilots; implementing and assessing; defining and verifying effectiveness; concretizing customer-orientation; and participating in planning the Koivukylä and Tikkurila senior citizens' centers.

In the fall of 2008, the workshops generated ideas for the service package of the gerontological center and defined customerships by jointly outlining the customer process at Vantaa's Services for the Elderly from the perspectives of the customers, employees, and management. The potential contents of the gerontological center were outlined in workshops and in-between them, and the significance of the partner network in the center's operations were outlined. Customers' activity was supported by providing a package that satisfies their needs. The starting point was open and preventive activities, in which anybody willing could participate. The customers in very poor state of health would come to the center by referral, for instance, as customers of daily activities. It was deemed important to give the center a customer-friendly name, instead of calling it a gerontological center. From the employees' perspective, the most important elements consisted of supporting multiprofessionalism and the possibility of utilizing and developing one's professional competency. The management deemed assessment and development of the effectiveness of the center to be important.

At this point, the gerontological center was envisioned as a mostly physical place where several actors networked regionally. Co-operation partners consisted of, among other things, sports services, health services, leisure and citizen services, youth services, volunteers, associations, and businesses. Coordinating premises and activities—for which the city bore the main responsibility—was regarded as a key support function. The center's operations were considered preventive, group-form activities, some of which were open and some targeted at specific customer segments. Another essential service was the café and meal service.

At the turn of the year 2008-2009, one of the project subgroups assumed responsibility for conceptualizing the gerontological center and piloting more in-depth planning. In early spring 2009, the team decided to pilot the concept in the Myyrmäki district. It was noticed that the pilot could not be planned without including local actors in Myyrmäki, which is why the conceptualization was planned in regional workshops. It was considered important that, as the concept develops, the pilot was expanded to other areas as well, for instance, Simonkylä and Koivukylä.

Myyrmäki pilot

The first network workshop was arranged in Myyrmäki on March 12, 2009. Around 40 organizational actors and city employees participated in the network. Ideas for the concept for Myyrmäki gerontological center were generated by means of teamwork and discussions. The central features of the concept were outlined as follows: The center is a modifiable low-threshold meeting place for people of different ages and different states of health offering independent and guided activities to individuals and groups. Peer counselors, volunteers, third-sector actors, and the city's multiprofessional employees work at the center. Daily activities and senior clinic constitute a fixed part of the gerontological center.

The next network workshop was arranged in Myyrmäki on May 11, 2009. Around 60 local actors, city employees, and project employees participated in the workshop. The workshop continued planning of the gerontological center on the basis of themes collected from the previous workshop. Teams envisioned the senior citizens' center by answering the questions "what, where, who and when." The workshop decided to set up a regional coordination group to promote the Myyrmäki pilot. The group consisted of eight persons representing different city units, local retirees' organization, senior trainers, and other local actors. The tasks of the group were planning the following network workshops and concretely promoting the Myyrmäki gerontological-center concept in general. The aim was to launch the Myyrmäki gerontological-center operations by the end of 2009.

In the course of fall 2009, planning the Myyrmäki gerontological center was continued in two network workshops, on September 24 and on November 25. The September workshop regarded café operations as a key development step that would enable the center's other operations. There were two core challenges to the café operations: where to find premises and managers for the café? Organized by the city, Myyrinkoti café could be open for a few hours per week, whereas there was demand for everyday café operations. The café run by Myyrmäki's retirees was already open on a daily basis in the local youth house, but resources were not sufficient to expand operations. The workshop could not find solutions for these challenges.

Student-assistants at Laurea University of Applied Sciences made a service chart of the Myyrmäki district for the November workshop. They collected all available activities targeted at the elderly, provided by the city, congregation, associations, and organizations. The service map was analyzed and it was immediately evident that describing the service map was a desired concrete measure. When studying the service map, it was found out that café operations—together with other activities—were already provided at different outlets. It became clear that the gerontological center should be more than just a café and a network built around it. It should a partnership

network for different—primarily local—actors (e.g. municipal units, organizations, congregation, volunteers, members of the municipality) not an individual place. In the November workshop, it was deemed important that local information on all services and operations be available to the local aging population and service providers. The possibility of arranging a fair or similar event for both the actors concerned and the elderly during spring 2010 was considered. The fair would be a way of creating new co-operation between the actors. Coordinating, informing and arranging the fair was assigned to the coordination team.

The next network workshop took place on May 26, 2010. The coordination team organized the workshop in which 34 local actors participated. The participants presented their operations, pondered on how to promote co-operation, charted holes in services, and prepared a brochure on local operations. The goal was that the coordination team promotes development work and strengthening of networks in Myyrmäki and its environs in West Vantaa. A brochure on operations targeted at the elderly in Myyrmäki and Kivistö was published in spring 2011, and an event targeted at the elderly in the region was planned for fall 2011.

Development in Simonkylä and Koivukylä districts

In December 2009, the team responsible for conceptualizing the partial project decided that during the course of spring 2010 the possibilities of expanding the pilot to the Simonkoti senior citizen's center were investigated. The aim was to utilize the experiences of planning the concept for Myyrmäki gerontological center in Simonkylä and Tikkurila. Since making the regional service chart was key to developing the Myyrmäki network, it was decided that Laurea's student-assistants make a similar chart of the Simonkylä and Tikkurila areas. The service chart was made in February-March 2010. Based on the chart, invitations were sent for the first local network workshop in which 47 actors participated.

In connection with the network workshop, a coordination team for Simonkylä was set up, summoned by the Simonkoti stimulus counselor. The Simonkylä senior citizen's center coordination team continued its operations, begun in the fall of 2010. On September 22, 2010, a "Joy and stimulus in life" seminar was held in Simonkoti; the 60 participants included employees, students, and volunteers.

Together with the Driving Change in Welfare Services for the Aged project, the City of Vantaa planned and built a new senior citizen's center in Koivukylä. The center was completed and inaugurated in the summer of 2011. The team responsible for conceptualizing the gerontological center monitored planning of Koivukylä center and in early summer 2010 decided that a gerontological center pilot is started in Koivukylä as well. It was also decided that a student-assistant of Laurea University of Applied

Sciences makes a regional service chart for Koivukylä. The chart was completed in August 2010.

The first network workshop of Koivukylä's senior citizen's center was held on December 13, 2010. The participants consisted of 31 representatives of organizations, volunteers, and city employees. The actors in the workshop got to know one another, the Koivukylä senior citizen's center, and its planned premises. The participants were pleased to be able to familiarize themselves with the plans and other network actors, but regretted that nothing more concrete was accomplished. In order to mend that, the workshop decided to widen the city's Koivukylä senior citizen's center planning team with representatives of the council for the elderly, Toimari ry, and senior trainers. Planning the Koivukylä senior citizen's center was continued in spring 2011 by this team, and the next network workshop was held in May 2011.

Summary of conceptualizing the gerontological center

The project aimed to develop a concept for a gerontological center in Vantaa, compliant with the objectives set (Figure 1). The starting point was to pilot a practical project in first one region and then spreading the concept to other regions. The conceptualization was based on the idea that the center is built around specific premises and operations, for example, daily activity center and a café operating in its premises. The limits of this way of thinking became, however, quickly obvious: city-provided premises in one area can act as the core of a gerontological center, but in some other area, the premises can also be an obstacle. Finally, the concept was based on network operations.

The Driving Change in Welfare Services for the Aged project piloted the concept of developing a gerontological center in three districts of Vantaa. Based on experience, key development elements can be brought to the fore. The starting point for development was making a regional service chart, on the basis of which all the local actors are summoned. The first joint meeting considers the competency of the local network and co-operation requirements. A coordination team, consisting of representatives of different bodies, is set to promote the work. The coordination team is responsible for arranging local network workshops where the members of the network get to know one another, plan and implement co-operation, learn to believe in the power of co-operation, and commit themselves to jointly promoting concrete issues. The coordination team is also responsible for local information and communication.

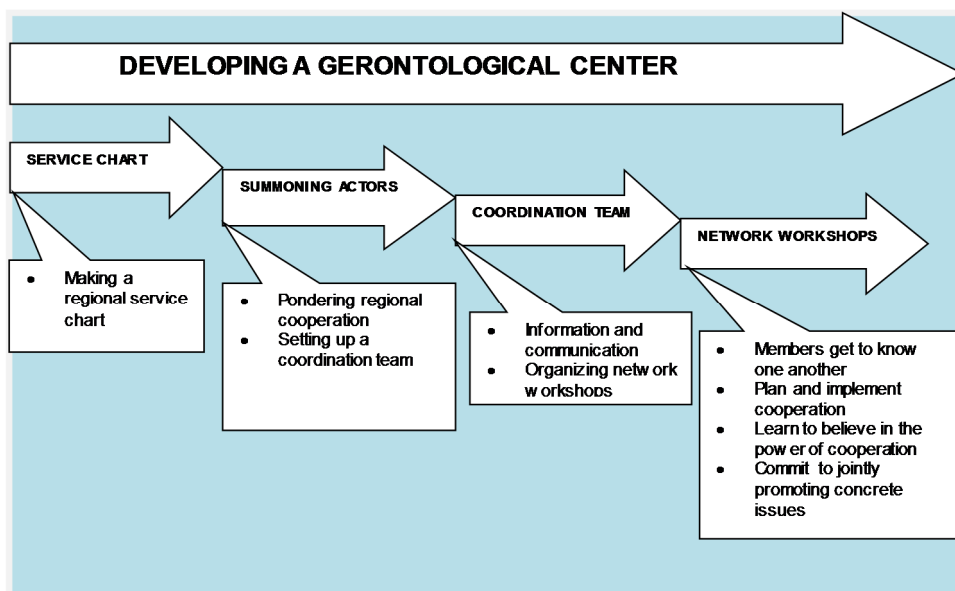


Figure 1: Concept of developing a gerontological center

Development process from the perspective of network management

Network management was one key development theme of the Driving Change in Welfare Services for the Aged project. The group of researchers at Aalto University designed a process model for network management. The model is described in detail in the network-management guide, generated in the project (see. www.verkostojohtaminen.fi), and in more detail in paragraph “Key elements of network development and networking process” of this article.

Network management can be defined as an enabler of networking. Trust and commitment are the core elements of the functionality of the network. It is important that the network manager avoid defining the network operations on behalf of the network. The members of the network trust in the objectives and adhere to agreed operating methods more when they have had the power to also decide on them. Networking demands time and sufficient possibilities of fruitful encounters so that there is time for trust and commitment to arise. Systematic co-operation translates into continuous planning, doing and assessing implemented in network workshops. In addition, coordination and facilitation are required. (Powell 1990; Kickert et.al. 1997; Keast & Hampson 2007; Morgan & Hunt 1994.)

The network-management process model consists of four stages. In the first stage, the task is to chart the network challenge and actors required for solving the challenge, as well as to summon and motivate the network. In the second stage, the network defines more specific goals and approaches for its co-operation. In the third stage, the network concretely promotes its objectives by means of systematic co-operation and monitors the progress of its operations. In the final, that is, the fourth stage, the network spreads and establishes the results of its work in wider networks. The progress of the stages is planned in such a way that good implementation of the previous stage promotes success in the following one.

The above-mentioned elements and process found their concrete manifestations in developing the gerontological center in many ways. First, it was noticed that, in the Myyrmäki case, undefined envisioning did not accomplish a concrete vision without piloting. Piloting made it possible to involve the actual actors in the gerontological center and their expertise. With the help of the workshops, concrete steps were taken, even though the progress was slow. Individual issues, such as arranging the café premises and resources, took a lot of time. Nevertheless, thanks to the chart of the regional network of actors, co-operation finally moved on. New actors were found for the network, and it soon became evident that the earlier individual issues were not the most important. The chart showed that the essential concrete challenge was how to gather all the local actors and their competencies around the same table to develop the gerontological center. The network finally defined a new objective: boosting the local network. The objective—found and defined in co-operation—increased the actors' commitment to developing the gerontological center.

Second, it was noticed that co-operation did not progress without a jointly agreed coordination model. The first Myyrmäki workshops were coordinated by the project, which was needed for launching the pilot. Coordination outside the local network did not, however, sufficiently commit the local actors. An important step was taken when the network chose its own coordination team whose representatives consisted of local actors, which make it easier for them to commit themselves to the work.

The third important observation was the network's commitment in Myyrmäki demanded a lot of time and network discussions for the actors to get to know one another, their expectations, objectives, and competencies. This long-term approach made it possible for the network to agree on joint objectives and approaches to which the actors were willing to commit themselves. For committing the network members, inclusive approach was key: in other words, workshop activities consisting of teamwork and joint discussions that were sufficiently coordinated and facilitated.

The fourth stage of the networking process—spreading and establishing the results of the development—started from Simonkylä and Koivukylä. Good practices learned from the Myyrmäki case were adopted in these two new projects. Networking of both

Simonkylä and Koivukylä was based on charting the service network. The networks were summoned and motivated to decide on the development objectives and approaches of their own areas. The objectives, approaches, and coordination teams were outlined in advance, but no decision was made: local networks were given a lot of power to generate ideas for their own objectives and approaches.

Development process from the perspective of practical management

The need to develop daily activities originated from the productive and financial challenges of the City of Vantaa's services for the elderly. Daily activities' functions were in need of updating: productivity was to be increased, meeting with customer needs was to be boosted, and compatibility with other services for the elderly was to be enhanced.

When the Driving Change in Welfare Services for the Aged project commenced in the spring of 2008, a new operating model had been adopted in Vantaa's daily activities. The most essential changes were developing the contents of daily activities into a more planned and goal-oriented direction and targeting daily activities only to customers in the worst state of health. The aim was to change the work culture from nursing into a more resource-based and rehabilitative one. The customer's earlier, more active role was to be emphasized. The change from a service day into an activity day well describes the desired change. Customer decisions on daily activities were made temporary in order to provide more residents with the possibility of participating. After the change, open daily activities were cut: they mainly consisted of assigning free-of-charge daily-activities premises for organizations and associations. The changes were not only significant for the customers, but also for the employees and partners.

When starting to change practices, what is needed is a clear conception of what is sought after, the ability to let the old and familiar go and thus make room for the new. This is often a long and painful process that requires perseverance and strong commitment to developing something new from the part of supervisors. Moreover, numerous discussions and negotiations with employees as well as customers and partners are required. Systematic information and communication are key. Leadership translates into communication especially in times of change.

Change has required the employees to learn many new things, on the levels of thinking, attitudes, and doing, for instance, as regards developing registration, new kind of networking, heading outward from daily activities, and unlearning old practices. The change has also made the employees consider "whether totally wrong things were done in the past."

Supervisors' unwavering support promotes employee's networking. The stimulus an employee needs may be expanding one's own competency, utilizing one's own expertise, or more versatile set of duties. Work units should also discuss what kind of an organizational or operating culture or leadership structure promotes and hinders networking and development.

Good management of a gerontological center requires, among other things, development of processes, internal and external co-operation and organizational structures; utilization of technologies and operating environment; as well as influencing them. When developing the quality of functions and services, the aim is that customer expectations and needs be met: who the services are targeted at and at what requirements. When developing work processes, one must consider the functions and services produced. Furthermore, the aim is to ensure creation of an environment that promotes the employees' actions and commitment to development. Values, attitudes and community's way of acting influence the organization and attitude toward development. (Aalto & Marjakangas 2008, 93 -94.)

Daily activities are regarded as an essential function in also future senior citizen's centers. The current customer criteria of rehabilitative daily activities need to be updated, for instance, as regards the groups that most benefit from the limited provision of daily activities. The open daily activities planned for the Koivukylä senior citizen's center will offer the residents, senior trainers and other actors a good possibility of creating activities based on local interests. The Koivukylä center will not have rehabilitative daily activities groups.

The local networks of gerontological centers are formed around the local-area principle. An easily accessed nearby service allows even an elderly person with limited functional abilities to participate. The goal is to develop and enable such operations that strengthen an elderly person's participation and social inclusion. The elderly are regarded as active partners in generating the center's operations. Because of regional differences, the local network of actors must be charted before starting actual development. Co-operation provides the possibility of utilizing the different actors' competencies, good ideas and operating models.

Multi-actor and versatile operations require methodicalness and coordination. The need for coordination became evident already at the very first network workshop of this project. The objectives and responsibilities of coordination must be determined. The model where a city's employee and, for instance, a senior trainer act as coordination partners or small group has proven functional. Coordinated volunteer operations are a necessary resource without which the activities of a gerontological center remain incomplete.

Considerations

According to Fränti and Pirinen (2006, 37), the problematics of development work conducted by experts is highlighted in projects. Fränti and Pirinen also underline that in interaction between competency networks, one can grow into a developer by engaging in development work. Learning things new takes place in the encounters and interaction between work, development groups, and studies. In project teams, competency and practice meet with one another. (Fränti & Pirinen 2006, 37.) Interactive learning and development was achieved in this project as well. The importance of partnering was highlighted in developing a gerontological center, also from the perspectives of developing competency, management practices, and network management. Co-operation and multiprofessionalism were seen on all levels as a significant factor, applicable to both this development and development related to gerontological expertise.

This project concretized how finding joint understanding within a multi-actor and multi-discipline network requires searching for a common language and shared definitions of the concepts used. Vantaa's senior citizens, professionals in health care and social services, Laurea's lecturers and students, and school of economics' researchers all have their own languages. Understanding these different languages required building of trust and "good will" among the actors at the beginning of the project. The importance of understanding and the concepts of language is also emphasized in working with customers and in customer-orientation.

Key to developing the gerontological center was that all the actors knew their own tasks and responsibilities and worked on the basis of their own individual roles. Responsibility for the joint goal dictated operations. Co-operation was smooth, since in development work all the parties concerned can be seen as beneficiaries developing their own competency as well as that of their respective organizations. The project workshops provided a novel kind of possibility of including the elderly and future service users in the development.

From the perspective of the LbD model, it was essential to include students in development. Defining the student's role in the project was a challenge, since a student can participate in the project for periods of varying lengths at different stages of the project. Health and Social Services students' work at the project was integrated into their different study modules, on-the-job learning, or thesis work. The students had different roles in workshop operations: they made service charts; collected data required for developing gerontological centers; interviewed the elderly, employees and partners; and introduced socio-cultural approaches in everyday work and welfare. Students' participation in the project for a very short time gave rise to questions such as how to get in in already ongoing operations as a full member of the network and develop one's

competency. Acknowledging the need for guidance and support and resources makes it easier for students to acquire true partnership.

Mäki (2008, 28–29) has described the challenges related to development from the perspective of a participating lecturer. It is not enough for the lecturer to have strong substance knowledge and pedagogical competency, because project work also requires community- and network competency. Learning is tightly linked to the community where one operates. Through community- and network competency, individual competency becomes owned and used by the community as a whole. At issue are skills other than interaction: one must understand the competencies of experts from other work cultures, and to utilize those competencies, community- and network competency is required. It is also important to combine one's own competency to that of others, which makes it possible to generate something new from different kinds of knowhow. The challenges described by Mäki can be identified as different actors'—not only lecturers'—challenges in developing the gerontological center. In addition to one's own substance knowledge, creating new competency requires unprejudiced community- and network competency where the richness is multidisciplinary work. Trust and motivation as well as appreciating the skills of others open up possibilities for generating new knowledge and competency.

Identifying, defining and further developing the process were key to this project as regards the perspectives of the Learning by Developing (LbD) model, practical management, and network management. Concrete work must begin by setting up goals and defining the means how the goals are to be obtained and how the process is to be assessed. Opening discussion and outlining what is to be striven at and what can be accomplished together are of crucial importance to co-operation both at the beginning of the project and throughout development work. An experience- and research-based inclusive and listening approach commits the actors to co-operation and creates trust between the members of the network.

The Driving Change in Welfare Services for the Aged project made it possible to start co-operation. The future of the gerontological center looks good, if networking is systematically and sufficiently focused on also in the future. Now that the project has ended, one question remains open: "How to continue development or reform operations in order not to go back to the 'old'?" The minimum needed in the future is assessing and monitoring what added value networking operations of the gerontological center brings in services for the elderly and how the operations should be further developed together with the partners. This entails workshops—arranged often enough—where the network members can participate in a joint planning, implementation, and assessment process. In addition, developing the employees' competencies and wellbeing-at-work shall be solidly accounted for, so that they have the possibility and motivation to support the development of the network. Active coordination and information are also needed so that the networks in different regions are kept updated. The city's management and

supervisors are not solely responsible for these tasks: they shall, however, make sure that the networks themselves can assume these duties.

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Authors

Päivi Keskinen
Master of Health care
Manager of Supported housing
Vantaa city
paivi.keskinen@vantaa.fi

Anne Eskelinen
M.Mus.
Senior Lecturer
Laurea University of Applied Sciences
anne.eskelinen@laurea.fi

Timo Järvensivu
D.Sc. (Econ.)
Research manager
Aalto University School of Economics
timo.jarvensivu@aalto.fi

Evaluation of development of co-operation between Vantaa home care and health center reception services

Anne Vesterinen and Leena Pekkonen

Abstract

In our Home Care Renewal project, the team selected co-operation between home care and health center reception services as one of the main targets of this program. By developing processes between these two organizations, the aim was to renew the current practices of Vantaa Home Care and to enhance productivity. We had workshops go through the processes of this collaboration, and in the end, the decision was made that the final proposals and decisions to push this renewal should be made locally. The parties attending these workshops included home-care and health center reception services employees from Tikkurila and Koivukylä, two districts in Vantaa.

This article evaluates the development of co-operation between Koivukylä and Tikkurila home care and health center reception services. The evaluation questions (59) were about home-care and health center reception services employees' ideas on co-operation: its significance, implementation, level of participation, and obstacles to co-operation. The responses came from 40 home-care employees and 37 health center reception services employees. The data were analyzed by quantitative and qualitative methods.

Co-operation was considered very positive and seen as a way to assess and evaluate care. There was no co-operation with customers and patients, though. The employees got support from their leaders but needed rules for developing co-operation. The means of co-operation were reactive instead of being proactive, mainly in the form of paper and e-mail. There were no joint house calls or meetings about a patient's care.

The experiences of co-operation were mainly positive; employees had a feeling of appreciation and interaction. Lack of time and planning were deemed the biggest threats to co-operation. The main purpose of co-operation was to develop the quality of care.

Overall, the main target of the project - to develop co-operation between home care and health center reception services - was not achieved. Employees did not share their knowledge; they worked as individuals and consulted only when necessary. The patient was not seen as a common interest. In the future, we must have concrete targets for our development work and be sure about people's commitment and active participation. To get some results and better quality, we need different kinds of professionals and we need to see the customer as a co-operation partner.

Introduction

This article assesses the development of co-operation between home care and health center reception services in two districts of Vantaa: Tikkurila and Koivukylä. The evaluation was targeted at the employees' views on co-operation and its importance; realization of co-operation; participation in co-operation; and obstacles to co-operation.

Co-operation between home care and health center reception services was chosen as one of the development focuses of the Home Care Renewal project. The project aimed to reform home-care procedures to enhance productivity. According to studies (Zwarenstein & Bryant 2002; Virtanen 1999), co-operation between employees of different organizations increases work productivity and efficiency, and increases the employees' satisfaction with work. In addition, the employees' competency develops through co-operation between different professional groups, and new models for division of labor are developed. In the Health and Social Welfare department, co-operation between different organizations and its functionality is deemed important for productive customer care. Co-operation is a necessary precondition for finding functional care solutions to secure good overall customer care (Williams & Laungani 1999).

Leaders of Vantaa's home care and health center reception services identified development needs related to co-operation in order to implement comprehensive care of shared customers. The project development team agreed that the customer-co-operation development challenge is met with workshop operations. Home-care and health center reception services employees were invited to workshops, and the parties discussed and considered possibilities and methods of co-operation. At the end of the workshops, it was agreed that the parties plan and agree locally on practices promoting co-operation.

At present, health- and social welfare employees are required to be able and willing to develop themselves and their work. Development focuses on the ability to observe and

identify backgrounds of phenomena; the ability to draw valid conclusions; as well as the ability and willingness to work actively to bring about change. The results of competency and development work are reflected in high-quality customer care and positive impacts on the environment. An analytical and systematic approach and searching for the truth manifest one's attitudes toward development. Analyticity refers to using one's brains and searching for evidence. Systematics refers to organization of values and observations of problems on all levels. A person searching for the truth courageously seeks the best knowledge, even though he or she must simultaneously accept issues that do not support his or her earlier beliefs. (Heikkilä & Jokinen 2008.)

The majority of Vantaa's home-care customers are elderly and they may be simultaneously customers of home care, health center reception services, and perhaps other organizations of the health and social welfare department. Joint customers required better-planned and more flexible co-operation between service providers. It is important for an employee working at the health and social welfare department's service system to understand the entirety formed by the different parts of the system, other organizations and professionals, and the complex interaction relations included in the system. The employee should also understand him/herself as part of the entire service-system package. (Ala-Nikkola 2003; Isoherranen et.al. 2008.) According to Paukkunen's study (2003), shared expertise and responsibility, acting on one's own initiative, being generally active, and appreciating one's own and another field's knowledge are advanced co-operation facilities. Co-operation partners' equality, mutual trust, flexible interaction, and awareness of the need to learn co-operation skills promote the participating parties' commitment.

Understanding customership as a customership shared by the entire service system is not unproblematic. Decision-making in health care is to a significant extent dictated by the organization and its interests to which an elderly person is being transferred. Co-operation between organizations inevitably demands that organizational borders be lowered and that others be accounted for, but organizations are afraid of losing their freedom and autonomy. (Ala-Nikkola 2003; Kokkola et.al. 2005.)

When analyzing customer co-operation, one must realize that the customer and his/her relatives are essential co-operation partners. Ensuring the customer's participation in planning and producing services is important for the productivity of care. The customer's participation possibilities are at their lowest point when he/she is only entitled to information on services. The customer's possibilities are a tad better when he/she is consulted and when he/she has a genuine possibility of influencing service planning and implementation before decisions are made on the services in question. The customer's participation possibilities are at their best when he/she, in the planning stage, has the power to participate in the decision-making process as an equal partner. (Ala-Nikkola 2003.)

Evaluating the development of co-operation between Koivukylä and Tikkurila's home care and health center reception services generates data for further work to those responsible for developing co-operation with customers. It is expedient that development continues after termination of the project and cover Vantaa's home care and health center reception services as a whole without forgetting to include customers in co-operation. Referring to Arnkil (2006), best practices are always something local, applied by the local "practical community." In other words, at issue is a specific social innovation within a specific context. Transferring this "anchored" practice from one place to another, i.e., generalizing it, is no simple task. It requires a multiform learning process and communication including silent knowledge.

Theoretical starting points for co-operation

Co-operation is regarded as a multidimensional phenomenon whose definition varies depending on the perspective and philosophy of science applied. Synonyms for co-operation consist of partnership, joint operation, and coordination (Jäppinen 1989). Co-operation is characterized by mutual positive dependency between the partners and shared responsibility (Warjus-Ulvinen 2005). Paukkunen (2003) defines co-operation within health and social welfare as the partners' joint and planned communication-, evaluation-, decision-making- and working-together process that aims at a goal—specified by the partners—that satisfies the customer's welfare needs and during the course of which the expertise and competency of each partner is respected and appreciated.

Co-operation can be viewed as, among other things, co-operation competency, multiprofessional co-operation, R&D co-operation, and network-like co-operation. Co-operation competency is comprised of co-operation skills and co-operation management. Co-operation skills refer to the employee's co-operation skills and ability as well as characteristics required in co-operation. Co-operation management means that the employee has such co-operation-related theoretical knowledge that he or she applies in practice. (Jauhiainen 2004; Pelttari 1997.) Cook et.al. (2001) emphasize that customer-oriented co-operation competency means that the customer's individual needs for care are identified and that care and service are based on those individual needs.

Multiprofessional co-operation aims at achieving a joint goal by sharing knowledge, skills, tasks, experiences, and/or authority. The concept may refer to intra- or inter-organizational co-operation, random or established forms of co-operation, and co-operation based on professional roles or co-operation seeking a new synthetic way of thinking. (Määttä 2007.)

According to Pärnä (2008), creating multiprofessional co-operation is a learning process that is consciously guided and led. Co-operation entails not only characteristics based on

organizations', work cultures' and professions' own dynamics but also issues related to individuals' and groups' own operations that may both encourage and limit formation of co-operation. It is possible to choose such co-operation approaches to development projects that increase communication, community spirit and trust, and thus promote local building and establishing of a multiprofessional co-operation culture.

R&D co-operation can be viewed from the perspective of partnership, in which case the aim is to create a long-term, mutually beneficial and equal co-operation relationship. The partnership model as a co-operation form between different organizations is, however, a very challenging form of co-operation. Partnership usually requires crossing of borders and that all the partners assume responsibility for developing operations. In addition, partnership requires joint information-management and negotiation tools and preventive agreements where the partners' liabilities and the objectives and forms of co-operation are specified. (Teräs & Lintula 2009.)

In network-like work, the key factor is not technical competency but attitude toward meeting. It is based on an understanding of the meaning of relationships to an individual. Networks are always present in meetings, either physically or in internal dialogues of the customer and employee. Being a social creature, an individual cannot detach him/herself from his or her relationship networks under any circumstance; the networks hide an abundance of resources to be utilized. (Honkanen 2010.)

Forms of professional co-operation often used in nursing and care consist of, among other things, work-unit meetings, consultation, peer evaluation, and teamwork. Joint meetings where work-related issues are discussed promote the professional development of nurses belonging to the work community, if the meetings are such that it is possible to speak openly and listen to the other members of the work community. Planned and regular meetings promote commitment to joint values and vision. Using consultation and peer evaluation, a nurse can develop and expand his/her competency by giving constructive feedback to and receiving it from colleagues. Teamwork is characterized by methodicalness and goal-orientation, and it entails that each team nurse has his/her own clear responsibilities and tasks to achieve the common goal. Teamwork requires a good flow of information and exchange of information. (Latvala 2001.)

Co-operation can be developed, and what is key to developing it is awareness of the problems of co-operation. When developing co-operation, it is important to ensure that the organization's co-operation structures do not become an end in themselves. The structures must be flexible and change according to requirements and situations. The elasticity and flexibility of co-operation means that the existing operational structures are questioned and can be changed, that familiar co-operation practices and work environments can be narrowed or expanded. (Ojuri 1996; Flink & Saarinen 2002). Besides flexible structures, employees' co-operation- and development skills are also

required. Collegialism, way of communication that listens to partners, trust in and respect for the other persons' professionalism are characteristics of co-operation skills. Furthermore, the work community's shared values and norms guide working. (Paukkunen 2003.) By training and critically reflecting on one's way of working, everybody can learn from his/her own mistakes and change his/her operating methods (Mäkisalo 2004).

Implementing evaluation

Evaluation of the development of co-operation between Vantaa's Tikkurila and Koivukylä districts' home-care and health center reception services employees is based on the employees' views on co-operation, its realization and obstacles to it, as well as the significance of co-operation. The aim is to produce data on the development of co-operation for further work and thus support those responsible for development in finding appropriate solutions for the progress of the development process after termination of the project.

To evaluate how well the development objective was achieved, answers to the following questions were sought:

1. What is the attitude of home-care and health center reception services employees toward co-operation in general?
2. How is the co-operation between home care and health center reception services manifested in the workplace?
3. What kind of co-operation is an individual home-care and health center reception services employee involved in?
4. What kinds of experiences do home-care and health center reception services employees have of co-operation?
5. What is the significance of co-operation according to home-care and health center reception services employees?
6. What factors constitute objectives to co-operation according to home-care and health center reception services employees?

Collecting and analyzing evaluation material

The data-collection method was a questionnaire to access all the employees of home care and health center reception services. When compiling questions measuring co-

operation, the indicator developed by Paukkunen (2003) was chosen for the questionnaire. Paukkunen's indicator measures co-operation learning during professional instruction in health and social welfare as well as the impacts of learning on health- and social welfare employees on their co-operation at work. To ensure reliability, it was decided to use an existing indicator.

The questionnaire consisted of 59 questions, of which the first six charted the respondents' background information. Background variables consisted of the employees' demographics (sex, place of work, position, length of work experience), and their roles in the development project. One of the questions related to co-operation was open, while the rest (52 questions) were questions in the form of statements with four-step Likert scale. The option "cannot say" was added, which allowed the respondents not to take a stand. The open question aimed to collect descriptive data, supplementing the quantitative data that could not be charted by means of closed questions. The questionnaires were given to home-care and health center reception services leaders on Oct. 11 and 12, to be delivered to the employees. At the same time, feedback boxes were placed in the units. Altogether 168 questionnaires were handed out, of which 65 to Tikkurila health center reception services and 45 to home care. Twenty-eight questionnaires were delivered to Koivukylä health center reception services and 30 to Koivukylä home care.

Health-care students picked up the feedback boxes on Oct. 20 and 21. Altogether 77 questionnaires were returned to Laurea University of Applied Sciences: 23 from Tikkurila health center reception services and 19 from Tikkurila home care. Koivukylä health center reception services returned 14 questionnaires and Koivukylä home care 21. The response percentage of Tikkurila health center reception services was 35%, Tikkurila home care 42%, Koivukylä health center reception services 50%, and Koivukylä home care 70%. SPSS for Windows 18.0 analytics software was used for analyzing the quantitative data. Frequency and percentage distributions, on the basis of which input errors were corrected, were calculated from the data. Lacking observations were not replaced. The "cannot say" option was removed from the set of possible answers in order to get the respondents' view on the subjects of the questions. The data is described by means of analyzing the frequencies, percentages and key figures of variables. The decimals of percentages were rounded up to integers, which is why the total percentages do not always equal 100%. Mean variables were made of endpoints measuring the different dimensions of the same issue. The homogeneity of mean variables was tested with Cronbach's alpha coefficient whose limit was 0.60 (Metsämuuronen 2003). Background variables' ratio to mean variables and endpoints was analyzed with the help of Spearman's rank-order correlation. Differences between groups were tested with the nonparametric Mann-Whitney U test, which was most suitable when the distribution of variable was oblique (Heikkilä 2008).

There were few responses to the open question, and they were short expressions. A summary was made of those responses, which are not separately reported in the results part but included in other results.

Ethical considerations

The evaluation was targeted at development of co-operation between home-care and health center reception services employees, and it was based on the employees' opinions of co-operation and factors related to it. Customer co-operation aims to ensure joint, good and productive customer care. Assessing the co-operation between employees in different work units is not in itself an ethically sensitive subject.

The evaluation data was collected by means of questionnaires that were given to home-care and health center reception services leaders who handed them out to their employees. Director of Services for the Elderly and Disabled Matti Lyytikäinen and Director of Health Services Timo Aronkytä had informed the employees about the evaluation of to what extent the co-operation development objective was achieved. The cover letter to the questionnaire explained the purpose and benefits of the questionnaire, voluntary participation, and keeping the responses anonymous. Moreover, the cover letter listed the names and contact information of the people responsible for the evaluation, as well as the role of Laurea University of Applied Sciences.

Home-care and health center reception services employees' views on development of co-operation

Respondents' background information

The subjects were 77 Tikkurila and Koivukylä health center reception services and home-care employees. Of the respondents ($n=77$), 37 (48%) worked in health center reception services and 40 (52%) in home care. Of the respondents, 42 (55%) worked in Tikkurila and 35 (45%) in Koivukylä. (Table 1.) The majority of the subjects were women ($n=73$; 95%); only four men responded to the questionnaire.

Table 1: Employees' workplaces per offices

Workplace		Office		Total
		Koivukylä	Tikkurila	
	health center	14	23	37
	home care	21	19	40
Total		35	42	77

Table 2 describes the positions named by the respondents. The majority of the respondents were practical nurses (fr=27; 35%), the second most common profession was nurses (fr=24; 32%). There were ten doctors (13%) among the respondents.

Table 2: Respondents' professional standing

Occupation	Number	Percentage
Nurse	24	32
Public-health nurse	4	5
Practical nurse	27	35
Doctor	10	13
Home-care leader	3	4
Health centers leader	1	1
Other	7	9
Total	76	100

Ten respondents (13%) had work experience under one year, around a third had either 1-5 years' work experience (fr= 26; 34%) or more than 10 years' work experience (fr=25; 33%).

When asked about the respondent's role in the Home Care Renewal project, the majority (fr=34; 44%) said they had heard about the project, while a third (fr=23; 30%) did not know about the project. Three subjects, working in home care, said they were responsible for establishing the development work. Seven subjects, four of which worked in home care, said they knew the project objectives and had participated in workshops. The majority (fr=37) of subjects working in health center reception services had either heard about the project (fr=17, 46%) or did not know about the project (fr=16; 43%). Nobody working in health center reception services said they were responsible for establishing the development work. Of the subjects working in home care (fr=40), the majority (fr=17; 43%) had heard about the project, and nine subjects responded that they knew the objectives but had not participated in workshops.

Co-operation between home-care and health center reception services employees

The employees' co-operation was first analyzed with the help of random variables per study questions: employees' attitudes toward co-operation (questions 1.1-1.7), co-operation between employees manifested in the workplaces (questions 2.1 – 2.10), employees' participation in co-operation (questions 3.1 – 3.12), experiences of co-operation (questions 4.1 – 4.3, 4.5, 4.8, 4.11 and 4.14), significance of co-operation (questions 4.4, 4.6-4.7, 4.9-4.10 and 4.12-4.13), and obstacles to co-operation (questions 5.1 – 5.9).

According to the responses, both home-care and health center reception services employees had a positive attitude toward co-operation (mean 1.57; std. 0.369), even though the respondents disagreed on co-operation manifested in the workplaces (mean 3.03; std. 0.529). The respondents agreed to some extent on the obstacles to co-operation (mean 2.38, std. 0.592). Some of the respondent agreed and some disagreed to some extent on their own participation in co-operation (mean 2.71, std. 0.524). Most differences were found when asking about the significance of co-operation (mean 2.63, std. 0.844). (Table 3.)

Table 3: Co-operation between employees in Tikkurila and Koivukylä

Subject	Mean	Standard deviation	Median	Mode
Employees' attitudes toward co-operation	1.57	0.369	1.57	1.29
Co-operation manifested in workplaces	3.03	0.529	3.00	3
Employees' participation in co-operation	2.71	0.524	2.73	2
Experiences on co-operation	2.54	0.722	2.43	2
Significance of co-operation	2.63	0.844	2.33	2
Obstacles to co-operation	2.38	0.592	2.43	2.67

There was a significant dependency between the obstacles-to-co-operation average variable and the place-of-work background variable ($r=-0.665$, $p=0.000$). There were more home-care than health center reception services employees who agreed on obstacles to co-operation. The difference between the groups was statistically very significant ($p=0.000$).

Employees' attitudes toward co-operation

The employees' attitudes toward co-operation were evaluated by questions about joint planning, co-operation skills, employees' responsibility for co-operation, and the significance of co-operation from the perspective of customer care.

The respondents agreed fully or to some extent on co-operation as a professional skill (fr=73; 95%), employees' responsibility for participating in a shared customer's care and evaluation (fr=70; 91%), and the possibility of co-operation when there is a joint view on the objectives of customer care (fr=72; 94%). The respondents also agreed fully or to some extent on the joint view on the objectives of customer care that is a precondition for flexible co-operation (fr=71; 94%). Three respondents disagreed fully and nine to some

extent on flexible co-operation without joint planning. (Table 4.) Background factors had no impact on the employees' attitudes toward co-operation.

Table 4: Employees' attitudes toward co-operation

Home-care and reception operations employees' attitudes towards co-operation	Number of respondents	Mean	Standard deviation	Mode
1. Flexible co-operation requires joint perspective on customer care	74	1.36	0.538	1
2. Co-operation is not flexible without joint planning	71	1.85	0.804	2
3. Co-operation skills can be developed by training	74	1.68	0.599	2
4. Co-operation skills are part of professional skills	76	1.36	0.602	1
5. Employee is responsible for participating in joint planning and assessment of customer care	74	1.49	0.602	1
6. Co-operation is possible when there is a joint view on customer-care objectives	73	1.55	0.528	2
7. Productive customer care depends on planned co-operation between co-operation partners	72	1.76	0.569	2

Co-operation in home-care and health center reception services workplaces

Co-operation realized in home-care and health center reception services workplaces was evaluated by questions targeted at developing co-operation, practices, ground rules, and customer co-operation.

About half (fr=42; 55%) of the respondents agreed fully or to some extent on the statements that co-operation between home care and health center reception services is developed in the workplaces and that leaders encourage co-operation (fr=36; 47%). A third of the respondents (fr=24; 31%) was responsible for agreed home-care and health center reception services consultation practices. The respondents disagreed fully or to some extent on realized house calls carried out in co-operation with home-care and health center reception services employees (fr=55; 72%), care and service plans for customers drawn in co-operation (fr=50; 65%), and assessment of achievement of care- and service-plan objectives (fr=54; 70%). (Table 5.)

Table 5: Co-operation in workplaces

Co-operation between home care and reception operations manifested in workplaces	Number of respondents	Mean	Standard deviation	Mode
1. My workplace has a description of home-care and health center customer-care process	43	3.00	0.900	3
2. In my workplace, customers' care- and service plans are drawn in co-operation between home care and health center	59	3.31	0.895	4
3. In my workplace, achievement of customer-care and service-plan objectives is assessed in co-operation between home care and health center	59	3.42	0.700	4
4. In my workplace, meetings on issues related to customer care are arranged between home care and health center	58	3.22	0.918	4
5. In my workplace, ground rules for co-operation between home care and health center have been agreed	54	3.07	0.723	3
6. In my workplace, co-operation between home care and health center is developed	55	2.09	0.727	2
7. In my workplace joint house calls by home-care and health center employees are made	63	3.44	0.713	4
8. In my workplace, consultation practices related to co-operation between home care and health center have been agreed	51	2.73	0.874	2
9. In my workplace, the leader encourages co-operation	53	2.19	0.900	2
10. In my workplace, induction includes presentation of co-operation between home care and health center	56	3.29	0.780	4

There was a significant connection between the background factor workplace and the factor assessing the achievement of care- and service-plan objectives in co-operation ($r=0.404$; $p=0.001$) and the factor jointly agreed consultation practices in health center reception services and home care ($r=0.406$; $p=0.003$).

There were more health center reception services employees than home-care employees who agreed that the achievement of objectives of care- and service plans were assessed in co-operation. The difference between the groups was statistically significant ($p=0.002$). (Figure 1.)

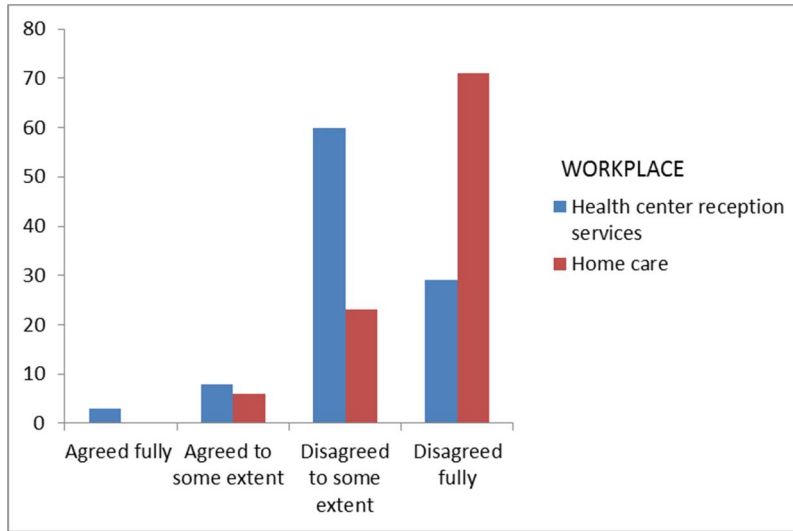


Figure 1: Achievement of objectives of care and service plans assessment in co-operation

Likewise, there were more health center reception services employees than home-care employees who deemed that consultation practices were jointly agreed. The difference between the groups was statistically significant ($p=0.004$). (Figure 2)

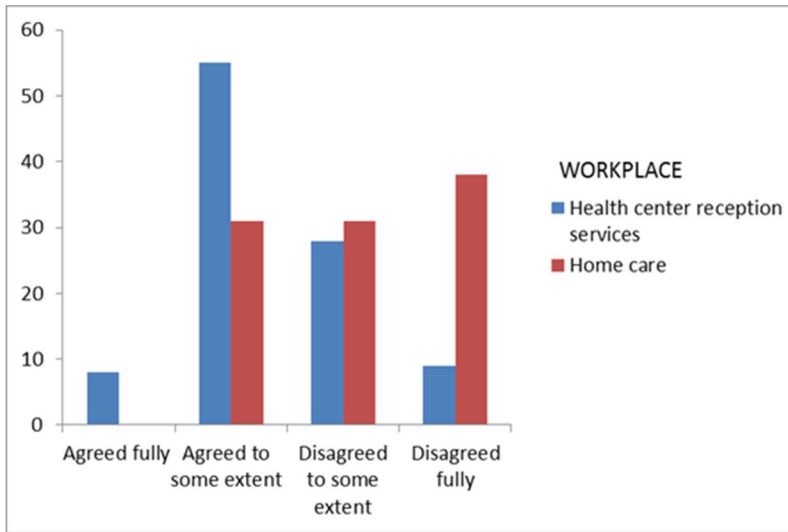


Figure 2: Jointly agreed consultations practices

Employees’ realized co-operation

Employees’ realized co-operation was evaluated by questions targeted at the ways of co-operation and implementation of customer co-operation. The respondents fully agreed on utilization of customer data registered in health center reception services and home care (fr=60; 78%) and independent contacts with co-operation partners (fr=63; 83%). The respondents agreed fully or to some extent on participation in co-operation over the phone (fr=55; 72%), finding additional information on joint customers (fr=52; 68%), and finding additional data on customer co-operation with the help of documentation and office tasks (fr=41; 55%). (Table 6.) According to the responses to the open question, customer co-operation with partners—primarily other nurses and doctors—took place by e-mail as well. The respondents disagreed fully on their participation in joint house calls (fr=58; 75%) and negotiations on customer co-operation between home care and health center reception services (fr=47; 61%). The respondents disagreed fully or to some extent on their participation in compiling joint care- and service plans for customers (fr=52; 68%) and assessing the productivity of care (fr=57; 74%). Many respondents claimed to be fully or to some extent unaware of joint customer-care practices (fr=35; 45%). (Table 6.) Background factors did not have a connection with the employees’ realized co-operation.

Table 6: Employees' realized co-operation

Employees' participation in co-operation	Number of respondents	Mean	Standard deviation	Mode
1. I perform customer co-operation with home care/health center over the phone	73	2.10	0.945	2
2. I perform documentation and office duties related to customer co-operation	65	2.48	1.091	2
3. I make house calls together with home-care/health center employees	69	3.77	0.598	4
4. I participate in meetings between home care and health center where issues related to joint customer care are addressed	64	3.61	0.726	4
5. I participate in compiling a joint customer-care and service plan	66	3.33	0.950	4
6. I cooperate on assessing the productivity of customer care	66	3.39	0.802	4
7. I utilize customer data/care data entered by health center and home care in my work	71	1.69	0.803	1
8. I participate in events developing co-operation between home care and health centers	61	2.98	1.133	4
9. I know the co-operation practices related to caring for shared customers	55	2.84	0.788	3
10. I actively contact my co-operation partners	69	1.61	0.647	1
11. I know where to find further information on shared customers, when required	69	2.04	0.716	2
12. I know what kind of customer-care information my partners want me to relay to them	57	2.53	0.782	2

Employees' experiences on co-operation

The questions assessing the employees' experiences were targeted at appreciating professional skills, co-operation partners' expertise and interaction, as well as co-

operation practices and decision-making. Many of the subjects (fr=77) chose the “cannot say” alternative for the questions in this part (range 33-55). The respondents agreed fully or to some extent on appreciating their professional skills (fr=36; 47%), reciprocal interaction (fr=31; 40%), and expertise of co-operation partners (fr=19; 25%). (Table 7.)

The respondents disagreed fully or to some extent on the methodicalness of co-operation meetings (fr=24; 31%) and clarity of co-operation practices (fr=23; 30%). (Table 7.) When asked about the equality of the partners’ decision-making, 54 (70%) of the subjects gave no answer, and when asked about reduction in the territorialism between different professional groups, 53 (69%) of the subjects gave no answer.

Table 7: Employees’ experiences on co-operation

Experiences on co-operation	Number of respondents	Mean	Standard deviation	Mode
1. My professional skills are appreciated in co-operation between home-care and health center employees	41	2.02	0.651	2
2. Co-operation meetings have always been planned	39	2.92	1.061	4
3. Participants in co-operation have made decisions as equal partners	23	2.57	0.843	2
4. Territorialism has diminished in the course of co-operation	24	2.38	0.647	2
5. Interaction between co-operation partners has been reciprocal	44	2.23	0.711	2
6. Clear co-operation practices between the co-operation partners have been agreed on	32	3.03	0.933	4
7. Different professional groups have participated in co-operation on the basis of their expertise	29	2.31	0.930	2

Employees’ views on the significance of co-operation

The significance of co-operation was evaluated by asking about the significance from the perspectives of work and customer care. More than half of the subjects chose “cannot say” for the questions in this part (range 42-59). Twenty-six (34%) respondents agreed fully or to some extent on co-operation as developing quality and 22 (29%) on co-operation’s possibility of enhancing identification of customer problems. Sixteen (21%) of the respondents disagreed fully or to some extent on co-operation reducing difficult

customer situations and co-operation as boosting operations and reducing overlapping work 14 (17%) (Table 8.)

Table 8: Employees' views on the significance of co-operation

Significance on co-operation	Number of respondents	Mean	Standard deviation	Mode
1. Co-operation has increased work-related resources	28	2.25	0.967	2
2. Co-operation has enhanced identification of customers' problems	31	2.29	0.783	2
3. Co-operation has diminished overlapping work	31	2.48	0.926	2
4. Co-operation has improved the customers' possibilities of participating in deciding on their care	18	2.55	0.784	2
5. Co-operation has reduced difficult customer situations	27	2.63	0.967	3
6. Co-operation has boosted work	26	2.73	1.116	4
7. Co-operation has developed the quality of customer care	35	2.31	0.900	2

Home care and health center reception services' obstacles to co-operation

Obstacles to co-operation were evaluated by questions about use of time, planning co-operation, prejudices, and professional obligations. The respondents agreed fully or to some extent on their own lack of time as an obstacle to co-operation (fr=21; 27%). The respondents agreed fully or to some extent on poor planning of co-operation (fr=47; 61%) and partners' lack of time as obstacles to co-operation (fr=46; 60%). A third of the respondents (fr=24; 31%) disagreed fully on the obligation to professional secrecy as an obstacle to co-operation. The respondents disagreed fully or to some extent on employees' prejudices (fr=33; 43%) and co-operation partners' different views on co-operation needs as obstacles to co-operation (fr=35; 46%). (Table 9.)

Table 9: Employees' views on obstacles to co-operation

Obstacles to co-operation	Number of respondents	Mean	Standard deviation	Mode
1. Poor planning of co-operation	53	1.77	0.697	2
2. Lack of time in my work	63	1.84	0.700	2
3. Co-operation partners lack of time	52	1.88	0.583	2
4. Employees' prejudices against co-operation	49	2.96	0.935	4
5. Scant knowledge of co-operation partners' work and expertise	56	2.27	0.842	2
6. Obligation to professional secrecy	54	3.11	1.022	4
7. Partners' different views on the need for co-operation	45	3.02	0.812	3
8. Difficulty in changing established approaches	53	2.58	0.795	2
9. Employees' strong professional identity	41	2.68	0.789	3

1=agree fully, 2=agree to some extent, 3=disagree to some extent and 4=disagree fully

There was a significant connection between the background factor workplace and the factors employees' prejudices ($r = -0.489, p=0.000$), obligation to professional secrecy ($r = -0.475; p=0.000$) and difficulty in changing established approaches ($r = -0.679; p=0.000$). There were more home-care employees than health center reception services employees who agreed on the employees' prejudices, obligation to professional secrecy, and the difficulty in changing established approaches as obstacles to co-operation. The differences between the groups were highly significant as regards prejudices ($p=0.000$), obligation to professional secrecy ($p=0.000$), and changing established practices ($p=0.001$). (Figures 3, 4 and 5.)

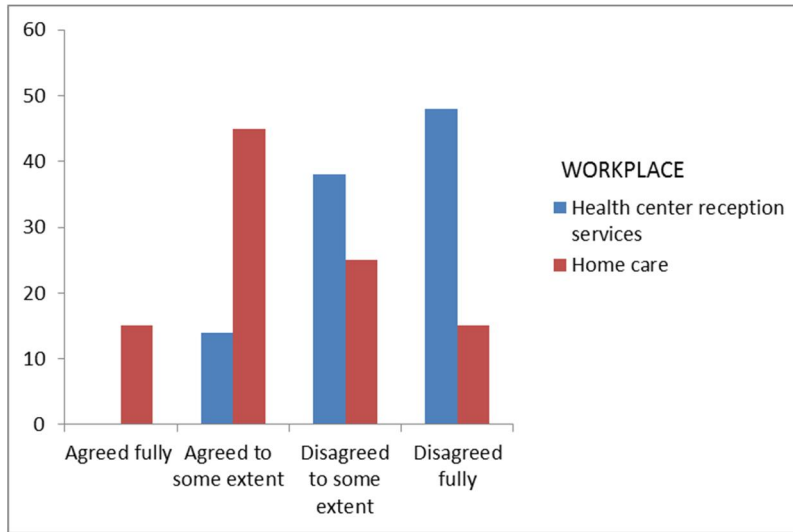


Figure 3: Employees' prejudices in co-operation

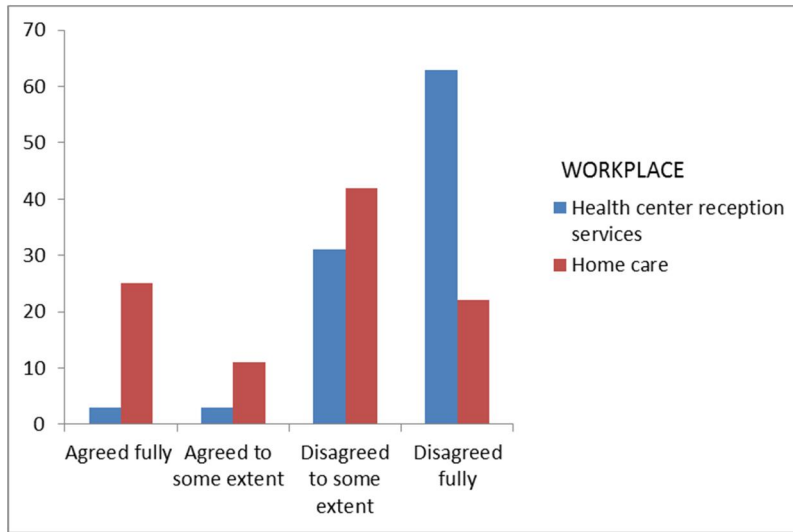


Figure 4: Professional secrecy as an obstacle to co-operation

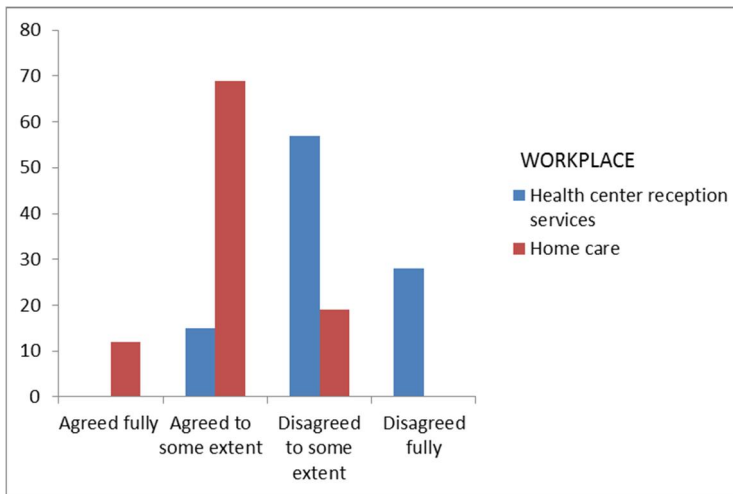


Figure 5: Difficulty in changing established approaches as an obstacle to co-operation

Considerations about evaluation

Evaluating reliability

The development of co-operation between Tikkurila and Koivukylä’s home-care and health center reception services employees was evaluated with a questionnaire targeted at the employees’ views on co-operation, its significance and realization (manifestation in the workplaces), participation in co-operation, and obstacles to co-operation. The data was collected by means of a questionnaire in order to access all the home-care and health center reception services employees in both Tikkurila and Koivukylä.

An indicator was planned for the questionnaire whose closed questions followed the indicator applied in Paukkunen’s (2003) thesis. The indicator was originally devised by a study group evaluating co-operation on health and social welfare. The indicator was evaluated by an expert team in connection with an education trial (Paukkunen 2003). In this evaluation, an open question was added to the questionnaire in order for the employees to state their personal opinions on the development of co-operation between reception operation and home care. The subjects consisted of home-care and health center reception services employees in Koivukylä and Tikkurila. The results may have been affected by the scarcity of responses. In particular, Tikkurila home care and health center reception services returned few questionnaires. The total number of respondents was 77. The minimum response percentage recommended is 60% (Heikkilä 2008). The response percentage of Tikkurila’s health center reception services was 35% and that of home care was 42%, whereas the response percentage of Koivukylä’s health center reception services was 50% and that of home care 70%. The length of the questionnaire may also have affected the reliability of results.

External factors that may have reduced reliability consist of, among others, employees' opinions on the necessity of assessment. Furthermore, the timing of the survey, leaders' attitudes toward evaluating co-operation, instructions for the questionnaire and response-related factors may have reduced reliability. There was an abundance of lacking observations. The results describe the development objectives achieved at the time the evaluation was made.

Main results and suggestions for further measures

This article evaluates the development of co-operation between home care and health center reception services in two districts of Vantaa: Tikkurila and Koivukylä. The evaluation targeted at the employees' views on co-operation, its significance and realization, participation in co-operation, and obstacles to co-operation. The employees of both home care and health center reception services viewed co-operation very positively. Co-operation was seen as part of an employee's professional skills and responsibility for participating in planning and assessing customer care. The respondents were unanimous in the statement that co-operation becomes possible and is flexible when there is a shared understanding about the objectives of customer care and customer care itself.

Nevertheless, co-operation on customers was not productive in everyday work. The employees did not pay joint house calls, plan customer-care and service plans, and together assess the achievement of care objectives. Some of the employees were of the opinion that ground rules for co-operation had not yet been agreed on, but they added that co-operation was currently being developed and that leaders encouraged co-operation. The views of the health center reception services employees differed to some extent from those of the home-care employees. In the opinion of the health center reception services employees, achievement of customer-care and service-plan objectives was assessed in co-operation and consultation practices were agreed on.

Many employees tried to cooperate in their own work, but the methods used were reactive instead of proactive, requiring co-operation. Some of the employees cooperated on document and office duties. When required, the employees contacted the co-operation partners, mainly doctors and nurses. Most contacts took place over the phone or by e-mail. The employees utilized data registered in medical records, but did not make joint house calls, and few participated in negotiations on customer co-operation. Many, however, had positive experiences on co-operation. The employees felt that their professional skills were appreciated and interaction with co-operation partners was deemed reciprocal. Nevertheless, co-operation meetings were deemed unplanned and practices unclear.

Developing the quality of customer care was emphasized as significant for co-operation. Some of the employees regarded co-operation as a possibility of improving identification of customer problems. Both one's own and co-operation partners' lack of time and poor planning of co-operation were highlighted as obstacles to co-operation. The views of home-care employees differed from those of health center reception services employees. Some of the home-care employees regarded the obligation to professional secrecy, employees' prejudices, and the difficulty of changing established approaches as obstacles to co-operation.

The evaluation showed that since the project objective of "developing co-operation between home care and health center reception services" was not achieved during the course of the project, the process of developing co-operation remains in its early stages. The actions of Koivukylä and Tikkurila's home-care and health center reception services employees signify co-operation where expertise, knowledge and interaction are not shared, but where the traditional division of labor prevails. The employees have their own roles and they work separately in their work units, consulting mainly experts and their colleagues. From the perspective of co-operation, customer-orientation and joint customership do not dictate the employees' actions.

For future work, it is good to set concrete objectives for developing co-operation and to require employees' active participation in development. Employees' positive attitudes toward co-operation and leaders' support promote achievement of the objectives of the development work. The team that will be in charge of developing co-operation in the future shall consist of experts representing different professional groups in order to ensure multiprofessionalism and development of a co-operation culture. In order to attain productive co-operation, obstacles to co-operation must be discussed and solved. Knowing one's partner and supporting his/her work and understanding the role and responsibilities of the partner promote co-operation. In customer co-operation, the customer as a co-operation partner is key. Including the customer in co-operation enhances the results and quality of care. Since developing home-care and health center reception services activities does not end at the termination of the project, but continues as internal development, we propose the following factors to be considered and reflected upon:

- Operating conditions play a major role in producing home-care services and in home-care decision-making. In the decision-making processes, the managers, employees, customers and their relatives meet with resource-dictated operating conditions to which customer needs are adapted. There are tensions between the financial and efficiency requirements of service production and the value basis of operations. The employees must constantly balance increased demand for services and scarce service-provision. Strict finances cause changes in co-operation relationships as well. Other service providers, representatives of another organization and profession are not seen as co-operation partners: co-

operation may be built on competition and conflicts. One must take into consideration that one's co-operation partners have sufficient possibilities of considering, discussing and analyzing customer data (Ala-Nikkola 2003:94).

- Networking is essential. Care processes in particular must be clarified to develop joint operations and networking.
- In order to create functional co-operation, all the co-operation partners must have sufficient knowledge on the activities of the different partners and on the ground rules for co-operation. People with the ability and facility to act in flexible co-operation with others by utilizing welfare technologies are required. This demands crossing borders and open and concrete co-operation in accordance with regional interests.
- Developing co-operation between different operating units demands development competency from the employees. At its best, expertise in development translates into collective work-community expertise that takes a lot of time to create. Commitment and establishment require willingness to and acceptance of change from the parties primarily involved.
- The majority of home-care customers are elderly people whose quality of life and factors related to it will be increasingly important in targeting services for the elderly. The services shall be customer-oriented, which refers to service production based on customer requirements. When assessing service requirements, one must account for the subjective needs and resources of the aged, as well as health-care and social-welfare professionals' situation-based assessments. Assessing the service requirements for an elderly person is most sensibly conducted at the elderly person's home, since it is difficult to accurately assess the service needs during a reception. Versatile assessment of customer requirements can only be realized through co-operation by experts.

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Appendix 1.

Mean variables' Cronbach's alpha coefficients

Main variable	Number of variables	Cronbach's alpha
Attitudes toward co-operation	7	0.691
Co-operation realized in workplace	10	0.727
Employees' participation in co-operation	12	0.720
Experiences on co-operation	7	0.902
Significance of co-operation	7	0.868
Obstacles to co-operation	9	0.835

Authors

Anne Vesterinen
LicEd., M.Sc. (Health Sci.)
Principal Lecturer
Laurea University of Applied Sciences
Mobile phone: 040 830 6145
anne.vesterinen@laurea.fi

Leena Pekkonen
Master of Health Science
Senior Lecturer
Laurea University of Applied Sciences
Mobile phone: 046 856 7392
leena.pekkonen@laurea.fi

Vantaa Senior clinic's good practices

Lilja Palo and Kirsi Leinonen

Abstract

This article examines Vantaa Senior clinic's best practices resulting from the development of the Senior clinic in the course of the Driving Change in Welfare Services for the Aged project, which was conducted from 2008 to 2011. Vantaa Senior clinic's best practices consist of process description and invitation method of health meetings. Of the Senior clinic's products, best practices comprise the following: medical examination of caregiver; health meetings for the elderly; and extensive contents of both medical examinations and meetings. Finally, this article describes documentation of operations as another best practice.

In the Senior-clinic concept-compilation stage, the Senior clinic's target groups were identified together with why and how people applied for the services in question. In this stage, also the products and approaches were identified. Two full-time employees were allocated for the Senior clinic. In order to clarify Senior-clinic operations, process descriptions of medical examinations for health meetings with people aged 75 or more and caregiver's medical examination were devised. The process progresses from sending of invitations to potential further measures. Each year, invitation to a health meeting is sent to Vantaa residents who are 75 year old, live at home, and are not included in home care. As of the fall 2009, operations were expanded to also cover caregivers aged 65 or older with whom the City of Vantaa has a caregiver agreement. Caregivers are offered the possibility of an annual medical examination conducted at the Senior clinic. Health meetings with 75-year-olds and caregivers chart health-promoting lifestyles, such as nutrition, physical exercise, social contacts, consumption of tobacco and alcohol, as well as oral health. The meetings entail several functional-ability measurements. In addition to the above, the customers are provided with guidance and counseling on health and welfare.

Documentation of operations was also one development object in the Senior-clinic project. This documentation can be utilized in assessing and further developing the work

conducted at the clinic. Regular reporting helps to make the Senior clinic transparent and widely known. After naming the products, one can monitor, for instance, annual number of customers and time spent on products.

The customers are adamant that the services provided by the Senior clinic be continued and that invitation to the Senior clinic be sent at least at two-year intervals. One option for arranging preventive activities to people of pensionable age is to offer group-form health counseling to recently retired people and, later on, to provide them with personal health meetings. Permanent staff enables development of work at the Senior clinic. Identifying essential knowledge is crucial for record keeping; following up this information is significant for the health and welfare of, for instance, a 75-year-old.

Introduction

Senior clinic's objective is to help the elderly promote their own welfare and health, so that they could live at home for as long as possible. Health is promoted, among other things, by supporting the customer's existing resources, for instance, by strengthening his/her social relations and informing about services and issues related to normal aging. (Valvanne 1995, Pitkälä & Strandberg 2007.) Another important focus area is supporting caregivers (Valvanne 1995). This article considers Vantaa Senior clinic's good practices and the clinic's development from the Memory, Rehabilitation and Internet Welfare Clinic project to the Driving Change in Welfare Services for the Aged project to the current Senior clinic. The Senior clinic operates on the principle of invitation. Each year, senior citizens turning 75, who are not included in home care, are invited to a health meeting at the Senior clinic. Since the fall of 2009, also caregivers aged 65 and older have been invited to these health meetings. In addition, the customers are provided with phone consultation and group-form health counseling.

Senior clinic's starting points

Health promotion at the core

The Senior clinic's customers are Vantaa residents aged 75 who do not use home-care services at the time of being invited and caregivers aged 65 and older who have signed a family caregiving agreement with the city. The Senior clinic strives to promote or sustain the health of elderly people invited to a health meeting or medical examination. At the Senior clinic, the elderly person's resources are charted and he/she is offered information on activities targeted at the aged, with which it is possible to strengthen or maintain existing resources. This chapter analyzes promotion of elderly people's health in the context of the Health 2015 public health program and quality recommendations for the elderly. In addition, the state of health of caregivers and customers aged 75 and older as

well as their experiences on the benefits of health services are analyzed with the help of research data.

The Health 2015 public health program acts as an extensive framework for public health promotion and dictates, for its part, promotion of elderly people's health. According to the program, average improvement in the functional abilities of people aged 75 and older should continue similarly to the development during the past 20 years. (STM 2001.) The importance of health and welfare promotion of the aged as well as preventive operations is also emphasized in the quality recommendations for care and services for the elderly. The quality recommendations aim at a positive development of the welfare and health of the elderly as well as enhanced quality and effectiveness of services. (STM 2008, 9.)

Health promotion may be both promotive and preventive. Promotion is based on a positive health concept, identifying and utilizing resources in order to promote the health of an individual and community. Promotive measures are taken before problems arise. They help to boost an individual's health, functional abilities and resources, develop the environment and service system, and create functional participation possibilities. Promotive measures may result in, for instance, reduction in an elderly person's loneliness as his/her social contacts increase. (Liimatainen 2007, 33; Terveysten edistäminen esimerkein 2005, 8, 13, 39.)

Prevention is divided into primary, secondary and tertiary prevention. Primary prevention aims to prevent diseases by reducing individual risk factors (Godfrey 2001; Liimatainen 2007, 31). Even though it is possible to prevent some diseases—such as fractures—in an advanced age, it is often more important to maintain an elderly person's functional abilities and quality of life, support their independence, and reduce the need for long-term or permanent care. (STM 2003.) Secondary preventive measures treat existing diseases as well as possible and boost self-care of long-term diseases. Tertiary prevention refers to decelerating impairments caused by diseases. Tertiary prevention aims to rehabilitate a sick elderly person and maintain his/her remaining resources. (Godfrey 2001; Liimatainen 2007, 32; Terveysten edistäminen esimerkein 2005, 8, 13, 39.)

Health promotion is considered a possibility for the aged, since data on the benefits of health promotion are indisputable (Kiiskinen et.al. 2008). Preventive services should be offered, at least, to members of risk groups (STM 2008), even though finding members of those groups can be challenging. Some municipalities have offered house calls or medical examinations to risk groups, the most common of which are people with memory disorders, caregivers, widows, people with diabetes, people in risk of falling, and safety-phone customers (Seppänen et.al. 2009).

Many studies indicate that medical examinations for the elderly are beneficial, and the aged themselves also consider them necessary (Leinonen et.al. 1996). In 30%-40% of

medical examinations, findings requiring measures to be taken are found, for example, due to high blood pressure (Heikkinen et al. 1992; Leinonen et al. 1996; Kohvakka 1999). Effective treatment of hypertension is especially useful for preventing stroke and heart failure even up to very advanced age (Strandberg 2005). Studies have also proven the benefits of, for instance, influenza vaccinations for the elderly (e.g. Gross et al. 1995). Nevertheless, only about half the people aged 65 and older take the vaccination. (THL 2009.)

Despite research data, medical examinations for the elderly are not systematically included in health services, but in the 2000s municipalities' have actively developed preventive services for the elderly and many municipalities have or are planning senior-, age- and elderly clinics and counseling centers. The Health Care Act (1326/2010), entered into force on December 30, 2010, obliges municipalities to arrange counseling services promoting the health, welfare and functional abilities of the elderly.

Vantaa's Senior clinic has its roots in the Memory, Rehabilitation and Internet Welfare Clinic project carried out in Vantaa's Hakunila district from 2004 to 2006. Key to the project were nurse's medical examinations for 75-year-olds and preventive house calls for 80-year-olds. After termination of the project, the nurse's position was established as a permanent post. The medical examinations were continued as part of the city's own community services for the elderly. As of 2008, senior-clinic operations were developed as part of the Driving Change in Welfare Services for the Aged project. In the fall of 2009, medical examinations for caregivers of the elderly were adopted as an operating method, and in 2010, senior-clinic operations were expanded to cover citizens turning 75 each year who are not included in health and social welfare services.

State of health and functional abilities of the elderly

Customers aged 75 are a very heterogeneous customer group. The age group consists of both people in a good state of health and still partially involved in working life and people who barely manage at home on their own or who rely on the help of others. Common to the customers of the senior clinic is a long life experience, which shall be individually accounted for. It is essential that an elderly customer be understood and his/her needs be heard. Moreover, information offered in an understandable way helps the customers participate in their own care (Tuorila 2009).

Self-care consists of such measures with which the elderly can promote their health and welfare in their own life situation (Kuusinen 1993). The Senior clinic can promote the customers' self-care preventively by measuring their blood pressure and blood glucose contents, boosting social activities, and supporting versatile diet and physical exercise. Health counseling also aims to reduce the elderly customers' falls, infections, and cardiovascular disease. To support coping at home, the need for home alterations and technical aids is charted (Liimatainen 2007, 32; Routasalo 2002).

Elderly customers shall be encouraged to independently promote their health and welfare. It is possible to have an effect on several risk factors by simultaneously increasing physical exercise and following a versatile diet. The eating habits of the elderly have improved over time. For example, the quality of grease used on bread has become lighter, and use of vegetables, fruits and berries has increased. Men's smoking has diminished. Meanwhile, alcohol consumption has increased during a 10-year study period, especially as regards women. During the same period, women have increased their physical exercise, whereas men have remained on the same level as before (Sulander, et.al. 2006).

Rissanen (1999) has studied daily coping at home of people aged 65 and older (N=157). In case of women, the majority of self-care measures were related to physical health. Around 60% of the respondents attended to their physical health by exercising, eating healthily, and avoiding tobacco and alcohol. Self-care related to psycho-social health consisted of, among other things, hobbies and meeting friends. Self-care related to changes in one's state of health included following a diet, taking care of medicines and hygiene, and pedicure.

A few percent of the women studied were careless about their health, as witnessed in the following statements: "I do not have to do anything" and "I have not thought about it" (Rissanen 1999). In case of men as well, self-care related to physical state of health amounted to almost half of their health care. For men, physical exercise often translated into functional exercise. In addition, healthy lifestyles were emphasized. For men, self-care related to psycho-social health mainly meant good human relations. Self-care related to changes in one's state of health included regularly taking one's medicines, following a diet, reducing the consumption of salt, and weight-watching. Similarly to the women, a minority of the men was careless about their health. (Rissanen 1999.)

Studies on the resources of the elderly emphasize the importance of continuous meaningful activities and maintenance of life management (Hokkanen et.al. 2006; Juvani et.al. 2006; Andesson 2007). Key to maintenance of life management is living at one's own home (Juvani et.al. 2006; Anderson 2007). Resources related to meaningful activities generally refer to hobbies (Hokkanen et.al. 2006) and everyday chores (Anderson 2007). Friends, relatives, and social activities make life meaningful (Hokkanen et.al. 2006) and increase the possibilities of coping at one's own home for a long time (Roine et.al. 2000).

Feeling of loneliness has been shown to increase with age (e.g. Vaarama 1999a; Jylhä 2003), and a third of the aged feels lonely (Tilvis et.al. 2000). Good human relations have an impact on preventing the elderly's social exclusion, loneliness, and depression (Routasalo et.al. 2005, 7, 8). Human relations also have an effect on preventing memory disorders (Tilvis et.al. 2000). Group activities comprising discussion or physical exercise

diminish feelings of loneliness (Hytönen et.al. 2007). Loneliness and poor social networks diminish the quality of life of caregivers and the elderly.

Meeting a caregiver at the Senior clinic requires knowledge of family caregiving and recognition of situations related to family caregiving. A caregiver's commitment to the person cared for is seen both at the Senior clinic's reception and during a house call in such a way that the caregiver-customer wants to talk about not only his or her state of health but also his/her family situation and the disease of the family-care recipient. A study on promoting the health of aged caregivers showed that the welfare of the caregiver and the welfare of the family-care recipient are interconnected and that promoting the caregiver's health must account for the family situation. (Leinonen 2009.)

Studies show further that, when acting as caregivers, the caregivers do not have time to sufficiently account for their own state of health, since the needs of the family-care recipient always come first (Leinonen 2009; Metso & Mäkelä 2001). Caregivers' self-governed health promotion is only possible to the extent allowed by the family caregiving situation; for instance, going out for a walk is not easily possible for all caregivers. (Leinonen 2009.) Furthermore, help and attention on the part of the health-care personnel are usually targeted at the family-care recipient only, and the caregiver feels being left alone with his/her own needs (Metso & Mäkelä 2001; Haapaniemi et.al. 2005, 311-322; Kaskiharju et.al. 2006).

According to Pinquart & Sörensen' (2003) study, caregivers have a poorer physical health than non-caregivers. The biggest differences are found between depression, stress, and subjective wellbeing in general. Family-care recipients' dementia and behavioral disorders enhance caregivers' dissatisfaction and physical and mental strain the most (Viramo 1994). The most stressed of all are caregiver spouses (Stengård 2005).

According to studies, caregivers wish for more data on family-care recipients' diseases and support forms available (Gothon 1991; Kaskiharju et.al. 2006; Leinonen 2009), which is why the Senior clinic has to be able to provide versatile information. Caregivers also desire more time off and rest (Gothon 1991; Stengård 2005; Leinonen 2009), as well as mental support, for instance, in the form of conversation (Gothon 1991; Kaskiharju et.al. 2006; Leinonen 2009). Kaskiharju et.al (2006) also underlines the significance of social support for care solutions and ethical questions, as well as access to peer support.

Good practices identified at Vantaa Senior clinic

The good practices presented in this article follow the Instructions for Compiling Good Practices, described at Sosiaaliportti.fi (Sosiaaliportti.fi website 2010). Vantaa Senior clinic's good practices consist of process description of health meetings, invitation method, and comprehensive contents of health meetings. Of the Senior clinic's products,

the following are highlighted as good practices: caregivers' medical examinations and health meetings for the elderly. The last good practice to be presented is documenting of operations.

To clarify senior-clinic operations, process descriptions were compiled for health meetings for 75-year-olds and medical examinations for caregivers. The process starts from sending of invitations and progresses all the way to potential further measures. Figure 1 describes the Senior clinic's process as regards health meetings for 75-year-olds.

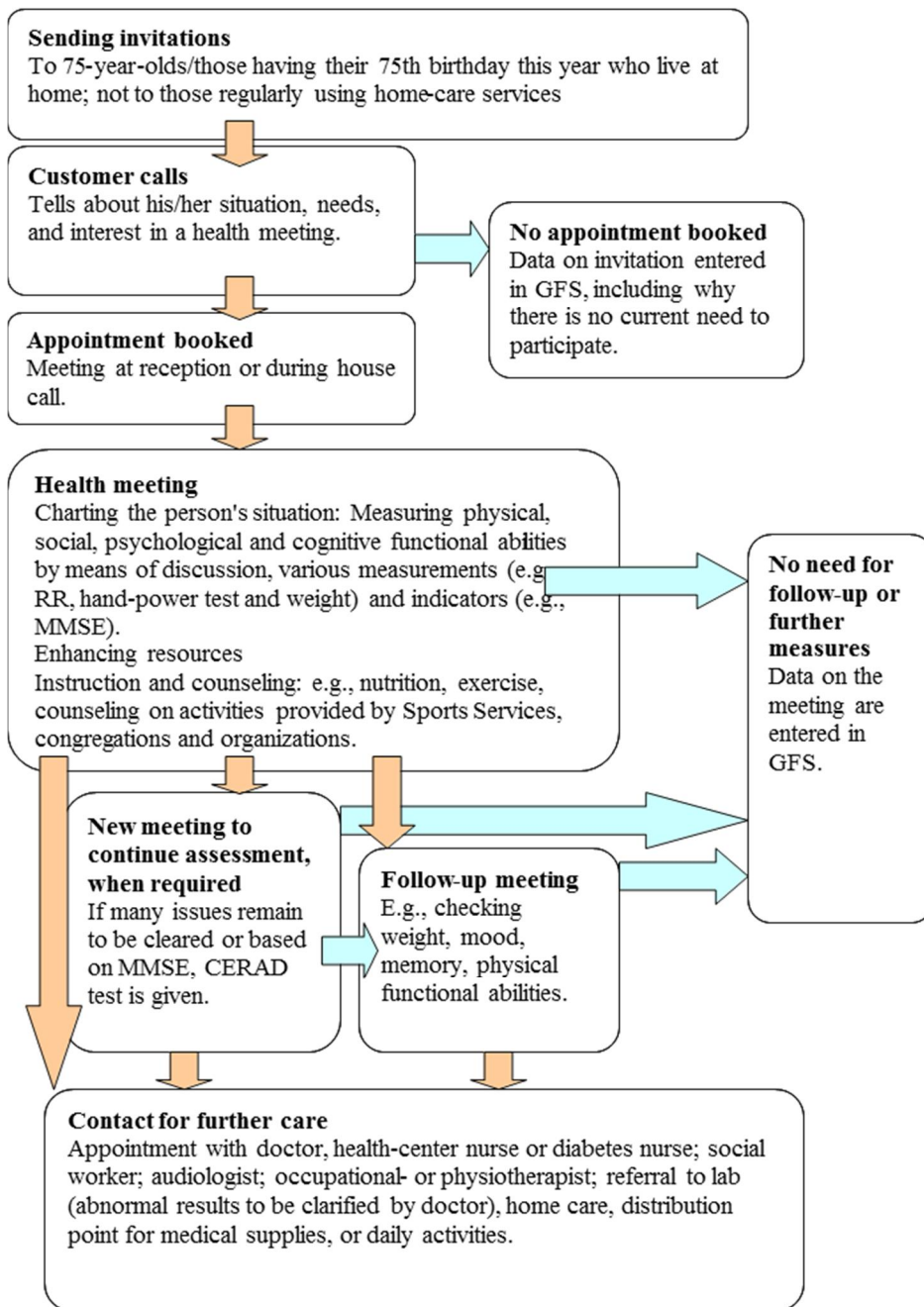


Figure 1: Senior clinic process: Health meetings for 75-year-olds
City of Vantaa
Services for the Elderly and the Disabled

The following were named as the Senior clinic's customer and time-tracking services: health meeting for 75-year-olds at the Senior clinic's reception or during a house call; caregiver's medical examination at the Senior clinic's reception or during a house call; phone consultation; group consultation; other medical examination at the Senior clinic's reception or during a house call; as well as guidance, counseling or control visit.

Caregivers who had drawn a family-caregiving agreement with the City of Vantaa did not have the possibility of using occupational health services. As of fall 2009, Vantaa Senior clinic started to give medical examinations for caregivers aged 65 or older. Medical examinations for caregivers have been considered highly useful. One recognized good practice is that the Senior clinic is an impartial body as regards decisions on family caregiver allowance, which means that a confidential care relationship with a caregiver is possible. The importance of empathetically listening to caregivers is emphasized in medical examinations for caregivers. The discussion topics consist of, among other things, how a partnership turns into a care relationship, processing caregivers' feelings and ethical questions related to them. Physical measurements often indicate caregivers' heightened blood pressure. Caregivers requested health meetings in order to gain support for caring for their own health (Leinonen 2009).

The invitation method was deemed good, since it makes it possible to access an entire age group. In Vantaa, the target groups receive the invitation to a health meeting by mail. The invitations are mailed in stages during the calendar year. Staging helps to avoid congestion of the appointment service. The invitation informs the recipient of senior-clinic activities, which also helps make these activities better known. The invitation letter includes a brochure on issues key to promoting the health of the elderly: versatile and sufficient nutrition and physical exercise; maintaining social relations, for instance, with the help of services provided by the city or various organizations; as well as a list of the most common problems in identifying factors detrimental to health and functional abilities, and treating those problems at an early stage. This system also makes it possible to relay important information to those who do not make an appointment for a health meeting.

Each year, senior clinic employees send invitations to senior citizens turning 75 on the basis of population-information data. Handlers of family caregiver allowance mail the invitations to their own customers each year on the basis of customer-register data. Senior clinic's own personnel who concentrate on senior-clinic work, its development and assessment is also deemed to be a good practice. Vantaa Senior clinic's services are voluntary and free-of-charge to the customers. Many customers are encouraged to participate, since they do not have to pay for the service.

The extensive health meetings last for about two hours per customer, during which the customer's entire physical, mental and social well-being, functional abilities, and lifestyles are charted. The meeting charts the customer's entire physical, mental and

social wellbeing, as well as his/her functional abilities with the help of a multi-page form. The form has for several years been developed on the basis of The Association of Finnish Local and Regional Authorities' house-call form. The meeting charts lifestyles related to health such as nutrition, physical exercise, smoking, alcohol consumption, and oral health care. All customers' intake of calcium and vitamin D is analyzed, and they are given instructions for potential calcium- and vitamin D supplements with the aim of preventing fractures. (Riikola & Alhava 2008; Ravitsemussuositukset ikääntyneille 2010.) In addition, the customer undergoes several measurements such as blood-pressure measurement, sight and hearing test, balance and hand-power test, and memory test. When required, the customer is referred to laboratory tests or consultation by a doctor, physiotherapist, occupational therapist, or social worker. Also during the visit, the customer's need for home care or daily activities is assessed. In addition to the above, the customer is given general information and counseling on health and welfare.

Health meetings with the aged make it possible to gain knowledge of such issues affecting health and welfare that the customer would not have mentioned or acknowledged as a health problem without specific questions. For instance, lowered hearing, which may lead to depression, dementia or social isolation, is not always realized as a health hazard. Difficulties in urination are common, and experience shows that many elderly people regard them as normal age-related changes. If untreated, elderly men's difficulties in urination due to benign prostatic hyperplasia may cause obstruction of the urethra. Likewise, excessive alcohol use is usually not mentioned unless asked about. Extensive health meetings are financially sound, for instance, compared with a single appointment for measuring blood pressure at the health center.

Health-promoting approaches shall be consciously used. For example, resource-centered counseling discussion makes it easy for the customer to participate in the discussion. The practices of a resource-centered counseling discussion have been named as follows: invitation to participate, chatting, questions about feelings, exploratory speaking, feedback showing the other person has been listened to, and neutrality of speaking. (Kettunen et.al. 2002, 216-217.)

Students at Laurea University of Applied Sciences have assessed senior-clinic operations in their theses. The customers were satisfied with the invitation procedure, extensive contents, and time reserved for the meeting. The customers wanted the customer relationship to continue. (Laitinen & Martikainen 2009.)

Documenting operations can be utilized in assessing and developing work. Regular reporting increases the visibility of the Senior clinic and makes it more widely known. After naming products, one can monitor the number of customers and time spent on products.

Considerations

This article has addressed both promotive and preventive services provided by Vantaa Senior clinic. The age group annually invited to senior-clinic health meetings consists of 75-year-olds and caregivers aged 65 or older. At the moment, resources only allow just some customers to be invited to a control visit. In Laitinen and Martikainen's thesis (2009), the customers wanted the senior-clinic services to continue in such a way that invitations to the Senior clinic are repeated at least at two-year intervals.

At the age of 75, there has already been at least ten years from retirement and access to preventive occupational health services. In order to be able to identify diseases and health risks as early as possible, health meetings should be started soon after retirement, and they should continue at regular intervals for as long as the customer lives at his/her home and until he/she needs heavier municipal services such as home care (STM 2008). The contents of the services should always include information on an elderly person's versatile and healthy nutrition, physical exercise, and the importance of social relations. Services could be offered differently to different age groups. Group counseling makes it possible to access large groups. Health counseling of the group form could, for instance, be offered to the recently retired who would later on be offered individual health meetings. Easy-to-access and affordable restaurants make it possible for people living alone and those who cannot cook healthy food to have access to good nutrition. Arranging exercise groups may promote not only maintenance of good functional abilities but also making and maintaining social contacts.

Permanent employees make it possible to develop Senior clinic's work. When an employee can plan his/her own work, even rapid changes are possible. Permanent employees know the municipal service organization and can give good service counseling. For example, an employee must know home-care services in order to be able to inform where to apply for the service, who is entitled to it, and what it costs. Senior info serves the employees as well. Compared with Vantaa's large number of residents, senior-clinic operations performed by two employees are vulnerable.

Vantaa is a geographically large area and its number of population is big and continuously growing. In order for the elderly in Vantaa to be able to live at their homes for as long as possible and stay in as good a physical condition as possible, senior-clinic operations should be developed into a regional multiprofessional team providing aged citizens living at their homes with preventive services. The team could consist of a nurse, rehabilitation counselor, physiotherapist, and memory expert. In order to support the elderly suffering from depression and the coping of caregivers, the services of a psychologist or depression nurse would introduce most welcome resources and expertise to the team. Senior-clinic services shall be available in different districts, so that they can be easily accessed. When the aim is to maintain a customer's good state of health, the

customer should be given health-maintenance guidance and counseling soon after retirement when he/she is no longer entitled to occupational health services. In the future, development of IT brings about new possibilities. One must constantly account for elderly citizens who after 10-20 years from now will have totally different facilities for using electronic services than the elderly of today.

Registration shall be able to identify information essential for a 75-year-old's health and welfare, and which methods should be developed or adopted to increase the health and welfare of the elderly. For instance, a retired physiotherapist became empowered when given the opportunity to act as a volunteer worker supervising an exercise group for the elderly. On the other hand, many elderly people became empowered when searching for suitable group activities through the Senior clinic. Data collected at the Senior clinic are entered into case files, after which they can be utilized by the entire health and social welfare department.

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Authors

Kirsi Leinonen
Head Nurse of Health Promotion
Sipoo/Finland
kirsi.leinonen@netbaron.fi

Lilja Palo
Master of Health Science
Senior Lecturer
Laurea University of Applied Sciences
Mobil phone +358 40 830 6152
lilja.palo@laurea.fi

Evaluation of care plan documents and competencies of care plan registration among nurses and care workers in home care, supported housing and rehabilitative day care services

Anne Vesterinen and Hannele Niiniö

Abstract

One of the developmental focuses in the Home Care Renewal project was the competence of care-plan documentation by nurses and care workers in home care, supported housing units and rehabilitative day care services. The goal was to develop productivity in the City of Vantaa's Community Services for the Elderly. Every team chose a responsible worker, and these workers, so called Kivas, were given a training program to improve their competence of care-plan documentation. The idea was that every Kiva would instruct the other workers in the team in these matters.

This article evaluates the competence of the responsible workers (Kivas) and their team members about making care plans and documenting them. The goal was to produce knowledge for nursing staff, managers and directors of Community Services for the Elderly for future development work after the project.

The evaluation data was gathered by a questionnaire of statements. The two main targets of the questionnaire were the responsible workers and their team members' own evaluation of their competence about the Graphic Finstar (GFi) ICT-program and using documented information in their work. The data was analyzed statistically. The other

data were nursing plans from home care services and supported housing units and they were analyzed by analytical criteria.

Some of the responsible workers' skills were excellent or good when using the GFi program. They needed more guidance on making follow-up plans and final evaluation of care. The team members' skills in using the GFi program were fairly good. They also needed more guidance on making follow-up plans and final evaluation of care.

The responsible workers' competence in utilizing documented information was fairly good. In their self-evaluation, they said they needed guidance when utilizing statistics and planning parts of the program. The team members' competence was slightly good. Some of the workers needed guidance on using statistics and the results of Rai evaluation in planning and evaluating clients' care plans. The responsible workers often used a client-centered way in registration and the team members fairly often, and they both used a descriptive style in documentation.

The actual documentation of nursing plans improved slightly during 2010. When comparing the different units, there were clear differences between them. In some plans, classifications of GFi program were used in autumn 2010 and also half-way evaluations were done. Care-plan documentation lacked nursing goals and evaluations of clients' resources, as well as influences of nursing. The principle of client-centeredness did not dictate documentation. Both the responsible workers and their team members evaluated their competence to be better than what the evaluation of nursing plans indicated.

The development work in improving documentation and competence of documenting is recommended to be continued because the nursing staff has gained parts of the whole during 2010. The positive attitude to develop their own competence and profession improves future work to achieve these goals.

Background of evaluation

This article evaluates the competence of documentation of the City of Vantaa's home-care, supported housing and rehabilitative day care services nurses responsible for documenting care work as well as that of participating team nurses. The aim was to provide information on documentation competence for the employees themselves, their leaders, and management of Community services after termination of the Home Care Renewal project. This evaluation constitutes a part of the entire nursing documentation and documentation competence assessment.

The aim of the Home Care Renewal project was to enhance the quality and productivity of home care, supported housing, and rehabilitative day care services by targeting development at, for instance, the employees' competencies. The project development

team named documentation of nursing as the target for the employees' competence. Documentation is considered one of the key competence areas of nursing (Pelttari 1997; Jauhiainen 2004). Besides theoretical management of documentation, nurses are required information-management skills and management of development (Jauhiainen 2004). Nursing documentation aims to secure continued client care and its target-based progress. Systematic documentation ensures the rights of both clients and employees, and electronic documentation enables real-time use of client information when making care decisions. (Kuusela et.al. 2006.)

The City of Vantaa's home care, supported housing and rehabilitative day care services have recognized development needs as regards the employees' use of the electronic client-information system and electronic documentation. The project development team agreed that the competency challenge is met with in-depth documentation training. The results of competence and development work are reflected in high-quality client care and positive impacts on the environment. A person who continuously strives to develop him/herself and his/her profession, courageously seeks the best information available, even though he/she may simultaneously accept information that does not support what he/she has previously learned (Heikkilä et.al. 2008).

Home-care, supported housing and rehabilitative day care services leaders chose nurses responsible for documentation, referred to as Kivas, with whom documentation training was implemented in the course of 2010. The training program was planned by a team consisting of documentation experts at the City of Vantaa's Community services for the elderly, the main user of the GFfi program used in Vantaa, and other actors involved in the project. Some of the team members also acted as trainers of the program. The nurses responsible for documentation who participated in the training shared their skills by guiding other team nurses in learning the basics of documentation. The key training method was networking where both Kivas' and other nurses' documentation competence developed on the basis of integrating individual and co-operational learning.

The learning objective of the training program was that home-care, supported housing and rehabilitative day care services employees can uniformly, systematically and daily document information on client care in the electronic patient-information system and that the entire staff can utilize the documented information when planning, implementing and assessing care in co-operation with the client. The contents of the training program consist of theoretical basics of documentation and learning guidance, the GFfi program used in Vantaa, and data privacy and security. From the very beginning of training, development of Kivas' documentation and competence were monitored by systematically collecting written feedback on instruction, on the basis of which the training modules were improved and developed to better meet with Kivas' learning requirements.

Evaluating nursing documentation and documentation competence provides leaders and those responsible for developing documentation with valuable information for future development. Documentation and documentation competency should be continuously developed in work communities as technologies advance. Developing the employees' competence ensures good client care and continuation of care. In this article we use term 'nurse' when speaking all respondents in spite of their different educational backgrounds.

Theoretical starting points for nursing documentation and documentation competency

According to the dictionary of synonyms (1989), documentation means: marking, entering into a book, listing, producing written material as evidence, and classification of written material. Nursing documentation constitutes evidence of care decisions, measures and the related resources (Kiviniemi et.al. 2007). According to the decree of the Ministry of Social Affairs and Health (298/2009), systematic care documentation means "describing a patient's care in medical-record systems in accordance with the stages of care decisions."

It is not easy to define the concept of competency, because competency cannot be objectively and rationally measured. In the context of working life, competency refers to one's ability to perform one's tasks and handle work situations. (Isopahkala - Bouret 2010.) In case of nursing, documentation competency refers to the concept of "professional competency." According to Helakorpi (2005), the starting points of professional competency consist of the knowledge and skills required in a certain profession as well as the different sides of personality that are formed, for example, by one's social environment. Competency is both individual and communal, not just knowing but more extensive performing by applying knowledge, concrete abstraction-formation, and continuous analysis and development. Competency is contextual and its evaluation is value-tied to the operating culture in question. Raji (2003) analyzes professional competency from the perspective of knowledge. The types of knowledge in professional competency are researched knowledge, skills-based knowledge, ethical knowledge, and experiential knowledge. These types of knowledge are interconnected with the components of competency. Professional competency is based on four components: knowing based on researched knowledge, understanding meanings, performance, and situation management. The ability to manage situations requires that all the components are integrated into an entity.

Technological development and societal changes require nurses to continuously develop their professional competencies. At present, many health-care and social-welfare organizations deploy electronic medical records and patient-information systems. Nursing documentation requires use of electronic systems. According to Jauhainen's

study (2004), the professional competency of a nurse using ICT and communications technologies consists of ICT and change-management and development skills in addition to nursing. ICT skills in nursing include the basics of ICT and communications technologies, patient- and hospital-data systems and applications, as well as data privacy and security. Change-management and development skills consist of attitudinal facilities, life-long learning facilities, skills related to development of ICT & communications technologies in nursing, as well as research skills. (HoiData project's final report 2009.) The decree on patient documents dictates documentation entries. Required and sufficiently comprehensive data shall be entered in order to arrange, plan, implement and monitor good client care. The entries shall be clear, understandable, and flawless. A medical record shall be continuously kept in chronological order for each client. For example, all house calls made must be documented. (Decree 298/2009)

A national patient-document archive is currently being developed in Finland, so that the data entered in it can be returned to any patient-information system, not only to the original care-provider's one. Entries in electronic patient-information systems that are saved in the national archive shall comply with standard language required by electronic data-processing (Saranto et.al. 2008). Easily accessible, up-to-date and correct information in one place enhances service provision and improves the quality of care (Hämäläinen et.al. 2006).

The uniform national electronic documentation system requires documentation based on key information structures (Law 159/2007), which is already in use in some electronic patient-information systems. Electronic structure-based documentation enables efficient management and utilization of patient and care data (Kuusela et.al. 2006). This documentation model is based on the decision-making process and stages of the nursing process. Core data based on the structures of nursing process consist of need for care, care measures, results, summary, and they are all included in the national patient-information system. Data stored in databases in a standard form enables classifications and nomenclatures with which data can be relayed from one system to another. The documentation structures follow the FinCC classification (Finnish Care Classification). Nursing classification is comprised of care-requirement classification and nursing-measure classification. Documentation can be supplied with free-form text. When documenting the classifications, the client's care data are managed and care-processes become visible. Classifications make documentation uniform and systematic, which makes it possible to evaluate the quality of care. (HoiData project's final report 2009.)

Standard documentation primarily serves the client, but beneficiaries are also employees, nursing management, and R&D. Moreover, use of uniform documentation serves information retrieval, statistics, assessment of care, and quality assurance of health-care services. Standard national nursing documentation also makes it possible to compare data between organizations, which benefits development of nursing on a national basis. (HoiData project's final report 2009.)

Hereafter the nurses responsible for documentation are referred to as Kivas and the nurses participating in Kivas' documentation guidance are called participating nurses or team nurses.

Implementing evaluation

This article evaluates the documentation and development of documentation of the City of Vantaa's home care, supported housing and rehabilitative day care services Kivas as well as team nurses participating in the guidance given by Kivas. Documentation competency is evaluated from the following perspectives:

- Kivas' and participating nurses' self-evaluation of their competence in using the GFi program,
- Kivas' and participating nurses' self-evaluation of their competence in utilizing recorded data, and
- Kivas' and participating nurses' self-evaluation of their competence in client-centered documentation.

Documentation evaluation is targeted at supported housing and service-houses' client-care plans. Lauri's (2007) qualitative documentation criteria are applied to evaluation of care plans.

Collecting and analysing the data

The data used for evaluating documentation competency was a questionnaire in order to access all the nurses working in different parts of Vantaa. A questionnaire was compiled to collect the data, planned in line with Jauhiainen's (2004) views on documentation competency. The concepts of the indicator were based on both theoretical knowledge of documentation and the terms of the GFi program used in Vantaa. When compiling the questionnaire, the functionality, logic, understandability and feasibility of the indicator were ensured by a team whose members represented nursing, documentation and information-management experts. Based on discussions, the fifth structured question of the indicator was clarified by changing the alternative "cannot" into "cannot and need more guidance."

The questionnaire consisted of 31 questions put in the form of statements. Likert's four-step scale was applied to the statements. However, the "cannot say" alternative was added, so that the respondents could choose not to take a stand. The scale scores were: 5=excellent, 4=good, 3=fairly good, 2=cannot, need more guidance, and 1=cannot say. The data was collected from Kivas on November 2, 2010, during a training day. All the 36 Kivas working at home care, supported housing or rehabilitative day care services

returned filled-in forms. The data from the participating nurses was collected in November 2010. The forms were given to Kivas on the November training day to be further delivered to the participating nurses at their workplaces. The forms were returned by mail to Anne Vesterinen, Principal Lecturer at Laurea University of Applied Sciences. Altogether 97 forms were returned.

SPSS for Windows 18.0 analytics software was used for analyzing the quantitative data. Frequency and percentage distributions, on the basis of which input errors were corrected, were calculated from the data. Lacking observations were not replaced. The "cannot say" option was removed from the set of possible answers in order to get the respondent's perspective on the subject in question. The data was described by means of analyzing the frequencies, percentages and key figures of variables. The decimals of percentages were rounded up to integers. Mean variables were made of endpoints measuring the different dimensions of the same issue. The homogeneity of mean variables was tested with Cronbach's alpha coefficient whose limit was 0.70 (Heikkilä 2010). Background variables' ratio to mean variables and endpoints was analyzed with the help of Spearman's rank-order correlation. There was no significant connection between the variables.

Documentation evaluation data consisted of home-care and supported housing nursing plans. The plans are compiled by the nursing staff, and they are usually made together with the client. By mutual agreement between the project development team and home-care and supported housing management, nursing plans from two districts of Vantaa home-care units were summarily chosen for evaluation. Nine plans were chosen from one unit and 11 from the other. The numbers amounted to 5% of the unit's number of clients. The plans were first collected on June 3, 2010, and next on October 14, 2010. One nursing plan of each of Vantaa's six supported housing units was summarily chosen for evaluation. A decision was made to keep the number of plans small, since the supported housing units had recently adopted a new documentation way. Evaluation data consisted of copies of original plans without client-identification data with the exception of the clients' sex and age in years. The copies were used to ensure the clients' anonymity. The plans concerning the clients of supported housing units were collected in May 2010 and at the end of October 2010.

The aim was to evaluate how the plans were documented by using Lauri's (2007) criteria for qualitative documentation, which are: logicalness, clarity, highlighting issues related to client consultation and care, as well as evaluation of the effectiveness of care. The planned evaluation could not be realized, because the care plans of many clients did not include any actual plan and because some documentation entries dated back to years before 2010. The results of the evaluation are presented as general descriptions of deployment of the above-mentioned evaluation criteria. The results account for Vantaa's agreement on documentation. In Vantaa, the agreed structure of nursing plans consists of nursing processes, need and goals set for nursing, implementation/means, and

evaluation of nursing. It has also been agreed that evaluation of nursing is implemented when there are changes in the client's situation or when three months from the previous evaluation have passed. Furthermore, it has been agreed that each house call is documented.

Ethical considerations

The evaluation was based on self-assessment of home-care, supported housing and rehabilitative day care services nurses who had participated in documentation training and guidance, as well as on documentation entries in nursing plans. Documentation competency is regarded as one core competency area in nursing. The research permit—addressed to Matti Lyytikäinen, director of services for the elderly and the disabled—also requested permission to use nursing plans as data. The permit required that home-care and supported housing leaders copied the nursing plans of randomly chosen clients, removed the clients' identification data, so that only the leaders themselves knew which clients' nursing plans were used as evaluation data. The copies included the clients' sex and age.

From the employees the data was collected on a questionnaire that was distributed to Kivas to be answered at a training event. The other nurses were given the forms at their workplaces. Director of services for the elderly and disabled Matti Lyytikäinen and service manager Anna-Liisa Korhonen had informed the employees about the assessment. Kivas were also informed about the evaluation in connection with training days. The cover letter to the questionnaire explained the purpose and benefit of the questionnaire, that participation was voluntary, and that the responses were kept anonymous. Moreover, the cover letter listed the names and contact information of the people responsible for the evaluation, as well as the role of Laurea University of Applied Sciences. The results of the evaluation can be utilized in further developing nursing and nursing documentation. Evaluating the employees' documentation competency is not in itself an ethically sensitive subject. The results of evaluating the employees' competency can be utilized when planning personnel training and when conducting work performance and development discussions.

Evaluation results

Respondents' background information

There were altogether 133 respondents, of which 36 were Kivas and 97 were nurses who had participated in guidance provided by Kivas. Of Kivas, 17 worked at home care, 15 at supported housing units, and 4 at rehabilitative day care. Table 1 presents the distribution of Kivas' workplace locations. One Kiva did not name the location of the workplace.

Table 1: Location of Kivas' workplaces

Districts	Number	%
Hakunila	3	8
Länsimäki	3	8
Tikkurila	6	17
Korso	4	17
Koivukylä	5	14
Martinlaakso	5	14
Myyrmäki	7	19
Respondents	35	97
No response	1	3
Total	36	100.0

Eighteen Kivas (50%) were practical nurses and 15 (42%) nurses. Three Kivas had some other educational background.

Two Kivas' home-care, supported housing and rehabilitative day care services work experience was less than one year. More than a third (fr=14; 39%) of Kivas marked the length of their work experience as at least a year but at max five years. Eleven Kivas (32%) had work experience between 5+ years and at max. 10 years. Nine Kivas' work experience exceeded 10 years.

Of the nurses participating in guidance by Kivas (fr=97), 64% were practical nurses, eight were nurses or public-health nurses and eight were home aids by education. Fourteen respondents said their educational background was other than the above-mentioned, and five gave no response to this question.

Of the participating nurses, 43% (fr=42) worked at home care, 38% (fr=38) at supported housing and 16% (fr=15) at rehabilitative day care. Two participating nurses gave no response to this question. Table 2 presents the distribution of workplace locations.

Table 2: Location of team nurses' workplaces

Districts	Number	%
Hakunila	10	10
Länsimäki	8	8
Tikkurila	27	28
Korso	12	12
Koivukylä	11	11
Martinlaakso	11	11
Myyrämäki	15	16
Respondents	94	97
No response	3	3
Total	97	100.0

Of the participating nurses, 37 had work experience amounting to over 10 years (38%) and 30 (31%) between 1+ year and at max. 5 years. Ten nurses (10%) had work experience worth less than one year and 17 (18%) between 5+ years and at max 10 years. Of the participating nurses, 72% (fr=70) said they had participated in Kivas' guidance 1-2 times, 14% (fr=14) 3-5 times, and five at least 6 times. Eight participating nurses gave no response to this question.

Kivas' and participating nurses' documentation competency

Self-evaluation of Kivas' and participating nurses' competency centered on using the GF program, utilizing documented information, and client-centered documentation.

The competencies of Kivas and nurses participating in their guidance are first analyzed with the help of average variables. Kivas estimated their skills in using the GF program to be good (avg. 4.11; std. 0.512), utilization of documented information to be fairly good (avg. 3.60; std. 0.541). Kivas said they use client-centered documentation often (avg. 3.94; std. 0.531) (table 3).

Table 3: Kivas' documentation competency

Objects (a)	Average	Standard deviation	Median	Mode
Using the GFi program	4.11	0.512	4.2	4.6
Utilizing documented information	3.60	0.541	3.5	3.2

5=excellent, 4=good, 3=fairly good and 2=cannot, need more guidance

Object (b)	Average	Standard deviation	Median	Mode
Client-centered documentation	3.94	0.532	4	4

5=always, 4=often, 3=sometimes and 2=never

The nurses evaluated their skills in using the GFi program as fairly good (avg. 3.65; std. 0.577) and utilization of documented information as slightly good (avg. 3.35; std. 0.587). The nurses said they use client-centered documentation fairly often (avg. 3.63; std. 0.531) (table 4).

Table 4: Documentation competency

Objects (a)	Average	Standard deviation	Median	Mode
Using the GFi program	3.65	0.577	3.64	3.4
Utilizing documented information	3.35	0.587	3.25	3

5=excellent, 4=good, 3=fairly good and 2=cannot, need more guidance

Object (b)	Average	Standard deviation	Median	Mode
Client-centered documentation	3.63	0.598	3.59	3

5=always, 4=often, 3=sometimes and 2=never

Kivas' skills in using the GFi program for documentation ranged from excellent to fairly good (Mo 5-3; Md 5-3). The nurses' skills in using the GFi program ranged from good to cannot, need more guidance (Mo 4-2; Md 4-3).

Sixty-seven percent of Kivas evaluated as excellent their skills in documenting client-care period as terminated (avg. 4.54; std. 0.780; Mo 5); 56% in browsing client information with GFS (avg. 4.47; std. 0.654; Mo 5); 50% in seeking required client information (avg. 4.44; std. 0.607; Mo5); 50% in updating client-care plans (avg. 4.36; std. 0.761; Mo %). Ninety-one percent of Kivas assessed as excellent and good their skills in documenting basic care information (avg. 4.33; std. 0.632; Mo 4), 89% in documenting care measures

(avg. 4.31; std. 0.668; Mo 4); and 83% in compiling client-care plans with the GFi program (avg. 4.31; std. 0.796; Mo 5).

Nine Kivas (25%) evaluated they need more guidance on documenting further care plans (avg. 3.2; std. 0.964; Mo 3), four Kivas (11%) in both browsing Rai measurements (avg. 3.71; std. 0.893; Mo 4) and documenting final evaluation of care (avg. 3.76; std. 1.017; Mo3).

Thirty percent of team nurses evaluated as excellent their skills in updating service plans (avg. 4.05; std. 0.782; Mo 4); 27% in seeking client information with the help of GFi program (avg. 4.06; std. 0.723; Mo 4); 23% in compiling service plans (avg. 3.85; std. 0.838; Mo 4), and 21% in terminating client-care period with the GFi program (avg. 3.68; std. 0.941; Mo 4). Eighty-four percent of the nurses assessed as excellent and good their skills in documenting nursing interventions (avg. 4.02; std. 0.615; Mo 4); and 77% in documenting basic care information (avg. 3.88; std. 0.670; Mo 4).

Thirty-one percent of the nurses evaluated they need more guidance on documenting further-care plans; 29% in documenting final evaluation of care; and 24% in browsing Rai measurements.

Kivas' skills in utilizing documented information ranged from good to cannot, need more guidance (Mo 4-2; Md 4-3). Nurses' skills in utilizing documented information ranged from good to slightly good (Mo 4-3; Md 4-3).

Thirty-three percent of Kivas evaluated as excellent their skills in utilizing service plans in their operations (avg. 4.19; std. 0.668; Mo 4); and 22% in utilizing client lists in their work (avg. 3.60; std. 1.006; Mo3). Fifty-three percent of Kivas evaluated as good their skills in utilizing service plans in their operations; 50% in using Rava measurements in planning and evaluating client care (avg. 3.72; std. 0.659; Mo 4); and 44% in utilizing nursing plans in practice (avg. 3.69; std. 0.749; Mo 4).

Thirty-one percent of Kivas evaluated they need more guidance on utilizing service plan statistics (avg. 3.13; std. 1.056; Mo 2) and 33% in utilizing daily work plans (avg. 3.0; std. 0.970; Mo 3).

Twenty-two percent of the nurses evaluated as excellent their skills in utilizing service plans in their operations (avg. 3.72; std. 0.750; Mo 4). Sixty percent of the nurses evaluated as excellent and good their skills in utilizing service plans in evaluating care (avg. 3.72; std. 0.750; Mo 4); and 49 % in utilizing nursing plans in their operations (avg. 3.48; std. 0.767; Mo 4).

A third of the nurses (33%) evaluated they need more guidance on utilizing Rai measurements in design and evaluating client care (avg. 2.85; std. 0.790; Mo 3); 31% in

utilizing service plan statistics (avg. 2.87; std. 0.798; Mo 3); and 23% in utilizing the daily work plan included in the GFi program (avg. 3.06; std. 0.822; Mo).

Kivas' evaluations of the frequency of client-centered documentation ranged from often to sometimes (Mo 4-3; Md 4-3); and the nurses' from always to sometimes (Mo 5-3; Md 4-3).

Thirty-one percent of Kivas evaluated they document every client contact (avg. 4.14; std. 0.692; Mo 4) and 28% said they document feedback from clients (avg. 4.06; std. 0.715; Mo 4). Sixty-seven percent of Kivas evaluated that clients' status and resources are often seen in their documentation (avg. 4.14; std. 0.55; Mo). Sixty-four percent of Kivas assessed they often use descriptive documentation and 50% evaluative documentation. More than half of Kivas (56%) evaluated they often document nursing objectives as client's action or behavior (avg. 3.84; std. 0.735; Mo 4).

Three Kivas (8%) evaluated that they never document client's comment or opinions in nursing plans (avg. 3.38; 0.833; Mo 3). Two Kivas assessed that they never document nursing objectives as client's action or behavior (avg. 3.84; std. 0.735; Mo 4) and that they do not assess achievement of care objectives in connection with every client contact (avg. 3.50; std. 0.788; Mo 3).

Thirty-six percent of the nurses evaluated they always document every client contact (avg. 3.97; std. 1.016; Mo 5) and 27% said they always document feedback from clients (avg. 3.78; std. 0.963; Mo 3). Half the nurses (51%) evaluated that they often document client's status and resources (avg. 3.90; std. 0.668; Mo 4). Thirty-eight percent of the nurses said they use descriptive style (avg. 3.70; std. 0.780; Mo 4) and 36% evaluative style in documentation (avg. 3.64; std. 0.761; Mo 3).

Eleven of the nurses (11%) evaluated that they never assess achievement of care objectives in connection with every client contact (avg. 3.30; std. 0.808; Mo 3); and 10% that they never document client's comments or opinions in nursing plans (avg. 3.44; std. 0.865; Mo 3).

Evaluating nursing plans

First the results of evaluating the care plans of home care employees are described and then those of supported housing units. In this article, one home-care service unit is referred to as A and the other as B.

The actual plan was lacking from six of A's nursing plans for June (fr=9); which means that the evaluation only concerned three plans whose structures were: care process stages; need and objectives for nursing; and implementation/means. The process stage "care evaluation" was lacking from the structure. One plan used upper case in the plan.

Documentation entries in all the three places dated from either 2007 or 2006. Thus, the plans were not up-to-date and compliant with the evaluation criteria.

The actual plan was lacking from eight of B's nursing plans for June (fr=11) and the structure of three plans was based on the same nursing processes as in A's plans. The structure did not require evaluation. Of three plans, two had entries dating from 2009 and one from 2008, which means that the plans did not comply with the evaluation criteria.

Eight plans of A's nine nursing plans for October were evaluated, since in one of them the client relationship had terminated and the plan had not been copied. Seven plans had entries dating from 2010, and in only one of them the actual plan was lacking. The entries did not clarify whether they were made in connection with every house call or when required. Upper case was still used in compiling one plan. None of the seven plans described the nursing objectives; the objectives mainly described nurses' activities. A half-way evaluation was entered in three plans. The effectiveness of client nursing was not assessed. None of the plans had a description of client's resources. All the entries were compliant with the classifications of the GFi program.

There were nine of B's nursing plans for October to be evaluated, since two client relationships had terminated and the plans had not been copied. The actual plan was lacking from five plans. Only one plan had entries dating from the fall of 2010, when the client relationship had begun. This plan documented the nursing objectives and half-way evaluation, but it lacked evaluation of the effectiveness of nursing. The plan also had a clear and descriptive entry about the client's resources, and the entries were compliant with the classifications of the GFi program. The entries in the other plans dated from 2009 and 2008.

The evaluation consisted of nursing plans of clients living in six different service houses in May and October 2010. The actual plan for one of the May plans was lacking. The structure of the plans complied with home care's plan for June, and the entries dated from 2009-2006. One plan used upper case in writing the plan.

Evaluation of the October plans showed that the nursing plan for one client—probably the same as in May—was lacking. Three plans had entries from the fall of 2010 and other plans from previous years. All the three plans were clear and described the need for nursing and appropriate nursing objectives. One had a half-way evaluation and another had a documented evaluation of care results. Two plans described the client's resources and clearly documented client guidance and assessment of its results.

Considerations

Evaluating reliability

Documentation and documentation competency of Kivas and the nurses participating in Kivas' guidance were evaluated with the help of a self-evaluation questionnaire. Furthermore, documentation of nursing plans was evaluated with the help of specific evaluation criteria. The evaluation questions were targeted at the respondents' skills in using the GFi program, in utilizing documented information, and frequency of client-centered documentation. The questionnaire was chosen as the data-collection method, because it made it possible to simultaneously access nurses in different locations in Vantaa.

An indicator was planned for the questionnaire on the basis of Jauhiainen's (2004) perspectives on documentation competency. The indicator was devised by a team whose members represented expertise in nursing, documentation, and the GFi program. Two health care lecturers of Laurea University of Applied Sciences evaluated the logicalness, understandability and feasibility of the indicator. The form was not pretested.

Home-care, supported housing, and rehabilitative day care services nursing staff who had participated in documentation training and team nurses whom Kivas had instructed at their workplaces responded to the questionnaire. Kivas responded to almost every question, whereas some of team nurses left some questions unanswered. As far as the nurses are concerned, some results may have been affected by the scarce number of responses. In addition, the length of the questionnaire may have affected the reliability of results.

External factors that may have reduced reliability consist of, for instance, the respondents' views on the necessity of evaluation. Other factors that may have diminished the reliability of results include timing of the questionnaire, leaders' attitudes toward documentation and evaluation of documentation competency. Lacking observations were found to some extent in the responses given by the team nurses.

The evaluation data also included nursing plans for clients of one home-care service unit and six supported housing units in two districts of Vantaa. In order to increase the reliability of the evaluation results, the plans were collected both at the beginning and end of documentation training. On the other hand, the reliability was diminished by the scarce number of plans and service units.

Evaluations of documentation competency are based on Kivas' and team nurses' self-evaluations and reflect their opinions on their competence at the time the evaluation was made. The results of evaluating nursing plans describe home care and supported

housing units documentation practices in May and October 2010. The results of the evaluation can be utilized in further developing documentation and care work after termination of the project.

Main results and proposals for further measures

This article evaluates the documentation and documentation competency of the City of Vantaa's home-care, supported housing and rehabilitative day care services Kivas as well as team nurses participating in the guidance given by Kivas. Evaluation of competency was based on Kivas' and team nurses' self-evaluation regarding their skills in using the GFi program, in utilizing documented information, and in client-centered documentation. Documentation was evaluated by applying documentation-evaluation criteria to the care plans made for home care and supported housing clients.

Kivas' skills in using the GFi program were good. Kivas had excelled skills in entering client's care period as terminated, browsing client information, seeking client information and updating client's service plan. Furthermore, Kivas' skills in documenting basic care information, nursing activities and client's service plan were very good. Some of the Kivas still needed more guidance on documenting client's further-care plan, final care evaluation and browsing Rai measurements. The team nurses' skills in using the GFi program were slightly good. Some of them had excellent skills in updating and compiling client's service plan, seeking client information and terminating client's care period. The nurses had good skills in documenting basic care information and basic nursing activities and in browsing client information. Some nurses still needed more guidance on documenting client's further-care plan, final care evaluation and browsing Rai measurements.

Kivas' skills in utilizing documented information were slightly good. Some of the Kivas had excellent skills in utilizing client's service plan, and some had very good skills—both in practice and in care evaluation—in utilizing client's service plan, Rava measurements and nursing plans in their operations. Kivas still needed more guidance on utilizing the service-plan statistics and work-plan parts. The nurses' skills in utilizing documented information proved to be slightly good. Several nurses had excellent skills in utilizing client's service plans in their own operations, and many of them could well utilize client's nursing plans and list of clients in their own operations. Some of the nurses needed more guidance on utilizing Rai measurements in planning and assessing client care, as well as on using the service-plan statistics.

Kivas used often and team nurses fairly often client-centered documentation. Some of the Kivas always documented every client contact and feedback. Many of the Kivas often documented client's state of health and resources by using a mostly descriptive documentation style. Likewise, many of the Kivas often documented nursing goals as

client's actions or behavior. A few Kivas never documents nursing goals in a client-centered manner nor evaluate achievement of nursing objectives.

Nurses participating in documentation training used client-centered documentation somewhat often. Some of the nurses always documented every client contact and feedback. Some of the nurses often documented client's state of health and resources by using a descriptive style. Some of the nurses never evaluate achievement of care objectives nor client's opinions in the nursing plan. In the course of 2010, there was some progress in client nursing plans for home-care and supported housing clients, even though there still were some nursing plans that completely lacked the actual plan. In Vantaa, documentation instructions for documentation structure and manner dictate the personnel's documentation. There were, however, clear differences in documentation between different service units. Some of the fall 2010 plans had used the classifications of the GFi program and some of them also had half-way evaluations. The contents were especially clear in the plan for one supported housing client. Shortcomings in documentation were manifested as lack of nursing objectives, assessment of client's resources and evaluation of the effectiveness of care. The principle of client-centeredness did not dictate documentation.

The evaluation showed that the competency of Kivas participating in documentation training enhanced in the course of the project, especially as regards using the GFi program, but both Kivas and team nurses had evaluated their competencies significantly better than what was shown when evaluating clients' nursing plans. It may be that achieved personal learning had not yet found its visible form in the nursing plans collected in October 2010. Compared to Kivas, the competency and development of the team nurses remained scarce, even though the nurses, too, improved their skills in using the GFi program. In the October plan, use of classifications and half-way evaluations had increased to some extent. One must account for the fact that use of components and classifications may be based on the model template of the GFi program. One should also consider whether poor ICT skills explain some of the problems the nurses had when using the program.

Furthermore, the evaluation showed that the team nurses needed to enhance their competence in nursing work and theoretical documentation. Their shortcomings in these areas were manifested as defects in finding, using, applying and assessing information. Some of the Kivas, too, had corresponding shortcomings. Documentation of nursing plans, care objectives, evaluation, patient counseling and assessing the effectiveness of care require not only theoretical knowledge of nursing and documentation but also understanding of the significance of information. It is worthwhile to consider the relation of nursing staff's shortcomings in theoretical competency to their willingness to learn new things as well as their willingness to learn learning facilities. At present, health care and social services employees are required to develop their competencies and their work.

The authors propose that development of documentation and documentation competency be continued, since the Kivas participating in documentation training did achieve modules included in overall mastering of documentation in 2010. Positive attitude toward developing one's competency and profession promotes achievement of the objectives of future development. The authors propose the following for consideration as regards the development of home care, supported housing and rehabilitative day care services documentation and documentation competency.

- theoretical basic studies in documentation are planned and implemented to nursing staff. The long-term studies are implemented by an expert and they include supervised and evaluative practice.
- Kivas become networked and have their competencies assessed by peers; they instruct one another in connection with network meetings on enhancing documentation. Networking is systematic and responsibilities are shared.
- the development of Kivas' documentation competency is supported with the help of documentation development days, arranged 2-4 times a year.
- ground rules for documentation shall be jointly considered
- the concept of "nurse responsible for documentation" shall be clarified; what it means, entails, and how responsibility is manifested
- one topic of work performance and development discussion shall be "conception of documentation competency, development, and expertise"
- personnel are required to develop their competency and work.

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Appendix 1.

Mean variables' Cronbach's alpha coefficients:

Mean variable (Kivas)	Number of variables	Cronbach's alpha
Using the GFi program	12	0.867
Utilizing documented information	10	0.848
Client-centered documentation	6	0.843
Mean variable (Team nurses)	Number of variables	Cronbach's alpha
Using the GFi program	12	0.914
Utilizing documented information	10	0.888
Client-centered documentation	6	0.877

Authors

Anne Vesterinen
LicEd., M.Sc.
Principal Lecturer
Laurea University of Applied Sciences
tel. +358 40 830 6145
anne.vesterinen(at)laurea.fi

Hannele Niiniö
M.Ed., Senior Lecturer
Project Manager
Laurea University of Applied Sciences
tel. +358 40 5624440
hannele.niinio(at)laurea.fi

Evaluation of documentation training to Vantaa's employees of home care, supported housing and rehabilitative day care services

Anne Vesterinen, Hannele Niiniö and Tuula Heinonen

Abstract

This article describes the evaluation and results of documentation training to employees (further used also 'nurse') of the City of Vantaa's home care, supported housing and rehabilitative day care. The aim was to provide the employees and their leaders with data on learning documentation, instructing others on documentation, as well as changes in documentation. The data would then be utilized in further development of documentation after termination of the Home Care Renewal project. Developing documentation was one of the development focuses of the project, and this article constitutes a part of evaluation the development of nursing documentation.

A training program based on integration of individual and co-operational learning was devised to develop documentation. Training was targeted at nurses responsible for documentation, so-called Kivas, who later instructed other nurses—referred to as team nurses—at their workplaces. The evaluation data was collected by means of a questionnaire given to both Kivas and team nurses participating in training. The questionnaire consisted of both free-form questions and questions in the form of statements. The quantitative data was analyzed statistically, whereas data-based contents analysis was applied to the qualitative data. The evaluation focused on Kivas' learning of documentation skills, their instructing others, as well as changes in documentation. Evaluation of the team nurses was based on documentation guidance and changes in documentation.

Kivas' documentation of nursing plans became more systematic and faster as a consequence of learning the nursing process. Their skills in using the Graphic Finstar (GFi) ICT program improved. Some of the Kiva's gained basic knowledge and skills in using the GFi -ICT program, whereas others deepened their skills in using and mastering the GFi. Likewise, Kivas' documentation confidence increased as they learned more in the course of the learning process. Understanding and mastering the GFi -ICT program advanced Kivas' skills in instructing others in documentation, which was seen in their enhanced evaluation skills and use of grounds in training. Kivas' improved instruction skills, learners' positive attitude toward learning, training events' encouraging and interactive atmosphere, and leaders' positive attitude enhanced Kivas' on-the-job instruction. Meanwhile, unfavorable work conditions, learners' negative attitude, and Kivas' inexperience as instructors presented obstacles to successful instruction.

The changes in the team nurses' documentation competencies translated into better understanding of the entirety of documentation, accelerated documentation, utilization of electronic data, systematic documentation methods, and increased confidence in documentation. The changes in Kivas' documentation practices signified overall development of documentation, daily documentation of nursing plans and clients' service plans, as well as enhanced documentation practices.

Both Kivas and team nurses were of the opinion that documentation practices in the work units developed in the course of the training process. Documentation became a daily, customer-oriented activity, and the amount of overlapping documentation diminished. The change for the better clarified planning and evaluation, but development of the flow of information remained on a low level. Some of the work units had agreed on joint registration practices.

The evaluation verified that the documentation competencies of both Kivas and team nurses developed during the training process, especially as regards use of the GFi -ICT program. Development of structural documentation was seen in halfway evaluations of customer care and use of individual classifications. Management of theoretical knowledge of caring and documentation referred to understanding of the nursing process and its different stages.

Development work on improving documentation and documentation competence is recommended to be continued, since the development obtained in documentation supports learning of new things and enhanced competencies, thus improving the overall quality of nursing. In this article we use term 'nurse' when speaking all respondents in spite of their different educational backgrounds.

Background of the evaluation

The evaluation aims to provide the employees, leaders and management of Vantaa's community services with data on the results of training for further development. The evaluation is based on two sets of data. One set of data consists of Kivas' (the nurses responsible for documentation who participated in training) opinions on their documentation learning, instruction provided by them, and changes in documentation. The other set of data consists of the team nurses' (the nurses who participated in training given by Kivas) opinions on documentation guidance and changes in documentation.

The project development team agreed that the documentation learning challenge as regards use of electronic patient-information systems and electronic documentation is met with in-depth training targeted at home-care, supported housing and rehabilitative day care nurses responsible for documentation, that is, Kivas. It was further decided that after completing their own training, Kivas instruct the other nurses, that is, team nurses, in documentation at their workplaces.

The training program was planned by a team consisting of documentation experts at the City of Vantaa's community services for the elderly, the main user of the GFi -ICT program used in Vantaa, and other actors involved in the project. Some of the team members also acted as trainers of the ICT program. The learning objective of the training program was that home-care, supported housing and rehabilitative day care employees can uniformly, systematically and daily document information on customer care in the electronic patient-information system and that the entire personnel can utilize the documented information when planning, implementing and assessing care in cooperation with the customer. Another objective was that Kivas instruct their workmates in learning documentation, as well as maintain and develop their documentation competency to be able to act as documentation experts at their workplaces. Based on the learning goals, the essential training contents consisted of theoretical basics of documentation and learning guidance, the GFi -ICT program used in Vantaa, as well as basics of data privacy and information security.

Documentation training was implemented in the course of 2010. Throughout training, Kivas' documentation and guidance development was evaluated by means of feedback collected after training events. The feedback given was a basis on which the training contents were developed. Trainers, Kivas and team nurses, learning was based on networking where individual and co-operational learning were integrated into an entity. In the training context, this development method was called the "zipper model." Kivas participating in advanced training shared their individual learning by guiding team nurses on learning documentation and its basics at their workplaces. At the workplaces, documentation development of both Kivas and team nurses was also based on

communal learning. By guiding the learning of others, Kivas' own learning developed as well. Based on the feedback data collected from Kivas at the training events, development of training contents and instruction boosted the trainers' expertise.

Documentation of caring and nursing and documentation skills should be continuously developed in work communities as technologies advance. Developing the employees' skills ensures good customer care and continuation of care.

Theoretical starting points for learning nursing documentation

Globalization, deepening development of the information society, technological advances, as well as societal and financial changes leave their marks on work and working life. The changes require employees to learn new kinds of facilities and continuously develop their competencies throughout their careers. According to Mannermaa (2008), future employees are required to have the following characteristics: versatile thinking and versatile ego, willingness to change, work-development facilities, life-management skills, and proactivity.

With technical and technological development, many health and social welfare organizations use electronic medical records and electronic patient information system that demand care work documentation. According to Jauhiainen's study (2004), the professional competency of a nurse using ICT and communications technologies consists of ICT and changemanagement and development skills in addition to nursing. ICT skills in care work include the basics of ICT and communications technologies, and management of patient- and hospital-data systems and applications, as well as data privacy and information security. Change-management and development skills consist of attitudinal facilities, life-long learning facilities, skills related to development of ICT & communications technologies in care work, as well as research skills.

Besides learning, nurses have the possibility to develop their own competency, profession and professional field throughout their careers. The starting points for learning consist of the learners' earlier knowledge and experiences, problem-solving methods, and their way of perceiving the world. Cultivating, supplementing and rebuilding the above as well as testing lead to learning. Learner's own experience, reflection, conscious understanding of the subject of learning, and applying new knowledge to a different situation or context is essential in learning. (Ruohotie & Honka 2003.) Adult learners integrate—through experience—the knowledge they gain to previously learned theoretical and practical knowledge. During the learning process, learners use self-regulation knowledge, which refers to metacognitive and reflective knowledge and skills. Meta cognitive skills help learners consciously observe their way of thinking and learning. Good metacognitive skills promote critical analysis and evaluation

of one's own actions; in other words, reflection. (Tynjälä 2005.) Metacognitive knowledge refers to learners' awareness of their own schemes, strategies and processes, as well as their conscious perception of themselves as learners. This kind of knowledge evolves gradually throughout one's life. (Rauste-von Wright et.al. 2003.)

Reflection is a critical steering and learning element. By reflecting, learners assess and question their own beliefs and presumptions. At best reflection translates into observation of the grounds for one's own beliefs, which can result in a new kind of understanding of the world. (Ojanen 2006; Järvinen et.al. 2000.) Reflection makes people aware of the sensibility and appropriateness of actions. Discussion helps to achieve analytical learning, but the leader's most important tool is the art of learning. (Saranpää 2007.) When leader's work is based on internalized pedagogics, guidance aims to make it possible for the learner to develop his/her picture of the world. The learners are driven by the wish to find a deeper level of understanding, as well as noticing and dismantling patterns and blind spots. The guidance process focuses on work based on the learners' experiences. At issue lie joint research and thought processes that work on experiences and situations. Guidance creates new, changing reality with the help of speech and writing. In open dialogue, the leader and learner create a common reality where they understand each other. The aim is to understand the other party's verbal and nonverbal communication and, through this understanding, build awareness and learning. (Ojanen 2006.)

Implementing evaluation

Evaluation aims to produce information on the results of training given to home-care, supported housing, and rehabilitative day care personnel from the following perspectives:

- Kivas' perception of their own individual learning,
- Kivas and team nurses' perceptions of documentation instruction and
- Kivas and team nurses' perceptions of changes in documentation

The above-mentioned information helps to develop documentation training and competency after termination of the project. Documentation and documentation competency should be continuously developed in work communities as technologies advance. Developing the employees' skills ensures good customer care and continuation of care.

Collecting and analyzing the data

The evaluation of documentation learning and documentation development presented in this article constitutes a part of evaluating caring and nursing documentation and

competency. The data was collected by means of a questionnaire. Planning the questionnaire relied on Jauhiainen's (2004) view on documentation competency. When compiling the questionnaire, the functionality, logic, understandability and feasibility of the indicator were ensured by a team whose members represented nursing, documentation and information-management experts.

The questionnaire targeted at Kivas consisted of 13 questions, both open ones and statements. The open questions collected Kivas' perceptions of their learning, documentation guidance and changes in documentation. Four-stage Likert scale was applied to statements focusing on changes in documentation. The option "cannot say" was added to the scale, which allowed the respondents not to take a stand. In addition, the questionnaire included five questions charting Kivas' background information. The data was collected from Kivas on November 2, 2010, during a training day. All the 36 Kivas returned filled-in forms.

As far as the team nurses are concerned, the data was collected in November 2010 by means of a questionnaire that was partly based on the one targeted at Kivas. Questions in the form of statements about documentation guidance were added to the form. The form consisted of altogether 15 questions about guidance and changes in documentation. The question about the significance of change was an open one. The form had six questions charting the team nurses' background information. The forms were given to Kivas on the November training day to be further delivered to the participating nurses at their workplaces. The forms were mailed to Laurea University of Applied Sciences; altogether 97 forms were returned.

Inductive content analysis by Latvala and Vanhanen-Nuutinen (2001) was applied to analyzing the data collected by the open questions. At first, the responses were read per questions. It became evident, however, that some of the responses were scarce and partly unclear expression-wise. When reading the responses, the unit of analysis became the respondent's written logical entity of the subject. Clear and understandable logical entities were taken from the forms and written into text compliant with the terms used in the questions. The analysis was continued by simplifying the units of analysis, after which the data was classified on the basis of differences and similarities between expressions. Expressions with similar meanings were combined into a descriptive class, which was given a name describing its contents. Then the descriptive classes were turned into classes based on a comparison of their contents, and named. Open questions about changes in documentation could not be analyzed with inductive content analysis, due to their scarcity in both number and contents; the results are based on the summary of the responses given.

SPSS for Windows 18.0 analytics software was used for analyzing the quantitative data. Frequency and percentage distributions, on the basis of which input errors were corrected, were calculated from the data. Lacking observations were not replaced. The

"cannot say" alternative was removed from the responses. The data was described by means of analyzing the frequencies, percentages and key figures of variables. The decimals of percentages were rounded up to integers. Mean variables were made of endpoints measuring the different dimensions of the same issue. The homogeneity of mean variables was tested with Cronbach's alpha coefficient whose limit was 0.70 (Heikkilä 2010). Background variables' ratio to mean variables and endpoints was analyzed with the help of Spearman's rank-order correlation. There was no significant connection between the variables.

Ethical considerations

The evaluation was based on the perceptions of documentation learning and changes in documentation of home-care, supported housing and rehabilitative day care nurses who had participated in documentation training and guidance. Documentation competency is regarded as one key competency area in nursing (Jauhiainen 2004). The results of the evaluation can be utilized in further developing nursing documentation. Evaluating the documentation learning and development of nursing staff is not in itself an ethically sensitive subject; the results of evaluating the personnel's actions and competency can be utilized in planning HR training as well as in connection with work performance and development discussions.

The data was collected on a questionnaire that was distributed to Kivas to be answered at a training event. The other nurses were given the forms at their workplaces. Director of services for the elderly and disabled Matti Lyytikäinen and service manager Anna-Liisa Korhonen had informed the employees about the evaluation. Kivas were also informed about the evaluation in connection with training days. The cover letter to the questionnaire explained the purpose and benefit of the questionnaire, voluntary participation, and keeping the responses anonymous. Moreover, the cover letter listed the names and contact information of the people responsible for the evaluation, as well as the role of Laurea University of Applied Sciences.

Evaluation results

Respondents' background information

There were altogether 133 respondents, of which 36 were Kivas and 97 were nurses who had participated in guidance provided by the Kivas (referred to as team nurses).

Of the Kivas ($n=36$), 17 worked at home care, 15 at supported housings units and 4 at rehabilitative day care. Table 1 presents the distribution of Kivas' workplace locations. One Kiva did not name the location of the workplace.

Table 1: Location of Kivas' workplaces

Districts	fr	%
Hakunila	3	8
Länsimäki	3	8
Tikkurila	6	17
Korso	4	17
Koivukylä	5	14
Martinlaakso	5	14
Myyrmäki	7	19
Respondents	35	97
No response	1	3
Total	36	100.0

Half of the Kivas (fr=18) were practical nurses and 15 were nurses. Three Kivas had some other educational background. Two Kivas' home-care, supported housing and rehabilitative day care work experience was less than one year. Slightly more than a third (fr=14; 39%) of the Kivas marked the length of their work experience as at least a year but at max. five years. Eleven Kivas (32%) had work experience between 5+ years and at max. 10 years. Nine Kivas' work experience exceeded 10 years.

Of the nurses participating in guidance by Kivas (fr=97), 64% were practical nurses, eight were nurses or public-health nurses and eight were home aids by education. Fourteen respondents said their educational background was other than the above-mentioned, and five gave no response to this question.

Of the team nurses (fr=97), 43% (fr=42) worked at home care, 38% (fr=38) at supported housings and 16% (fr=15) at rehabilitative day care. Two team nurses gave no response to this question. Table 2 presents the distribution of workplace locations.

Table 2: Location of team nurses' workplaces

Districts	fr	%
Hakunila	10	10
Länsimäki	8	8
Tikkurila	27	28
Korso	12	12
Koivukylä	11	11
Martinlaakso	11	11
Myyrmäki	15	16
Respondents	94	97
No response	3	3
Total	97	100.0

Of the nurses, 38% had work experience amounting to over 10 years (fr=37) and 31% (fr=30) between 1+ year and at max. 5 years. Ten nurses (10%) had work experience worth less than one year and 17 (18%) between 5+ years and at max. 10 years. Of the team nurses, 72% said they had participated in Kivas' guidance 1-2 times, 14% 3-5 times, and five at least 6 times. Eight participating nurses gave no response to this question.

Kivas' documentation learning

Kivas' views on their documentation learning were charted with an open question. Based on analysis of the data, six classes stood up: Planning care work and updating plans; Daily documentation; Theory and responsibilities of care work; Skills in the GF-i-ICT program; Kiva's own learning process; and Supervising in Kiva's role.

Based on the analysis, the Planning care work and updating plans class consisted of two descriptive classes: Structure of care plan and Quality of care plan.

In the descriptive class Structure of nursing plan, Kivas said they had learned the different stages of nursing plan and planning customer care. The respondents said they more fully understood nursing plans and found documentation clearer.

"Making a care plan has become clearer. ...a tool for planning good care"
(form 18)

"Nursing and rehabilitation plan has become clearer. I can better document customer needs, methods, and evaluation" (form 24)

In the descriptive class Quality of nursing plan, Kivas said they had learned the importance of regularly documenting plans, customer-centered documentation, and updating evaluations of customer's functional abilities. Kivas had become familiar with the new nursing classification. Quality of planning was reflected in documentation flexibility, speed and confidence.

"Documentation must be up-to-date in caring for the patient, the importance of Rai, Rava...updates in the care plan." (form 35)

"...I may have better internalized the significance of documentation and the principle of customer-centeredness." (form 13)

"Thanks to training and practice, compiling care plans has become more flexible and, above all, faster." (form 31)

The Daily documentation class consisted of the descriptive classes Documentation practices and Documentation quality.

In the descriptive class Documentation practices, Kivas stated that they had learned the importance of uniform practices, documentation accuracy, and systematicity.

"Documentation practices have become uniform as many issues were clearly agreed on during training." (form 31)

"I have learned to more clearly document issues related to follow-up of care and...at least once a week." (form 22)

"In my opinion, the most important issue is that we have uniform documentation practices." (form 36)

In the descriptive class Documentation quality, Kivas said they had learned the importance of customer-centeredness and updating of basic information. Quality in daily documentation was described with the words: easier, faster, more specific.

"Documenting monitoring of daily care has changed: earlier I often recorded what I had done, nowadays what the customer has done." (form 24)

"...paid more attention to updating personal data, relatives' contact information, etc..." (form 15)

The Theory and responsibilities of care work class consisted of the Principles of care work, as well as Process- and information-security descriptive classes.

In the descriptive class Principles of care work and process, Kivas said they had learned customer-orientation, and methodicalness, comprehensiveness and continuity of care, as well as cooperation.

"Important for the continuity, methodicalness of customer care and, for example, important for the continuity of short-term care. (form 31)

"...I may have better internalized the significance of documentation and the principle of customer-centeredness." (form 13)

"I have learned...what is accomplished by making care and service plans and keeping them up-to-date. This benefits more comprehensive work with customers." (form 16)

"Nowadays I even understand the importance of final evaluation and how to find it on a computer about a new resident." (form 24)

In the descriptive class Information security, Kivas said they had learned to understand an employee's responsibility for documentation, the significance of documentation in securing the employee in case of unclear responsibilities, and the significance of information security. As benefits Kivas mentioned, among other things, enhanced continuity and methodicalness of care.

"Significance of documentation; it has always been important to me at work, it guarantees further care, secures the employee's back in care work. A tool for temporary employees." (form 35)

"I am for my own part responsible for responsible and good documentation" (form 25)

"I master issues related to information security better now as regards documentation." (form 11)

Based on the analysis, the Using the GFi -ICT program class consisted of the descriptive class Understanding the ICT program as a whole and development of skills.

The responses depicted the initial differences between Kivas' skills in using the GFi -ICT program. Some Kivas said they had learned the basics, whereas some deepened their skills in using the ICT program. Kivas also learned how to begin and terminate a care period using the ICT program. Kivas added that learning to manage the ICT program had also made them understand how to teach others to learn. Some Kivas said documentation had become easier and/or faster due to increased knowledge and skills.

"GFi regarding new customers, among other things, initial registration." (form 17)

"Clarification of the GFi path; new home-care customer, how to enter the data required, what to do at any given stage." (form 18)

"I have learned to seek and find new issues from GFi. This has made work easier and faster." (form 28)

The Kiva's own learning process class consisted of two descriptive classes: Own attitude toward documentation and increased confidence in documentation.

In the descriptive class Own attitude toward documentation, Kivas described that they had learned to manage panic situations thanks to their own learning and that documentation had become clearer. Kivas had become more confident in using the GFi - ICT program.

"Documentation is perhaps clearer than before. Therefore, I nowadays do not have to record as many panic situations or update important customer information, e.g., in connection with change of unit." (form 29)

"ICT programs have become familiar - courage to use systems." (form 6)

Confidence in documentation was reflected in learning information-acquisition using GFi.

"Finding information from GFi, I have become more confident...now a more comprehensive picture of the customer is available. Work is also easier because it is now known who cares for the customer on a daily basis." (form 27)

Based on the analysis, the Documentation guidance class consisted of the descriptive classes Learning-evaluation skills and Contents management.

Learning-evaluation skills referred to Kivas' abilities to discern the development of other nurses' documentation.

"...documentation is a difficult issue for many employees - why? The differences in competency are great." (form 1)

In the descriptive class Documentation contents management, Kivas described how— thanks to their own development— they had learned to use grounds when guiding others.

"When teaching others in the work community, I have been able to justify the importance of the matter and maybe better motivate others."
(form 28)

Kivas and team nurses' perceptions of guidance

Based on the analysis of the data, Kivas' descriptions of factors promoting guidance are divided into the following classes: Kiva as instructor, Trainee beside, Documentation training program, and Supportive leader.

The Kiva as instructor class consisted of three descriptive classes: Use of guidance methods promoting learning, Arranging resources, and Management of learning data. In the descriptive class Use of guidance methods promoting learning, Kivas told they had used repetition and documenting together, and they also described how their confidence in instructing had developed with experience.

"We have documented together with the trainees and studied instructions whenever problems have arisen." (form 3)

"I often used repetition in guidance when instructing about essential documentation contents." (form 2)

In the Arranging resources class, Kivas said they had arranged joint time for guidance at their workplaces.

"I have arranged time for guidance, so that everybody willing gets help with documentation, and it seems that they also actively ask for help."
(form 10)

In the descriptive class Management of the learning data, Kivas described guidance as easy and meaningful work, since expertise gained in training can be utilized in workplaces.

"It is easier to instruct others when I can better use the GFi -ICT program myself and I well understand the theory of documentation
(form 14)

"In training I focused on using the ICT program and can now instruct others." (form 34)

Based on the analysis, the Trainee beside class consisted of the descriptive class Trainee's positive attitude toward learning new, which was manifested in the trainee's active participation in documentation training, trainee's active posing of questions, and trainee's willingness to arrange time for training.

"Some of the team members applied for training themselves and asked many questions about documentation and GFI." (form 9)

"Some changed their work arrangements, so that we could together document customers' service plans in the afternoons." (form 25)

Based on the analysis, the class Documentation training program consisted of two descriptive classes: Kiva's documentation program promoting learning and Atmosphere promoting learning. In this descriptive class, Kivas described the long-term training as promoting learning and the ICT program as well planned.

"It is good that training lasts a whole year and one has time to repeat and one can ask about difficult matters." (form 13)

"From the beginning, the training days were known. And at the end of each training session, we discussed the ICT program of our next meeting." (form 33)

"The data was good, it supported one's own learning and instructing others, and it was available to everybody." (form 26)

In the descriptive class Atmosphere promoting learning, Kivas described work as conversational and sharing.

"One could always ask questions, and questions were appropriately answered. Sometimes issues were repeated." (form 26)

"In my opinion, it was good that problems could be openly discussed." (form 28)

"I met other Kivas with whom I talked about documenting and instructing. I gained good advice and tips on documenting problems." (form 25)

Based on the analysis, the Supportive leader class consisted of two descriptive classes: Leader as training-resource arranger and Leader as instructor. In the descriptive class

Leader as training-resource arranger, Kivas described the leader as a party resourcing training time and promoting training.

"The leader supports me by arranging joint time with team members. This way, training is sure to succeed" (form 1)

In the Leader as instructor class, Kivas described the leader as a participant in training and a partner promoting training.

"Our leader participates in training whenever possible." "My leader supports me by participating in training, e.g. in using GFi." (form 28)

Based on the analysis of the data, Kivas' descriptions of factors hindering training were divided into the following classes: Unfavorable working conditions, Trainees as challenges, and Kiva's inexperience as instructor.

Based on the analysis, the Unfavorable working conditions class consisted of poor resources at the workplace, which was manifested in nonfunctional computers, scarcity of computers, as well as difficulties in finding time together for Kiva and trainee.

"Computers suddenly got stuck and instruction had to be ended." (form 30)

"There were not enough computers. They are needed for patient work." (form 19)

"Busy work schedules prevented agreeing on time together. If time together can be found, training has to be interrupted because of some urgent work task." (form 18)

"Due to changing shifts, vacations and days off, there is no time together to train willing participants. Now training is fractured." (form 19)

Based on the analysis, the Trainees as challenge class consisted of two descriptive classes: Trainee's negative attitude and Poor basic facilities. In the descriptive class Negative attitude, Kivas described some trainees as unwilling to learn new, as well as unwilling to apply for and participate in training.

"Some trainees did not want any training at all. No time was suitable for them." (form 24)

"Some trainees resist guidance and do not understand the significance of documentation from the perspectives of customer and nurse." (form 4)

Poor basic facilities were manifested in the trainees' low-level basic ICT facilities and in their shortcomings in learning to learn.

"Some colleagues cannot focus on learning documentation. If one cannot use the computer, it is difficult to learn documentation. The basics of computer use should be studied first" (form 22)

In the Kiva's inexperience as instructor class, Kivas recorded their own doubts about their competencies and management of documentation contents.

"I may not have succeeded well in instructing others, should know more about good training methods." (form 8)

"I am not competent to instruct others in some documentation matters, because I do not master the matter in question myself. But I have tried." (form 5)

Team nurses assessed guidance by answering questions in the form of statements. The scale used in the statements was 5=significant, 4=sufficient, 3=poor, and 2=not at all. Based on the team nurses' evaluation, Kivas' training promoted the nurses' documentation development sufficiently (avg. 3.77; std. 0.619; Mo 4).

Of the nurses, 58% assessed that guidance promoted their documentation development significantly and sufficiently (avg. 3.96; std. 0.614; Mo 4), and 55% assessed that guidance standardized documentation practices (avg. 3.89; std. 0.602; Mo 4).

Thirty percent of team nurses assessed that training accelerated documentation poorly or not at all (avg. 3.65; std. 0.817; Mo 4), and 23% assessed that training systematized documentation poorly or not at all (avg. 3.68; std. 0.757; Mo 4).

Kivas and team nurses' perceptions of changes in documentation

Kivas and team nurses' perceptions of changes in documentation were charted by means of open questions. Kivas and team nurses assessed the significance of the change by answering questions in the form of statements. The values of variables ranged from 5=significant to 2=not at all. Almost all Kivas said their personal documentation and documentation practices at the workplace had changed. According to three Kivas, their personal documentation had not changed at all, whereas five Kivas said that there was no change in documentation at the workplace.

Change in Kivas' own documentation meant increased number and systematization of daily nursing plans and service plans. Many Kivas said they felt joy about their

competency and sharing it. The significance of documentation was linked to nurses' responsibility for ensuring the continuity of customer care. Documentation was also deemed to secure nurses' rights and to be part of their work. In addition, evaluation of care and service plans was deemed to have increased. The descriptions also emphasized more versatile use of the GFi -ICT program and, for example, more appropriate choice of components. Furthermore, documentation was deemed to have become more customer-oriented. Customer-orientation meant that customers' opinions were included in nursing plans.

Kivas' perceptions of documentation changes at work units were similar to descriptions of changes in personal documentation. Daily documentation had increased and become more systematic, which was seen in an increase in descriptions of customers' service requirements. Some work units had agreed on common documentation practices, which were seen to promote and clarify documentation. According to Kivas' descriptions, documentation at the workplace was seen as part of the care pathway, which ensures continuity of work and information transfer between team members as well as between co-operation partners. The team nurses' skills in using the GFi -ICT program had enhanced, and they could use the ICT program in a more versatile manner than before. The team nurses also worked more independently than before training. Documentation training was still needed and appreciated at work units.

Only 19 team nurses described their perceptions of documentation changes. The changes in the team nurses' documentation competencies translated into better understanding of the entirety of documentation, utilization of electronic data, systematic documentation practices, and increased confidence in documentation. The team nurses, in their descriptions, emphasized that they can perceive the entirety of documentation and understand the significance of documentation from the perspective of profitable customer care. They also linked the significance of documentation to a nurse's responsibility, referring to documents' accurate information as well as clarity and frequency of documentation. Change in documentation also means an increase in the descriptions of customer's state of health and resources. Work teams had agreed on common documentation ways. Thanks to enhanced skills in using the GFi -ICT program, the team nurses' information retrieval had become faster and use of customer lists had increased.

The significance of change in documentation is at first analyzed with the help of average variables. Kivas assessed the significance of the change as sufficient (avg. 3.88; std. 0.512; Mo 4; Md 4) as did also team nurses (avg. 3.80; std. 0.530; Mo 4; Md 3.88).

Seven Kivas (19%) deemed that documentation had improved significantly in the work community (avg. 3.86; std. 0.810; Mo 4). Of Kivas, 64% assessed that documentation had sufficiently clarified planning and assessing of customer care (avg. 3.91; std. 0.530; Mo 4), 61% assessed that documentation took place daily (avg. 3.89; std. 0.622; Mo 4),

and 50% that overlapping documentation had diminished (avg. 4.00; std. 0.609; Mo 4). Flow of information was assessed by 36% to have improved poorly (avg. 3.62; std. 0.780; Mo 4), and agreements on documentation contents and practices were poorly followed (avg. 3.72; std. 0.780; Mo 4).

Of the team nurses 32% (avg. 3.72; std. 0.780; Mo 4) assessed that the change into daily documentation was significant. In addition, 14% of the team nurses (avg. 3.72; std. 0.780; Mo 4) assessed that the change into more customer-oriented documentation was significant. Sixty-two percent of the team nurses assessed that documentation had clarified planning and evaluation of care (avg. 3.93; std. 0.750; Mo 4); and 57 % assessed that documentation had reduced overlapping documentation (avg. 3.95; std. 0.767; Mo 4). Despite development of documentation practices, 33% of the team nurses assessed that information flow had developed poorly (avg. 3.66; std. 0.711; Mo 4).

Considerations

Assessing reliability

Evaluation of documentation training was targeted at Kivas' perceptions of documentation learning, as well as team nurses'—who had participated in guidance provided by Kivas—perceptions of documentation guidance and changes. The questionnaire was chosen as the data-collection method, because it made it possible to simultaneously access nurses in different locations in Vantaa. A form was planned for the questionnaire on the basis of Jauhiainen's (2004) perspectives on documentation competency. The indicator was devised by a team whose members represented expertise in nursing, documentation, and the GFi -ICT program. Two health care lecturers of Laurea University of Applied Sciences evaluated the logicalness, understandability and feasibility of the indicator. The form was not pretested.

Kivas responded to almost every question, whereas some team nurses left some questions unanswered. The contents of some open questions in particular were short and scarce. As far as the team nurses were concerned, the results may have been affected by the small number and contents of responses. In addition, the length of the questionnaire may have affected the reliability of results.

External factors that may have reduced reliability consist of, for instance, the respondents' views on the necessity of evaluation. Other factors that may have diminished the reliability of results include timing of the questionnaire, leaders' attitudes toward documentation and evaluation of documentation competency. Lacking observations were found to some extent in the responses given by the team nurses.

The results describe Kivas and team nurses' perceptions of learning and guidance as well as changes in documentation at the time the evaluation was made.

Main results and proposals for further measures

This article described the results of evaluating documentation training. The learners were City of Vantaa's home-care, supported housing, and rehabilitative day care employees responsible for documentation who, as a result of their own learning, trained the employees in their own teams in documentation. The evaluation was based both on Kivas' perceptions of their own individual learning, documentation training and changes and team nurses' perceptions of documentation training and changes.

Kivas learned nursing planning, updating care plans, theory of nursing, responsibilities related to documentation, skills in using the GFi -ICT program, as well as guidance skills. As a result of learning, nursing processes and documenting of care plans became clearer and faster. Documentation became more customer-oriented, as the learners' understanding of the significance of assessing the customers' functional abilities and updating nursing plans deepened. Daily documentation became faster and practices became standardized especially as regards contents, and documentation practices became more specific. With learning, Kivas' skills in using the GFi -ICT program enhanced to a significant extent. Some achieved basic knowledge and skills, while some deepened their skills in using and mastering the ICT program. Understanding and mastering the ICT program promoted Kivas' learning to train, which means skills in assessing learning and use of grounds in training. Likewise, Kivas' documentation confidence increased as they learned more in the course of the learning process.

The significance of documentation became clear and was linked to a nurse's responsibility for ensuring the continuity of customer care. Understanding the significance of documentation referred to an employee's security in case of unclear issues of responsibility. Understanding also referred to an employee's responsibility for implementing care plans and for appropriately and systematically documenting implementation and evaluation into patient files by also accounting for factors related to information security.

Factors promoting Kivas' documentation guidance were connected with Kivas' own actions as trainers, trainees' attitudes, documentation training program, and leaders' actions. Learner-centered approaches, the courage to instruct, and arranging common training time promoted Kivas' guidance. Likewise, Kivas' theoretical management of documentation and care work, as well as their IT skills, promoted their guidance. Guidance was seen as meaningful work, since the competencies obtained could be utilized at the workplace. Because of trainees' positive attitude, applying for and actively participating in training by posing questions also promoted Kivas' guidance. The atmosphere and interactive working at the documentation training sessions, which

promoted learning, promoted guidance and supported Kivas' courage to train others. Other favorable factors consisted of Kivas' leader's participation in training situations and the leader's arrangements that made it possible for Kivas and trainees to find common time for the training sessions.

Meanwhile, unfavorable work conditions, learners' negative attitude, and Kivas' inexperience as instructors presented obstacles to successful guidance. Unfavorable work conditions referred to nonfunctioning computers and their too small number. Difficulties in finding common time for Kivas and trainees also prohibited successful guidance. Additional unfavorable factors consisted of trainees' unwillingness to learn new, apply for and participate in training, trainees' poor ICT skills and shortcomings in learning to learn. Kivas' doubts about the validity of training—manifested in their doubts about their training skills and management of documentation contents—constituted further factors preventing guidance.

According to the team nurses, Kivas' guidance developed documentation sufficiently, which was especially manifested in standardization of documentation principles and practices. Some of the trainees regarded participation in guidance as sufficient. Change in Kivas' own documentation meant increased number and systematization of daily nursing plans and service plans. Securing continued care and nurses' legal protection were highlighted as the significance of documentation. In addition, evaluation of nursing and service plans was deemed to have increased. Especially Kivas' skills in using the GFi - ICT program developed and diversified, and their documentation became more customer-oriented.

Kivas' perceptions of documentation changes at work units were similar to descriptions of changes in personal documentation. Documentation had increased and become more systematic, and some of the work units had agreed on common documentation practices. Documentation was considered to ensure the continuity of care, flow of information within the team and between co-operation partners. The changes in the team nurses' documentation competencies translated into better understanding of the entirety of documentation, accelerated documentation, utilization of electronic data, systematic documentation practices, and increased confidence in documentation. The change meant deeper understanding of documentation responsibility, which was related to document accuracy as well as clarify and frequency of documentation. In addition, the nurses' information retrieval had accelerated.

The significance of documentation change was assessed as sufficient in the work community. Some Kivas assessed that documentation had become significantly more customer-oriented. According to Kivas, documentation sufficiently clarified planning and evaluation of customer care, reduced overlapping documentation and became daily, whereas development of the flow of information remained on a low level.

According to the team nurses, documentation change into daily and customer-oriented documentation was significant. Documentation significantly and sufficiently clarified planning and evaluation of customer care and reduced overlapping documentation. The evaluation showed that Kivas and team nurses' documentation developed in the course of training. Referring to Jauhiainen's theory (2004), their skills in using an ICT application—in this case, the GFi -ICT program—enhanced. The results indicated fairly modest management of structural documentation. Development of structural documentation was connected with use of individual classifications and implementation of half-way evaluation. Management of theoretical basics of caring and documentation—imperative for documentation—referred to understanding of the nursing process and its different stages. Kivas' guidance developed the team nurses' documentation mainly as regards skills in using the GFi -ICT program. The results of the evaluation were fairly similar to Kivas and team nurses' evaluations of documentation competency.

Learning the theoretical knowledge and applying it, which is required in nursing documentation, was not evident in the evaluation results. Likewise, the results lacked evidence of learning in the following aspects: setting nursing goals and evaluation of customer care, patient counseling, and effectiveness of care, which are seen as criteria for high-quality documentation. Nursing staff need both theoretical knowledge of nursing and documentation when documenting.

Learning documentation and simultaneously giving documentation training has been a challenging task to Kivas. During training days, they have acted as learners and with learning, as instructors of colleagues in their teams. Studying documentation has required Kivas in particular—but also team nurses—to be goal-oriented and self-driven to attain their learning goals. The better Kivas and trainees have been conscious of their ideal learning methods and been able to adhere to them and the more they have worked and believed in their own success, the more successful they deemed their own learning. According to Tynjälä (2005), learner's activeness and combining metacognitive awareness with contents studies change the learner's perceptions of learning.

Gardemeister (2009) has outlined ingredients with which new competency management can be developed. Opposite each other are, among other things, management of equipment and management of a common focus of activity. This has to be accounted for in the development of documentation where IT systems play the main role and where even the best ICT-management skills do not guarantee high-quality documentation. On the other hand, nurses must nowadays master the use of essential electronic tools and their basics in order to be able to perform tasks aiming at securing customer care and its high quality. When developing documentation competency, the leaders' role is essential. Through tools and resources, a leader can enable learning situations, but more important is that leaders keep the matter on the table in meetings and work performance and development discussions.

Development of documentation and documentation competency should be continued. The development stage now obtained supports more in-depth learning and competency development in the future. Supporting the development of Kivas' competency is a crucial process for which there are many possibilities such as small-group peer support for Kivas and topical days implemented a few times a year.

Based on this evaluation, some nurses have problems with basic ICT skills while some have problems with the theoretical basics of nursing. They may need tailored extension studies. In these studies it is important that both the learners and trainers share a common view of the subject of learning. Utilizing the learners' experiences begins when planning a learner-centered study program. During this planning stage, information is collected on the initial documentation competency levels of the learners, difficulties with documentation, and the learners' learning methods. Methods based on the learners' ways of learning and that are applicable to contents learning are applied to instruction. Throughout training, feedback is collected on learning both from the learners and implementation of documentation, e.g., from care plans or other documents that manifest the level of competency. Based on the feedback, the study program and instruction can be developed, and the learners' process toward competent documentation can be better supported.

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Appendix 1.

Mean variables' Cronbach's alpha coefficients

Kivas:

Significance of documentation change; alfa value=8.825; number of variables 8

Team nurses:

Significance of documentation change; alfa value=0.917; number of variables 6

Significance of documentation change; alfa value=0.764; number of variables 8

Authors

Anne Vesterinen

Lic.Ed., M.Sc. (Health Sci.)

Principal Lecturer

Laurea University of Applied Sciences

tel. +358 40 830 6145

anne.vesterinen(at)laurea.fi

Hannele Niiniö

M.Ed., Senior Lecturer

Project Manager

Laurea University of Applied Sciences

tel. +358 40 5624440

hannele.niinio(at)laurea.fi

Tuula Heinonen

Physiotherapist, Supervisor

HR Planner, Project Coordinator

City of Vantaa

tel. +358 40 750 7316

tuula.a.heinonen(at)vantaa.fi

Students' perceptions of elderly care

Päivi Putkonen, Anne Toikko and Marika Ruohoniemi

Abstract

The study involved altogether 217 Finnish students (BC of Health Care and Social Services including Correctional Services, Primary Nurse, and a few BC students of Beauty and Cosmetics). In the autumn of 2010, the study sample was collected on a voluntary basis with a questionnaire. The respondents' average age was 26.1 years (women 86.2%) and average duration of studies was 1.6 years. Experience in care for the elderly increased positive attitudes towards elderly work. Positive experiences of the elderly increased willingness to develop elderly care ($p = 0.000$) and the ability to deal with anxiety caused by aging ($p = 0.000$). Of the students, 9.8% definitely wanted to work with elderly people after graduation; 29.8% were unsure; and 60.5% disagreed. Willingness to work with the elderly was related to willingness to develop the field ($p = 0.000$). The biggest obstacles were considered poor resources and negative experiences of elderly work, which were connected, inter alia, with physical and emotional stress, staff shortages, reluctance to develop the elderly, negative experiences of the elderly and own anxieties about aging. The study clearly showed that the students could be divided into two special groups: the "developers" and the "know-how-oriented" students. They had positive perceptions of elderly work and were willing to continue working with the elderly after graduation. The study field was associated with a willingness to work with elderly people after graduation ($\chi^2 = 30.490$, $p = 0.016$). The most willing were the primary nurse students and social services students, whereas correctional services and nurse / public-health students were less inclined. According to the students, the attractiveness of elderly work would increase if better resources were available. Hiring more employees was seen even more important than pay increases. A commonly voiced wish was that the workload be reduced. The means to accomplish the above are factors that facilitate the physical and mental workload of elderly work, as well as factors related to education and resources.

Introduction

Experiences and perceptions of elderly work influence health- and social-services students' willingness to find work in elderly work after graduation. The students value elderly work, but they do not necessarily want to work in the field. (Heinonen 1999.) On the basis of international experiences, it is not possible to develop elderly care only through integrative competency. Instead, precise training and specialization are required, that is, masters of geriatrics, geropsychiatry, elderly care, and social work for the elderly. (Kivelä 2001.) The students' negative experiences and perceptions of elderly work diminish their willingness to work in the field. Elderly work is demanding, because the elderly need comprehensive support. Social services professionals see and feel the customers' overall weakening that applies to not only their functions but also their ability to take care of everyday routines. Health-care employees often encounter patients with multiple diseases that cannot be healed, even though the progress of diseases can be decelerated and symptoms alleviated. We wanted to analyze students' perceptions and experiences of elderly work and elderly care. Earlier experience of elderly work or care was not required. What work- or attitude-related factors promote and what demote orientation toward elderly work? In this study, elderly work refers to all kinds of social services, nursing, beauty and cosmetics, and correctional services work where the elderly are customers. We also asked the students to list ways to enhance elderly work and factors that would promote their willingness to seek employment in elderly work.

Research material and methods

The research material was collected from two Finnish educational institutions in the fall of 2010. The research form was offered to both groups of students and individual students. Responding was voluntary; no earlier experience of elderly work, social services, health care, correctional services or beauty and cosmetics was required. The respondents were not asked to disclose their personal data; thus, no research register was created. Research permits were gained from the educational institutions before the study began. In addition to researchers, a group of health-care students at a university of applied sciences participated in collecting the material and planning the research form. The principles of good practices of ethical research were applied to reporting of the results, the respondents' identities were not disclosed, and the identities of the educational institutions were obscured. The quantitative factors of the material were not normally distributed (Kolmogorov - Smirnov). In addition, the form contained statements on the Likert scale, so the Spearman's rank-order correlation and cross-tabulation, chi-squared test, averages, and frequency distributions were chosen as statistical methods. The statistical abbreviations used are explained at the beginning of the appendices, after the References. The open questions were analyzed with an inductive contents analysis where words and sentences act as units of analysis. Itemization and qualification of contents were also used. The percentage distributions of

all the statements are presented in Table 1, divided by the subject areas: salary and resources, strain of elderly work, encountering the elderly, willingness to develop elderly work and oneself professionally, and observations in nursing. The extremes of the scale of responses (1-5) are combined in three alternatives describing negative attitude, uncertainty, and positive attitude.

Results

Responses were given by 217 students. The distribution of areas of study is described in Table 1.

Table 1: Areas of study

Area of study	Fr	%	Cumulative %
Nurse or public-health nurse	48	22.1	22.1
Practical nurse	76	35.0	57.1
Beauty care manager	6	2.8	59.9
Bachelor of social sciences	68	31.3	91.2
Bachelor of social sciences, correctional services	19	8.8	100.0
Total	217	100.0	

At the time of responding, the average age of the students was slightly above 26 years (Table 2). Of the respondents, 187 were women and 30 men. The average duration of studying was 1.6 years (Table 2). A little less than half the respondents reported their earlier vocation. Of them, 12% said they had had more than one vocation or task before studying or during present studying, and the rest had had one previous vocation or task. The students that did not report a previous vocation said that they had work experience in fields related to the elderly.

Table 2: Age and duration of studying (n=217)

Age (in years)		Duration of studying (in years)	
Average age	26.1	Mode	1.6
Range	16 – 55	Min - Max	0.5 - 3.5
Standard deviation	9.572	Standard deviation	0.7308

Some of the students (44.7%) had no experience in elderly work at the time of responding, so the research results reflect opinions based on both perceptions and experience. At the time of responding, 11% of the respondents said their work was related to the elderly. Of the respondents, 12.4% had work experience in elderly work (other than nursing) (Table 3) on average 32.2 months (All: n=212, Avg=4 months).

Table 3: Length of work experience (respondents > 0 month)

Work experience in months	Other than nursing (months), elderly work	Nursing (months), mainly elderly customers	Nursing (months), mainly other than elderly customers
Avg	32.2	15.3	61.1
Mo	1	1	1.5
Min	1	1	1
Max	180	180	360
Std	54.72506	32.11737	90.14800
Percentage of respondents	12.4%	41%	25.3%

The older the student, the more he/she had experience of this kind (Spearman: $r=0.207^{**}$, $p=0.002$). Work experience had been gained from service or dementia homes, service centers, health centers, home care, and nursing homes. Tasks included, among other things, everyday support, care assistant, guidance, supporting independence, home service or cleaning, multiservice work, daily activities, assistant at a health center, services for the disabled, correctional treatment, supervising hobbies, departmental help, and service manager. Work experience of that kind increased willingness to seek employment in elderly work after graduation ($r=0.193^{**}$, $p=0.004$).

Of nursing where the majority of customers were elderly (Table 3), 41% had experience amounting to on average 15.3 months (All respondents: Avg=6.3 months). Experience had been gained from, among other things, ambulance service; dementia, service and nursing homes; home care; service houses; wards for long-term care; rehabilitation institutions (e.g., rehabilitation for veterans); homes for the aged; old-age centers; health-center wards; hospitals, interval and assessment units; psychiatric units and hospitals; first-aid units; units providing orthopedic rehabilitation. Experience in nursing had been gained from the following tasks: basic nursing, on-the-job learning (practical-nurse, nurse, public-health-nurse students), and nursing.

Of the respondents, 25.3% had experience in nursing of mostly customers other than the elderly on average 61.1 months (All respondents: Avg=15.3 months). The older the respondent ($r=0.209^{**}$, $p=0.002$) and the longer studying had lasted ($r=0.173^{*}$, $p=0.011$), the more experience in nursing of mainly elderly customers had been gained. Workplaces consisted of, among other things, mental hospital, substance-abuse rehabilitation, mental health clinic, different units for the disabled, or subareas such as day care, dormitory, institutions, work activities, and education. Tasks included, for instance, nurse, psychiatric nursing, personal assistant, health-center assistant, childcare, child welfare, practical nurse, and working at a doctor's practice.

Perceptions and experiences of elderly work

The students deemed elderly-work resources insufficient. However, they had a slightly more positive perception of the sufficiency of services gained by the elderly (see Table 1).

The correlations between the following pairs are presented in Table 2. The older the respondent, the less he/she regarded elderly-work resources as sufficient and the less he/she regarded services for the elderly as sufficient and the more he/she favored the use of different art forms in rehabilitative nursing. Experience of the sufficiency of salary was connected with experience of the mental welfare of the aged in institutions; perception of the sufficiency of personnel, resources and services; and willingness to work in elderly work after graduation. If the salary was not deemed sufficient, neither were resources, and vice versa (Table 2).

When elderly work was deemed rewarding, it was said to have a good atmosphere (Table 3) and possibilities of professional development. In addition, creative methods in elderly work were important factors in flexible elderly-work routines. Likewise, use of different forms of art in rehabilitative work was considered important. In these cases, the students were willing to develop elderly work, and they had had positive experiences of the elderly, and they were not anxious about aging. These respondents potentially wanted to work in elderly work after graduation, and they felt that working in home care could be versatile and interesting.

If a student had had positive experiences of the elderly, the atmosphere was deemed good and the student had had many contacts with the elderly. They saw possibilities of professional development and deemed the use of creative methods and art forms important (Table 3). Willingness to work in elderly work after graduation ($r=0.339^{**}$, $p=0.000$) increased after gaining positive experiences. Elderly work was seen as physically strenuous (see Table 1).

Feelings of physical strain were connected with mental strain and negative experiences of elderly work (Table 4). These respondents also felt that elderly work lacked a sufficient number of employees. Experiences or perceptions of physical strain were also connected with poor resources, unwillingness to work in elderly work after graduation, and inappropriate salary in ratio to work demands. Less than half the students deemed elderly work to be mentally strenuous (Table 1). If elderly work was considered mentally strenuous, experiences of elderly work or the aged were more negative than positive, aging was considered anguishing, number of elderly-work employees insufficient, and working in home care was not regarded as versatile or interesting. Then, the salary for elderly work was not deemed appropriate in ratio to the work demands (Table 4).

All in all, 42.5% of all the respondents were absolutely sure or fairly sure that they can encounter an aggressive elderly (Table 1).

Factors other than age facilitating encountering an aggressive elderly consisted of: longer studies, work experience in elderly work (other than nursing), work experience in nursing primarily among the elderly, and work experience in nursing among mostly customers other than the elderly (Table 5). The respondents with plenty of experience in nursing the elderly deemed elderly work physically strenuous, while their positive experiences had increased and they were not afraid of encountering a dying or aggressive elderly (Table 5). Almost half the respondents (49.8%) were of the opinion that the elderly are given too much medication (Table 1). The older the respondent, the more he/she felt that the elderly are given too much medication. If the student's perception was that the elderly are given too much medication, he/she had also felt or come to the conclusion that the elderly feel mentally bad in institutions and that elderly work lacks a sufficient number of employees (Table 5).

Willingness to work in elderly work and develop it

Seventy-three percent of nurse and public-health nurse students did not want to work in elderly work after graduation. The rest agreed slightly, disagreed moderately, or agreed moderately. Slightly over half of the practical nurses did not want to work with the elderly after graduation; around 30% agreed slightly, disagreed moderately, and less than 20% agreed. None of the students of beauty care management wanted to work with the elderly. There number in this material was, however, small. Slightly more than 10% of students of social sciences were willing to work with the elderly, while a little less than 40% were undecided. The rest—slightly more than 50%—disagreed moderately or strongly. More than 80% of students of correctional services—that is, the majority—were not willing to work in elderly work after graduation, and the rest disagreed slightly and agreed slightly. There was a statistically significant difference between the professional groups ($\chi^2=30.490$, $p=0.016$). The area of study was also connected with one's willingness to deepen their knowledge basis: students of health care and social services wanted to deepen their knowhow in elderly work more than students of correctional services or beauty care management ($r=-0.180^{**}$, $p=0.008$). The percentage of respondents who felt it is possible to develop oneself professionally in elderly work amounted to 53.7%. They also were of the opinion that elderly work has a good atmosphere ($r=0.239^{**}$, $p=0.001$) and that elderly work is rewarding ($r=0.490^{**}$, $p=0.000$). These respondents deemed creative methods ($r=0.403^{**}$, $p=0.000$) and using different forms of art in rehabilitative elderly work ($r=0.300^{**}$, $p=0.000$) to be important. Willingness to develop professionally was also connected with one's willingness to develop elderly work ($r=0.428^{**}$, $p=0.000$), positive experiences of the elderly ($r=0.375^{**}$, $p=0.000$), and the experience that the elderly feel mentally well in institutions ($r=0.183^{**}$, $p=0.008$). These respondents wanted to work with the elderly also after graduation ($r=0.394^{**}$, $p=0.000$). Developers of elderly work (41%), for instance, considered elderly work rewarding ($r=0.344^{**}$, $p=0.000$), saw possibilities of professional development ($r=0.428^{**}$, $p=0.000$), and were willing to work with the

elderly after graduation ($r=0.498^{**}$, $p=0.000$). Willingness to work in elderly work after graduation was strongly connected with willingness to deepen one's knowhow ($r=0.610^{**}$, $p=0.000$).

Development proposals

Service systems constituted one main category in analyzing the open questions. The higher classes consisted of developing and increasing services for the elderly, as well as developing care and elderly work. The students wanted to pay more attention to the pleasantness of the elderly's housing and the environment: "homelike institutions would cheer the elderly up." There was room for development in increasing services and access to services, for instance, "removing inequality in caring for the elderly between municipalities," and developing the environment. Care-related development ($n=21$) included nutrition, medication and nursing itself. The majority of the respondents were studying to become practical nurses, nurses, and public-health nurses. Five students of social sciences wanted to develop the above-mentioned issues. Developing elderly work included development of work and professional skills, training in elderly work, and working conditions.

Working hours were to be facilitated by means of, for example, shorter shifts, clearer distribution of shifts, and pair/team work. Three respondents mentioned development of training. Responses to the question "What would make you interested in working with the elderly" were divided into two main categories: "what would make you interested" (183) and "what diminished or hindered your interest" (30). The proposals emphasized the importance of resources (74), especially the wish for better salary (51), and improved work characteristics (48), of which the most attractive were versatility of work and development possibilities. Encounters with the elderly (23) increase interest in elderly work. Interest was also increased by the following factors: increasing information and training (9), good characteristics related to the work environment (9), the elderly's positive characteristics (9), quality of care (6), functional approaches (8), and good characteristics of the work community (11). Factors preventing or reducing interest the most were personal reasons (lack of motivation/willingness, nothing makes me interested in elderly work, work is too heavy). Other factors preventing or reducing interest consisted of: defects in care, negative image in public, and insufficient resources. Nine students said that nothing could make them interested in elderly work.

Students of social sciences paid more attention to resources in general, for instance: "More resources for elderly work." Nurse and public-health-nurse students mentioned use of resources, individual salary, and inputs in technical aids and care places: "more resources are needed, for example, technical aids and care places." Practical-nurse students prioritized individual salary the most. In every area of study, one or several respondents highlighted the importance of increasing the number of employees in

elderly work. "It is important to increase the number of employees" – bachelor of social sciences, university of applied sciences, "more employees" – nurse, university of applied sciences, "Increasing the number of employees!!" – beauty care manager, university of applied sciences, "larger number of employees" – public-health nurse, university of applied sciences, "more employees" – bachelor of science in correctional services, university of applied sciences, "more employees" – practical nurse, were the most common replies. Increasing the number of employees (42) was deemed even more important than increasing the employees' salary (13). Pay increases were wished due to work demands: "Because the ratio of salary to the mental strain is too low." On the other hand, reducing strain was deemed to bring new workforce into elderly work: "If a nurse's job in elderly work were not so strenuous, more people would probably enter the field more willingly." The main categories consisted of factors promoting and facilitating elderly work both physically and mentally, as well as factors related to training and resources.

Considerations

According to Kivelä, interest in and willingness to study elderly work can be increased by making it possible to perform the practical professional orientation periods of basic-school and upper secondary school in different high-quality small group houses for the elderly and service centers for the elderly. (Kivelä 2006.) The results of this study show that earlier positive experiences of the elderly and of elderly work increase students' willingness to work with the elderly.

According to Hautala's study, students believe elderly work to be routine, heavy, underappreciated, and monotonous. The students had formed their image of elderly work based on clinical internship or earlier work experience. Elderly work was not regarded as an attractive field; nevertheless, half the students believed they would be employed in elderly work. The students without experience in elderly work had a negative perception of it (Hautala 2008). This research also arrived at similar results. In Hautala's study, elderly-work training was considered superficial, rudimentary, monotonous, and embellished. After training, more focus on special expertise and arousing interest was required. Training in elderly work was considered useful, even though it was not a popular field. Based on the study, training can affect the students' attitudes toward nursing in elderly work, and that co-operation between the employment sector and educational institutions should be strengthened. (Hautala 2008.)

In qualitative stories told by soon-to-graduate nurses, the following rose as topics: imbalance between salary and amount of work; personnel cuts caused by savings; demands for flexibility targeted at young nurses; temporary employment; and lack of

vacation accrued (Ora-Hyytiäinen 2004). The above results are supported by the results of this study.

Soile Juujärvi clarified the development levels of perception of care and fairness of altogether 66 practical-nurse, social-sciences and police students. The level of development of perception of care was connected with the types of moral problems the interviewees said they had encountered. The levels of perception of care and fairness were strongly interconnected. Perception of care included not only sensitivity to the needs of another person, but also established values and ethical principles targeted at promoting the welfare of others. Thoughts of care play a major role in everyday moral conception. In order to understand moral conception and activities, the perspectives of care and fairness are required. (Juujärvi 2003.)

Hirvonen's research results show that caring for the elderly is not appreciated in our society and that the resources for caring for the elderly are insufficient. Changes in the students' attitudes toward elderly work were visible: they became slightly more negative during training, even though the attitude toward the elderly remained positive. Hirvonen et.al. summarize that merely increasing resources will not probably suffice; elderly work needs vocational further education, training, and development of approaches by accounting for possibilities provided by technologies. (Hirvonen et.al. 2004.) The results of this research and similar results gained by other researchers generated a new perspective for consideration and research need: societal, moral, ethical, and educational attitudes toward the elderly and elderly work as well as perceptions of fairness and welfare in elderly work from the perspective of both caregiver and customer should take a more positive direction in Finnish society.

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Explanations for abbreviations

Fr	= frequency, number of variable's value
Avg	= average
Std	= standard deviation
Khi2	= chi-square test, in connection with cross tabulation
Cumulative%	= accumulation percentage
Min	= minimum, variable's smallest value
Max	= maximum, variable's biggest value
Mo	= mode, variable's most common value
p	= p-value (95% range, acceptable limit $p < 0.05$)
r	= value of correlation coefficient, range -1 – +1 (Spearman)
Range	= range (maximum – minimum)
Spearman	= Spearman' s correlation coefficient

Tables

Table 1: Percentage distributions of statements

Salary and resources V1 - V4 Mental and physical strain of elderly work V5 – V9 Encountering V10 – V15 Developing into an elderly-work expert and developing elderly work V16 – V23	Agree strongly, agree moderately (%)	Agree slightly, disagree slightly (%)	Agree strongly, agree moderately (%)
V1 Elderly work has a sufficient number of employees (n=214)	81.8	13.6	4.6
V2 Salary for elderly work is in ratio to work demands (n=211)	82.0	14.2	3.8
V3 Elderly work has sufficient resources (n=212)	77.3	16.5	6.2
V4 Various services for the elderly are sufficient (n=214)	64.9	24.3	10.8
V5 Elderly work has a good atmosphere (n=201)	22.9	51.7	25.4
V6 Elderly work is rewarding (n=214)	7.0	36.0	57.0
V7 I find elderly work mentally strenuous (n=211)	16.1	37.9	46.0
V8 I find elderly work physically strenuous (n=213)	6.5	23.5	70.0
V9 I have more negative than positive experiences in elderly work (n=212)	66.0	23.6	10.4
V10 I have had many contacts with the elderly (n=216)	40.7	27.8	31.5
V11 I have positive experiences of the elderly (n=215)	3.7	26.5	69.8
V12 I am not find anxious about aging (n=214)	23.8	25.7	50.5
V13 I can encounter an aggressive elderly (n=214)	25.3	32.2	42.5
V14 I am not afraid to encounter a dying person (n= 216)	23.6	18.5	57.9
V15 The elderly are mentally well in institutions (n=213)	50.3	41.8	7.9
V16 I want to deepen my knowhow in elderly work (n=216)	27.8	34.7	37.5
V17 Professional development is possible in elderly work (n=216)	16.2	30.1	53.7
V18 Creative methods are important in the flexibility of everyday elderly work (n=215)	1.9	22.3	75.8
V19 Different art forms have many possibilities in rehabilitative elderly work (n=211)	5.2	22.3	72.5
V20 I want to develop elderly work (n=213)	24.8	34.3	40.9
V21 I want to work in elderly work after graduation (n=215)	60.4	29.8	9.8
V22 I think the elderly are given too much medication (n=215)	13.1	37.2	49.8
V23 Working in home care is versatile and interesting (n=194)	17.0	50.5	32.5

Table 2: Sufficiency of resources (*=Spearman's rank-order correlation)

Variable pair	Rank order correlation* (r)	p-value	Variable pair	Rank order correlation (r)	p-value
Age * V3 There are enough resources in elderly work	-0.220**	0.001	V2 * V1 There are enough employees in elderly work	0.330**	0.000
Age * V4 Different services for the elderly are sufficient	-0.326**	0.000	V2 * V3 There are enough resources in elderly work	0.537**	0.000
Age * V19 Different art forms have many possibilities in rehabilitative elderly work	0.172*	0.012	V2 * V4 Different services for the elderly are sufficient	0.438**	0.000
V2 Salary for elderly work is in ratio to work demands * V15 Different art forms have many possibilities in rehabilitative elderly work	0.253**	0.000	V2 * V21 I want to work in elderly work after graduation	0.214**	0.002

Table 3: Rewardedness (V6= elderly work is rewarding)

Variable pair	Rank order correlation (r)	p-value	Variable pair	Rank order correlation (r)	p-value
V6 * V5 Elderly work has a good atmosphere	0.140*	0.047	V6 * V20 I want to develop elderly work	0.344**	0.000
V6 * V17 Professional development is possible in elderly work	0.490**	0.000	V6 * V11 I have positive experiences of the elderly	0.374**	0.000
V6 * V18 Creative methods are important in the flexibility of everyday elderly work	0.286**	0.000	V6 * V12 I am not anxious about aging	0.200**	0.004
V6 * V19 Different art forms have many possibilities in rehabilitative elderly work	0.285**	0.000	V6 * V21 I want to work in elderly work after graduation	0.390**	0.000
V6 * V23 Working in home care is versatile and interesting	0.373**	0.000	V11 I have positive experiences of the elderly * V5 Elderly work has a good atmosphere	0.223**	0.002
V11 I have positive experiences of the elderly * V10 I have had many contacts with the elderly	0.330**	0.000	V11 * V17 Professional development is possible in elderly work	0.375**	0.000
V11 * V18 Creative methods are important in the flexibility of everyday elderly work	0.300**	0.000	V11 * V19 Different art forms have many possibilities in rehabilitative elderly work	0.194**	0.005

Table 4: Physical and mental strain of elderly work

Variable pair	Rank order correlation (r)	p-value	Variable pair	Rank order correlation (r)	p-value
V8 I find elderly work physically strenuous* V7 I find elderly work mentally strenuous	0.382**	0.000	V8 * V9 I have more negative than positive experiences of elderly work	0.160*	0.021
V8 * V1 Elderly work has a sufficient number of employees	-0.322**	0.000	Elderly work has sufficient resources	-0.241**	0.000
V8 * V21 I want to work in elderly work after graduation	-0.162*	0.019	V2 Salary for elderly work is in ratio to work demands	-0.258**	0.000
V7 I find elderly work mentally strenuous * V9 I have more negative than positive experiences of elderly work	0.240**	0.000	V7 I find elderly work mentally strenuous * V11 I have positive experiences of the elderly	-0.146*	0.034
V7 * V12 I am not anxious about aging	-0.183*	0.008	V7 *V1 Elderly work has a sufficient number of employees	-0.137*	0.048
V7 * V23 Working in home care is versatile and interesting	-0.148*	0.040	V7 * V2 Salary for elderly work is in ratio to work demands	-0.149*	0.032

Table 5: Encountering an aggressive elderly and a dying person

Variable pair	Rank order correlation (r)	p-value	Variable pair	Rank order correlation (r)	p-value
V13 I can encounter an aggressive elderly* Duration of studying	0.150*	0.030	V13 I can encounter an aggressive elderly * Work experience in elderly work (other than nursing)	0.193**	0.005
V13 * Work experience in nursing (mainly the elderly)	0.308**	0.005	V13 * Work experience in nursing (mainly the elderly)	0.209**	0.001
Work experience in nursing (mainly the elderly) * V8 I find elderly work physically strenuous	0.256**	0.000	Work experience in nursing (mainly the elderly) * V11 I have positive experiences of the elderly	0.188**	0.006
Work experience in nursing (mainly the elderly)* V14 I am not afraid to encounter a dying person	0.315**	0.000	Work experience in nursing (mainly the elderly)* V13 I can encounter an aggressive elderly	0.308**	0.000
Age * V22 I think the elderly are given too much medication	0.192**	0.005	V22 I think the elderly are given too much medication * V15 The elderly are mentally well in institutions	-0.240**	0.000
V22 I think the elderly are given too much medication * V1 Elderly work has a sufficient number of employees	0.204**	0.003			

Authors

Päivi Putkonen
Development Manager Laurea Tikkurila
M.Sc. (Health Sci.)
Researcher, Aalto University School of Science and Technology
Laurea University of Applied Sciences
Ratatie 22, FI-01300 Vantaa
paivi.putkonen@laurea.fi

Anne Toikko
Instructor at Rinnekoti Foundation
Bachelor of Social Services
annetoikko@hotmail.com

Marika Ruohoniemi
Bachelor of Social Services
marika.ruohoniemi@gmail.fi

The Driving Change in Welfare Services for the Aged project publication describes the proven results gained during the course of the project. The goal of the project was to develop the structure and operations of Espoo and Vantaa's community services for the elderly in such a way that the share of institutional care in services for the elderly diminishes and that as many senior citizens as possible can live at their own homes also in the future. The development project was carried out in cooperation with the cities of Vantaa and Espoo, Aalto University School of Economics, as well as Laurea University of Applied Sciences' Tikkurila unit from February 1, 2008 to April 30, 2011. The project constituted a part of the European Social Fund's Leverage from the EU 2007-2013 Continental Finland's structural fund's operational program number 3. The project—under the administration of The Ministry of Education and Culture—was funded by the European Social Fund, Uusimaa ELY Centre (Centre for Economic Development, Transport and the Environment), as well as the cities of Espoo and Vantaa.

The articles in this publication primarily describe the results of cooperation on development. The results are described as development of networks, network competency, good practices, and employees' professional competency. In addition, the publication includes two articles, one of which considers and assesses the significance of development from the perspective of strategic management, and the other describes students' perceptions of elderly work.

Naturally, this publication cannot list all the achievements of the project or everything about the development cooperation the parties involved in the project accomplished in the course of more than three years. One essential achievement of the project was the development of an implementation method which is based on working in networks and developing both networks and network competency. All the project results are available at: www.muutosvoimaa-hanke.fi



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