Henna Myller (ed.)

HOME CARE 24H

Strengthening Competences and Renewing Operations Models

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Asiakaslähtöisyys
Inhimillisyys
Turvallisuus
Luottamus

24h kotihoito

ympärivuorokautisen
kotihoidon kehittäminen
seudullisena verkostoyhteistyönä
2008 - 2010

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PROLOGUE

The Developing Round-the-Clock Home Care as a Regional Network Co-operation project, the Home Care 24h project, was implemented in 2008–2011. The purpose of the project was to develop demanding round-the-clock hospital-level home care as an alternative for hospital care. The central development areas were discharging from the hospital, rehabilitation process, communication, documenting, support for relatives, and terminal treatment. The project was implemented as a multi-disciplinary and multi-professional network co-operation across regional and organisational boundaries. The participants were representatives of public and private sectors as well as patient organisations within social services and health care. The project was funded by European Regional Development Fund through the Regional Council of North Karelia, as well as the participating municipalities, the Joint Municipal Authority for Medical and Social Services in North Karelia, businesses, organisations, and North Karelia University of Applied Sciences.

In finding new ways of producing services for round-the-clock home care, the challenges in the project were related to the increasing need for home care and limited resources. The starting point of the development in the project was to secure the continuity of care especially in the discharging and transfer phases but also in home care. The overall care of the patient in various operational environments was developed so that it would be patient-oriented, safely designed, and economically sound and that it would take the expert co-operation between various actors into consideration.

This publication presents the participants' experiences in developing round-the-clock home care in North Karelia region from various points of view. The articles provide a varied, extensive idea of the whole scope of work within the project.

I wish to extend my heart-felt gratitude to all of You who participated in the project for the significant work and co-operation that has promoted the development of round-the-clock home care in many municipalities: developers from various organisations and work communities, superiors and executives, members of the steering group, teachers and students, and many experts. I hope the development of home care continues in an equally target-oriented, enthusiastic manner. I also wish to thank the authors who contributed in this publication and those who have assisted in the completion of this publication.

10 January 2011, Joensuu

Henna Myller
Project Manager

Developing Round-the-clock Home Care in North Karelia

Henna Myller

THE NEED FOR DEVELOPING HOME CARE

Renewing the structures of health care, financial factors, and operational efficiency are currently examined at a national level. There are plenty of development challenges on national, regional, and institutional levels, as well as at the level of units. The challenges are availability and sufficient volume of good quality care based on the health-related needs of the ageing population, as well as implementing and utilising purposeful communication and health care technology. Another challenge is to develop the service system so that the operation of various actors in the process, the state, municipalities, and the private and third sectors are taken into account (L169/2007 Project to restructure local government and services (Paras), Ministry of Social Welfare and Health 2008a, Ministry of Social Welfare and Health 2008b).

On a national level, the focus of health care is being shifted from hospital care to home care, which causes special challenges for the development of home care. The opportunity to live at home for as long as possible and receive the necessary treatment, care, and also demanding hospital-level care or terminal treatment at home is in line with the wishes of the elderly as well. The status of basic health care is also strengthened by renewing home care services. Other significant points in developing home care are promoting rehabilitation and support for relatives.

During the past years, home care has been developed considerably in our region, but the challenges of developing hospital-level round-the-clock home care are particularly topical in North Karelia. Two projects, “Laadukkaan kotihoidon kehittäminen Pohjois-Karjalaan hanke 2002–2004” (developing quality home care in North Karelia) and “Palliatiivisen hoidon kehittämishanke 2005–2007” (development project for palliative treatment), have contributed to creating a foundation and showing the need and urgency for developing round-the-clock home care in the region.

This project called “Developing Round-the-clock Home Care as a Regional Network Co-operation”, in short, “Home Care 24h”, started in August 2008. The project is funded by European Regional Development Fund and the funding is provided by the Regional Council of North Karelia. In addition, all the participating municipalities, the joint municipal authority, businesses, patient organisations, and North Karelia University of Applied Sciences have invested their self-financing shares.

There are plenty of reasons that speak for the project ranging national recommendations and development programmes (e.g. L169/2007 Project to restructure local government and services (Paras), Ministry of Social Welfare and Health 2008a,

Ministry of Social Welfare and Health 2008b), as well as health care needs, morbidity, health care costs, and re-organising social and health care services for the region's population. (POKAT 2010, Regional Centre Programme of Joensuu Region 2007–2010). In the social and health care strategies of North Karelia region municipalities in 2006-2008, the development of home care is in a central position.

The purpose of the project is to develop social and health care service structures in municipalities to secure round-the-clock come care in many areas of the region. The central development areas are discharging process, rehabilitation process, communication, documenting, support for relatives, and terminal treatment. Securing safe evening and night care for patients in need of round-the-clock care, also for the severely ill patients and terminal treatment patients, as well as support for relatives have been a special development challenge. The development is implemented in various ways in the participating municipalities; home care may be supported by outpatient departments, inpatient wards, organisations, and businesses, or home care may be implemented according to an individual operations model by applying principles of home hospital care or intensive home care.

The objective stated in the project plan (2008) is to develop home care services and service structures of intensive home care based on the principles of home hospital care in the participating municipalities as a regional network co-operation. The objective concerns safe discharge process from special hospital care to home care, and developing evening and night care, in particular. The second objective is to develop and strengthen the competences and leading skills of the actors, as well as network dialogue between the organisations, businesses, and other actors so that customer-based home care can be implemented seamlessly, safely, and economically. The objective also concerns the hospital-level competence of health care staff, consultation practices, and developing business co-operation

DEVELOPING THE DISCHARGE PROCESS

Signs of efficient social and health care are transferring patients from care location to another at the right time and treating them in the right place. In somatic special health care, the average length of a treatment period in Finland in 2005-2006 was 4 treatment days and in inpatient wards of health care centres approximately 30 treatment days. On the national level, the treatment periods in special health care of over 65-year-olds have become shorter and further care in basic health care still takes place before discharging. (Hammar 2008.) Based on empirical data and also Hammar (2008), a patient is often discharged on the same day or on the following day when the decision for discharging has been made. This gives very little time to prepare for the discharge. The most common discharge day is Friday, but discharging can also take place during weekends and evenings. The most critical times after discharging are the first few days, sometimes even two weeks, which is when complications or re-admitting to the hospital are common.

From the point of view of the patient, successful discharging and home care require sufficient assistance and well-timed services that support his/her coping and sense of safety. It is not often significant to a patient who or which institute provides the services, rather, it is significant that he/she gets the help needed and feels safe. Responding to patients' needs requires that the multi-professional employees share operation principles, that the co-operation is seamless, and that the communication is prompt. This assumes that the employees understand the entire treatment and service chain, as well as their own part in it. In this manner, it is possible to utilise the competence of various professional groups in the best possible way for the benefit of the customer. (Perälä & Hammar 2003.)

In North Karelia, the development challenge has turned out to be reassessing and organising the patient's further care possibilities with a special focus on the patient's discharging from special health care. The reason for this are "delayed transfer fees" (in Finnish: 'siirtoviivemaksu') charged by municipalities that were particularly high in some participating municipalities when the project started. Special health care inpatient placements were appointed to patients who should have been placed in basic health care or home care. (Turunen 2007.) Home Care 24h focuses on discharging intensive care patients so that the preparation time is customer-oriented, safe, and sufficient. Successful home care requires a carefully planned holistic and well-timed assessment of the situation. This has been supported by, for example, implementing a pre-discharge practice and focusing on improving treatment and services plans, and discharge or terminal treatment discussions in the fringe areas of the region (cf. Tepponen 2009). For these areas, video conferences will be tested for the patient's treatment and service plan discussions.

The discharging party has not always been aware of the treatment possibilities provided within basic health care nor have they been able to utilise the expertise of the third sector. Co-operation between municipal service providers has been scarce and there have not been many common practices. Managing the whole home care situation has been challenging in case the patient has needed services from several service providers. During the development process, the awareness of special health care and basic health care staff has been increased as concerns operation possibilities of the participants, which has promoted direct discharging. This has been intensified by the network co-operation that consists of multi-professional actors within special health care, basic health care, treatment and care service businesses, and organisations. In addition, service producers who promote and maintain discharging and home care within municipalities have developed their co-operation by networking. Regular co-operation meetings have opened new operation possibilities for local entrepreneurs in the form of service vouchers, for instance (see Hartikainen's article in this publication). Nursing staff's home care oriented thinking has been strengthened and considering home care as the primary form of further care for as many patients as possible has been supported. Some project municipalities have found that the role of a rehabilitation nurse is significant for successful discharging and have appointed nurses for this task. (cf. Hirvonen 2010, Tepponen 2009.)

COMMUNICATION AND DOCUMENTING

There is still room for improvement in data transfer of discharges from hospital. The continuous treatment and service chain can be broken due to lack of information when the patient is transferred from special health care to basic health care or home care, and, conversely, from home care to a hospital inpatient ward. When a patient is transferred, the responsibility and information of the patient's treatment is not necessarily transferred seamlessly to the receiving party or there are delays, because often no one is responsible for the entire treatment or service of the customer/patient. (Hammar 2008.) In North Karelia, communication about the patient's transfer from one organisation to the other has usually been dealt with on the phone. Phone communication has brought up responsibility issues concerning treatment instructions, language issues of nursing staff of foreign origin, but also audibility issues in remote areas. Varying views and knowledge about the customer's need for treatment, as well as ignorance as regards the operation of various service providers complicate combining services in the way that best serves the customer. In addition, paramedic care has had trouble getting information about the patients, which, in part, makes home care and paramedic care more difficult.

A shared patient information system, Mediatri, has been chosen for public health care in North Karelia. Its implementation and content development was started in stages in 2009 in different municipalities and in the Joint Municipal Authority for Medical and Social Services in North Karelia. The latest municipality that joined the project in 2011 is the City of Joensuu. The objective of Home Care 24h has been to create a uniform data transfer form or a summary of nursing for the region that considers the various needs of the work units of all organisations as concerns securing the patient's continued treatment. Common principles of structured documenting have been utilised in the planning. The idea is to use the information in the planned form in developing the Mediatri patient information system. A Home Care 24h expert in electronic communication and documenting participates in the planning cooperation team organised by the administrator of the Mediatri patient information system. The team focuses on acute emergency duty situations and critical information in patient transfers.

As the Mediatri patient information system is used only in the public side of the region's health care, up-to-date data transfers of patients transferring to private care and service homes or patients in need of paramedic care by the rescue department present a challenge. There have been negotiations with an actor who maintains the electronic patient information system of private nursing homes and the administrator of Mediatri. The main concerns are specifically up-to-date patient information transfer as concerns basic patient information, treatment summary, a doctor's epicrisis, and medication and rehabilitation plan. At the moment, the documented patient information are available for printing from the Mediatri system in patient transfer and discharge situations into private nursing homes and for the paramedic staff of the rescue department. Documenting and data transfer is also secured by using a mousepad designed within the project on which the important points in patient transfer

and discharging are printed. The mousepad has been distributed to the region's public and private health care organisations, and participating organisations. In addition, as the work practice assignment, a student nurse compiled a needs assessment for field documenting that is related to electronic documenting in paramedic care. This basic work is significant in developing the proportion of paramedic care in the electronic patient information system.

PROMOTING THE PATIENTS' REHABILITATION

Early intervention as to weakening health and functional ability, as well as effective treatment and rehabilitation are emphasised in quality recommendations concerning services for the elderly. The contents of rehabilitation services, especially rehabilitation services at home, should be developed. Good quality home care promotes rehabilitation and responds to the customer's physical, cognitive, mental, and social rehabilitation needs. Rehabilitation at home that supports independent living should focus on modes of rehabilitation provided at home. (STM, 2008a.)

Rehabilitation emphasises health-orientation, purposeful actions, and multi-professionalism. Health-orientation refers to assessing and supporting a patient's resources. Purposeful actions shows as documented goals in the treatment and/or rehabilitation plan that are assessed regularly. These can be used to support the patient's and the close relatives' active participation in the treatment. The task of a personal carer is to assess the functional ability of the customer, function as the co-ordinator of the multi-professional team, and compile treatment and rehabilitation plans in co-operation with the patient, relatives, and other participants. Action that promotes rehabilitation requires the knowledge and skills of a nurse, but also a general rehabilitation promoting work philosophy that everyone commits to. (Vähäkangas 2010.)

There are different kinds of rehabilitation plan versions that include description of functional ability, social situation, and therapies, for instance. Patients at hospitals, health care centres, nursing homes, or those already at home are not provided with a rehabilitation plan systematically. There are organisations, work communities, that use an exercise plan in addition to treatment and service plans. Compiling and using an exercise plan is, however, still occasional. The risk is that the rehabilitation is suspended when the patient is transferred from one organisation to the other due to lacking information.

This is why the rehabilitation plan should be complied in the organisation that is responsible for the treatment and rehabilitation. The rehabilitation plan should be seen as a process that aims at reaching a mutual agreement of the goals, methods, and assessment of the rehabilitation. Legislation governing rehabilitation stipulates that the rehabilitation patient and/or his/her relatives participate in the planning. The plan should be complied in writing. This is required by laws that stipulate that the plan is a requirement for granting benefits or certain services. The contents of the plan are determined primarily based on the needs of the customer, the operation of the organisation, and the usage demand of the plan.

Discharging and living at home require that the entire treatment and service chain including its participants implement the same, commonly compiled plans. It is important to have a shared model for a rehabilitation plan and its related sectors for this to be successful in the most flexible, continuous manner. This is way of creating a good practice so that basic health care, special health care, and private nursing homes and other health care service providers support the rehabilitation patient and his/her objectives. In addition, borrowing aids and realising home alteration work should be organised so that all participants are aware of the operating principles.

A common model for a patient's rehabilitation plan was compiled as a multi-professional co-operation in the Home Care 24h project. Its usability in securing the continuity of care and its significance have been tested in a pilot project in special health care, health centres, nursing homes, and intensive service living units for three months. It has proved to be a very important, significant part of continuity in rehabilitation. If the plan has been compiled and documented carefully with the patient and his/her relative, co-operation will be successful and committed. The plan has been found significant in multi-professional co-operation and in securing continuity in data transfer. It has also been considered a good assessment tool that promotes a shared treatment policy and further rehabilitation. (Härkönen et al. 2010.) The idea is that the rehabilitation plan designed and piloted within the project is entered into the electronic Mediatri patient information system.

Aid tool services area part of the broader rehabilitation service. Should the patient require their use, planning and monitoring them should be included in the rehabilitation plan. Informing about aid tool services is a part of municipal and joint municipal authority communication. The purpose of the communication is to provide sufficient information about aid tool services related to social and health care, and about what services are available, and where and how they can be accessed. The professional staff within social and health care must know how to direct the customer to the appropriate service and the responsible professional.

A regional service plan for aid tool services has been compiled in the area of the Joint Municipal Authority for Medical and Social Services in North Karelia that is an agreement about points such as the division of labour and responsibility, and consistent practices related to aid tools in the region. During the Home Care 24h project, it became apparent that aid tool services are not familiar even to staff who work within health care daily. There was uncertainty about whether the customer needs to pay for the aid tools and about who organises the borrowing or purchase; what are the criteria for being granted a tool and what kinds of tools were available. The division of labour between the central hospital and health care centres as to aid tools is also not always clear. During the project, a fact sheet about the region's aid tool services will be drafted in co-operation with the aid tool unit of the Joint Municipal Authority for Medical and Social Services in North Karelia for municipal organisations and a list of persons in charge of aid tools in municipal organisations will be collected.

THE ROLE OF A RELATIVE WITHIN HEALTH CARE AND AVAILABLE SUPPORT

Family and close relatives play an important role in changing life situations such as when a member of the family falls ill. The operation and the operational environment of health care can be strange and unfamiliar to the relative, so he/she needs information, support, and guidance. The role of relatives and their significance should be developed by promoting their interaction and co-operation with the nursing staff. (Åstetedt-Kurki, Jussila, Koponen, Lehto, Maijala, Paavilainen & Potinkara 2008.)

In the optimal situation, the relative can also be a partner to the staff and participate in the treatment of the patient to a suitable degree offering support to the patient (Åstetedt-Kurki et al. 2008). This calls for new thinking and culture in health care. It is also possible that the relatives feel they are the object of action, ones that are supported, not active participants. This is also acceptable and sufficient.

Supporting the relative provides the patient with a better chance to cope at home despite the illness. Support from relatives cannot, however, be a separate area of operation. The purpose of the support should be good assistance, care, and support from the relative. In addition to professional nursing, successful home care requires that the patient has a partner so that they will cope with the added burden of the everyday life. He/she is capable, strong, and motivated to be in the situation. This way of thinking sees the support of a relative as a part of good treatment. The partnership network provides the relative with the needed information, guidance, care support, domestic aid, peer support, recreation, and rest.

In North Karelia region, the patient organisations are varied and active. Their operational precondition is strong and developing (Yhteistä Hyvää 2007). The Home Care 24h project has increased awareness about all kinds of possibilities for operation for them (e.g. a professionally lead group, a course, or peer activities; implementing good practices by networking) and, by way of networking, promoted open co-operation based on partnership between municipal public health care providers, entrepreneurs, and patient organisations.

The challenges of round-the-clock home care in North Karelia are long distances, insufficient residential conditions, and the large aged population in relation to the other population of the municipality. There are not many private services available yet in small municipalities. Organising round-the-clock home care outside the densely populated area is successful only if relatives can be included in the co-operation with service providers, organisations, and possible neighbour assistance. It is possible to avoid institutional care of those in home care in cases when the relative becomes exhausted or is at a loss, or if the situation changes due to an emergency or crisis, if the relative support model is developed. Illness does not always mean there is a need for institutional care, but rather a situation that threatens home care. The project finds it important to recognise the factors that result in institutional care and how home care is possible, but also how the family/relative is “brought to be supported”. It is also important that the family/relative participates in compiling the treatment, service, and rehabilitation plan, as well as in the discharge and assessment meetings. It

is significant that the family has a dedicated personal carer / professional so that they know who to turn to. Networking has also been developed with pharmacies. Pharmacies have suggested joint medication assessment with a doctor in treating memory disorder patients and those with multiple diseases in particular.

TERMINAL TREATMENT AT HOME

Saattohoito Terminal treatment means good quality care for a dying patient and relative support in the final stages, before and after death. The core of the treatment is alleviating symptoms and pain. It is not dependent on a diagnosis, but requires a decision made with the patient to be transferred to terminal treatment. The starting point of terminal treatment is that the patient has a terminal illness without a prognosis for a treatment that will heal him/her or the patient has refused it, and the estimated remaining time is short. (ETENE 2003, Käypähoitosuositukset 2008, STM 2010.)

Terminal treatment is implemented in the inpatient wards of hospitals and health care centres, nursing homes, terminal treatment homes, and at the patient's home. One's own home as the terminal treatment location represents stability, which creates a sense of safety. In the home environment, the patient may feel free to act and his/her wishes may become better catered for.

In North Karelia, a terminal treatment patient can be treated at home, in a public health care institution, or in a private nursing home. There are no inpatient wards or terminal treatment homes specialised in terminal treatment in the region. Terminal treatment is mainly the responsibility of basic health care, but, at the moment, it is also taken care of in special health care inpatient wards. It would be ideal, if the home nursing / intensive home care / home hospital operation could also be extended to old people's homes and sheltered housing units in the region. This way the patient could be treated in a familiar nursing environment and would not have to change the institution during his/her last days.

Terminal treatment has been developed in North Karelia in a project called "Palliatiivisen hoidon kehittämishanke 2005–2007" (A development project for palliative treatment), for instance. The concepts and responsibility issues related to terminal treatment were clarified and terminal treatment competence was strengthened by networking and training. Terminal treatment practices were developed during the project and a patient-oriented terminal treatment model was created that also considers the role of the relatives. In addition, the project compiled several instruction sets for symptom-specific treatment.

The Home Care 24h project continues with the concrete work of the previous project as to turning good practices into everyday actions. However, Home Care 24h has specifically focused on organising the totality of terminal treatment. Organising terminal treatment at home is based on the patient's will, and including and supporting the relatives are also important factors (see the article by Riikonen & Kouvalainen in this publication). Common practices in terminal treatment at home have been created with the participating actors of the nursing network. There are new, refined operations models for special health care consultation practices and support ward

operation in different municipalities. The aim is that organisations or work communities have an appointed nurse responsible for terminal treatment. Another aim is to create a model and instructions for terminal treatment at home.

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THE TRANSFORMATION PROCESS OF THE SERVICE STRUCTURE OF SOCIAL AND HEALTH CARE SERVICES

Leena Laaninen

THE SOCIAL AND HEALTH CARE CO-OPERATION DISTRICT OF LIPERI MUNICIPALITY AND CITY OF OUTOKUMPU

Kunnissa Municipalities are experiencing a time of changes. The Council of State started a project called PARAS (TN: Finnish for 'best') in spring 2005 to renew the municipality and service structures. There is a willingness to secure a strong enough structural and economic basis for the services that are the municipalities' responsibility so that they are able to organise the services in the future as well.

The PARAS project makes consolidations of municipalities or municipal co-operation possible as co-operation districts of a minimum of 20 000 inhabitants. Co-operation is possible in social and health care in the form of joint municipal authorities, municipalities in charge, or social and health care divisions. Liperi Municipality and City of Outokumpu form a co-operation district that follows the skeleton law to secure social and health care services according to the host municipalities model from the beginning of 2009 (Social and health care service strategy for City of Outokumpu and Liperi Municipality for 2009-2012).

In addition to strengthening the structural and economic foundation, there is a national emphasis on the contents of social and health care services. The Council of State confirmed the National Development Programme for Social Welfare and Health Care (KASTE) on 31 January 2008. The challenge in the programme is to construct a genuinely unified service structure for customers and renew structures of wellbeing and health promotion. Municipalities must direct their existing resources in a new way and develop more effective methods and services. The main goals of the Kaste programme are:

- increasing participation and decreasing social exclusion
- increasing the wellbeing and health of the population, and simultaneously decreasing health inequalities
- improving the quality, effectiveness, and availability of services, and
- decreasing regional differences.

Securing sufficient and good quality services requires the ability to cross administrational borders, municipal borders, and even regional borders. Co-operation is important not least because this increases the amount of qualified employees in the municipality. Recruiting staff will become more crucial as the baby-boomer generation start retiring. Alongside municipal services, the demand of private services may increase among those with a financial standing. Globalisation may also bring international service providers to Finland and, there again, EU citizens may feel eager to come to Finland for their retirement and use the private or public services.

COALESCENCE OF SOCIAL AND HEALTH CARE SERVICES OF LIPERI MUNICIPALITY AND CITY OF OUTOKUMPU

Liperi Municipality and City of Outokumpu started an extensive co-operation within social and health care services in 2005. This helps to secure social and health care services better than the current structure. The aim is to secure availability of services, remove overlaps, and secure fluency in service and treatment chains. (Social and health care service strategy for City of Outokumpu and Liperi Municipality for 2009-2012.)

The councils decided in a meeting on 18 December 2006 that the co-operation shall be organised according to the so called host municipalities model referred to in the municipal law (L365/1995), which means that a joint organ is responsible for service production. This organisational form is also in accordance with the skeleton law (169/2007) that stipulates the municipal and service structure reform. The joint social and health care services of Liperi Municipality and City of Outokumpu are produced according to the host municipalities model since 1 January 2009. Liperi Municipality functions as the host. A joint social and health care board was founded for producing the services and it has elected members from both municipalities. Since 2009, the social and health care services staff of City of Outokumpu was transferred to the service of Liperi Municipality in accordance with the transference regulations. This created a work community of social and health care services of 400 employees.

GENERAL POINTS ABOUT THE CO-OPERATION

The vision of the social and health care services is that, by 2015, the population of City of Outokumpu and Liperi Municipality have equal access to social and health care services irrespective of where they live; that the social and health care services are of good quality and customer-oriented; and that the common quality system is in use. The strategic emphases of City of Outokumpu and Liperi Municipality social and health care services for 2009-2012 lie in wellbeing of children, youth, and families; developing treatment and care of the elderly; and developing mental health and substance abuse services. The first year of operation was strongly marked by the unification of service production and operation culture. To a large degree, joint practices and

criteria for providing services have been created, which has promoted equal access to services for the population. The objective of the co-operation is to secure extensive, good quality services that are economical. To support the development and transformation of the service structure, a service structure team was founded with representatives from the joint council, authorities, staff, and Polvijärvi (TN: municipality). The task of the team has been to assess the current service system and compile a "Service structure plan until 2015". In line with the reform, the service structure has been looked at from the point of view of decreasing institutional care, and developing services. One additional focus has been studying new ways to organise services. The service structure work is closely related to balancing the economy in Liperi and Outokumpu.

During the first year of operation, quality control work also started and the SHQS quality programme was launched. The first method trainings were organised in autumn 2009 and they continued during spring 2010. The aim is that internal auditing is complete by the beginning of 2012.

When the social and health care services staff of City of Outokumpu was transferred to the service of Liperi Municipality, common rules and practices have been improved. The largest units and the available collegial support have been experienced as positive. When the co-operation started, the basic work of the employees did not change, but, at the same time, the introduction of many new software programmes has taken time. Introducing the new patient information system Mediatri slowed the practice down in particular at the beginning.

At the moment, social and health care services are provided in four places: at the centre of Liperi, in Ylämylly, in Viinijärvi, and in Outokumpu. The organisation of social and health care services itself is divided into four profit areas: administration, health services, services for the elderly, and social services.

Administration of the co-operation and related requirements have been challenging on all levels. Issues related to finances are multiform and the amount of administrational documents has been considerable.

HEALTH SERVICES

In the profit area of health services, the greatest challenge with the service structure is centralising the services according to the service needs of the population. During 2009, a cost-effectiveness analysis was conducted that significantly supported solutions related to centralising. Within the co-operation, patients from Outokumpu have been treated in Liperi health care centre hospital, which would have otherwise resulted in accumulating special health care queue days. The benefits of the co-operation are visible in the practice of environmental health care mainly as the opportunity to employ short-term substitution nurses. In mental health care and substance abuse services, as well as in health counselling, the work load has been balanced between Liperi and Outokumpu. Small units with only a few employees have found working in a larger work community fruitful.

According to the Outokumpu model, the Liperi area started task transfers (public health nurses, nurses) and development of the treatment and prevention of diabetes. In doctor's receptions and child welfare clinics, a small-scale test with an electronic appointment system has been implemented that expanded to include those who are on Mareva medication treatment, so they can now access information about their blood test results and related instructions on their home computers. Dental care in Liperi and Outokumpu share an appointment booking system. Emergency dental patients have been directed to neighbouring municipalities during holidays because of holiday arrangements. Sharing staff between municipalities has been taking place by substitutions, for example.

SERVICES FOR THE ELDERLY

The joint ageing policy strategy of Liperi Municipality and City of Outokumpu for 2008-2015 was accepted in autumn 2008. During 2009 and 2010, services for the elderly have proceeded according to the accepted strategy and the national definitions of policy. The most significant developmental focus has been on decreasing institutional care. 25 placements in Liperi old people's home and 12 placements in Outokumpu old people's home were transformed from the use of institutional care into the use of intensive sheltered housing. Reducing institutional care placements continues in Outokumpu with 15 placements during 2011. In addition, a new 12-placement intensive sheltered housing units and small group homes (approx. 25 placements) have been planned for Outokumpu. Especially small group homes support the national development definitions of policy that aim at promoting new housing solutions and forfeiting institution-based services for the elderly.

A counselling service was started within services for the elderly. The one-number phone counselling began at the end of 2009. Wellbeing promoting home visits for over 75-year-olds have been secured and rationalised thanks to the co-operation. Day centres for the elderly in Liperi were prepared so that the operation could begin at the beginning of 2010. In addition, a group for family carers and patients has supported family members to cope with their everyday lives. In Liperi, in particular, co-operation with organisations has resulted in organising versatile day-time activities open for all. In Outokumpu, the co-operation with Kyykeri innovation village has resulted in organising open day-time activities for the elderly who are in a good condition. To secure equal access to services and correct treatment scaling of services, the service plans of home service customers were opened and re-assessed. In Liperi, a project called SAS (TN: based on the Finnish equivalent of "plan, assess, invest") was started with multi-actor meetings to support correct treatment scaling. The service voucher was also introduced in services provided at homes in September 2010. The TAK customer feedback system is also used extensively in old people's homes.

Participation in various projects such as the national Vanhus-Kaste (Kaste for the Elderly) project, the regional Home Care 24h project, and eOsmo projects has also promoted the development of services for the elderly.

HOME CARE 24H PROJECT

The co-operation district has participated in three sub-projects of the Home Care 24h project. These are: developing the discharge process, developing family support, and developing terminal treatment. Piloting the discharge process has resulted in the realisation that the customers need more home care services and meal services. In addition, the need for aid tools and medication dosage distribution are on the increase. The result was that in discharging a patient, more attention should be paid on further treatment and discharge instructions, as well as arranging the treatment and services plan meetings early enough. (Härkönen, Karjalainen, Knuuttila, Kouvalainen, Vihma & Venejärvi 2010.)

In the sub-project concerning developing family support, the piloting was done as organisation co-operation. Taking relatives into consideration has become important. Family carers' and relatives' need for support is accentuated especially with memory disorder patients, rehabilitation patients, and palliative treatment patients. (Härkönen et al. 2010.)

The result of piloting the terminal treatment at home was that terminal treatment at home was found necessary for those patients and families who were ready for it. The experiences of carers were mainly good and the customers/patients along with the relatives were satisfied with being able to arrange terminal treatment at home. In the future, it is considered important that doctors participate in terminal treatment at home and focus on developing it. (Härkönen et al. 2010.)

SOCIAL SERVICES

The first year of co-operation in social services has focused on supervisory duties in particular. All sectors of social work (child protection, adult social work, services for the disabled, social work for the elderly) have been developed and increased. In Outokumpu, the planning work for a new child protection unit, a municipal child protection institution, was started, new staff was selected, and the operation started in spring 2010.

A new work and day-time activity unit for substance abuse and mental health rehabilitation patients called Vaskikammari started in Outokumpu. Vaskikammari aims at influencing the control of buying housing services and reducing mental health rehabilitation patients' home consultation by special health care. The aim is to handle home consultation as a separate activity in the future. In Outokumpu, the need for substance abuse services is considerable and there is an increase in homelessness.

In work and day-time activities directed at the disabled, there has been a lot of content development, for example, the amount of home consultation has been increased. Institutional care for the disabled has been reduced by increasing homing

services. The operation of family counselling has been strengthened by transferring speech and action therapy services into their own operational areas. The operation of action therapy showed immediately as decreased costs.

In conclusion, there have been good opportunities for both quantitative and content-related development, and the service structure has been developed according to the national guidelines and local needs. The challenge in the development is maintaining the quality of services and responding to the service needs presented by the age structure of the population. The co-operation district has many good practices that all parties have been able to use. It feels good to notice that the co-operation has mainly been supporting and empowering.

Yhteenvetona voi todeta, että niin palvelujen määrälliseen kuin sisällölliseen kehittämiseen on ollut hyvät mahdollisuudet ja palvelurakennetta on kehitetty valtakunnallisten suuntaviivojen ja paikallisten tarpeiden mukaisesti. Kehittämistyön haasteena on palvelutason ylläpitäminen ja väestön ikärakenteen mukanaan tuomat palvelutarpeet ja niihin vastaaminen. Yhteistoiminta-alueella on paljon hyviä käytäntöjä, joita on pystytty hyödyntämään molemmin puolin. On hienoa todeta, että yhteistyö on ollut pitkälti toinen toista tukevaa ja voimaannuttavaa.

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DEVELOPING HOSPITAL LEVEL CARE AT HOME AND FURTHER CARE

Mari Hirvonen

This article is based on my Master's thesis of my university of applied sciences degree called *Developing Hospital Level Care at Home and Further Care*. In my thesis, I study the implementation of hospital level care at home and further care, and apply these practices to the North Karelia region. The thesis is an independent study, but it was commissioned by the "Developing Round-the-clock Home Care as a Regional Networking Co-operation" project.

Developing service structures that promote living at home and round-the-clock home care are central in the national social and health care service structure change. It is possible to improve independent living of the elderly and health care patients who receive treatment at home by improving their quality of life and interaction opportunities. Hospital level care at home and discharge teams are relatively new but, in many places, rapidly developing service models. Hospital level care and discharge teams can be considered interfaces of the so called basic special health care services that promote the functionality of special health care and basic health care (Regional Steering Group for Eastern and Central Finland 2009, 20). Hospital level care and discharge teams make it possible to organise services more flexibility and mobility for treatment than the traditional way. It is the advantage of both the patient and the care-providing sector that correct measures are taken at the right time and in the appropriate location. (Ministry of Social Affairs and Health Care 2008 and 2010.)

HOSPITAL LEVEL CARE AT HOME

Hospital level care at home refers to all forms of home hospital and intensive home care organised and implemented in different ways. In Finland, hospital level care at home is organised as actual home hospitals and as municipal home care in the form of, for example, intensive home care. At their best, services of hospital level care at home promote maintaining the patient's functional ability and rehabilitation possibilities. At home, the patients have a better opportunity for normal social relations and also privacy. A private home as the treatment environment gives the service and care its own, unique character. The relatives are very important partners to nursing staff in implementing treatment. The purpose of hospital level care at home is generally to respond to the patient's immediate need of hospital treatment or to the lessening need for it during, for example, the discharge process from special health care. Often,

preventing becoming hospitalised or promoting quick discharge are also mentioned as reasons for using hospital level care at home. (Jester & Turner 1998,1; Liikka 2006, 9; Saarelma 2005, 203; Sariola 2001, 1874; Visakorpi 2002.)

A patient in hospital level care at home is ill to the extent that his/her care would otherwise have to be organised in the traditional way at a hospital. Hospital level care at home should, indeed, be considered an option to hospital care. The care is always based on the patient's willingness to be cared for at home and requires an ability to commit to the care in the every-day environment. Teams that use this type of care use new forms of care such as evening nurse calls or monitoring calls (e.g. as terminal treatment patients are discharged). In addition, with these services, welcome opportunities can be created for implementing care of those patients who suffer from changes related to changing treatment locations. Hospital level care at home is also implemented at sheltered housing, dementia patient homes, and institutions for the disabled (also Jester & Turner 1998, 2). In addition, parents and relatives taking care of a child at home benefit from the services of the home hospital team.

Usually, hospital level care at home means treating infection patients (giving intravenous antibiotics), anaemia with blood infusion, terminal treatment patients, and those patients who require careful monitoring due to medication balancing (also Liikka 2006, 6; Visakorpi 2002). Even though treatment takes places at the patients' home, traditional health care service structures such as doctor's appointments at a health care centre can still be used in the treatment. Up-to-date assessment of the patient's need for treatment is essential in the implementation of treatment. The practical implementation always also depends on the available resources.

DEVELOPING FURTHER TREATMENT AND DISCHARGE TEAMS

The challenges related to organising discharging and further treatment are responded to in many places by developing discharge nurse practices or discharge teams. In addition to the actual discharging process, improving the quality of co-operation between various actors is important. The central principles of a discharge team are related to improving the sense of safety of the process and the patient by supporting the patient's coping, rehabilitation, and functional ability. The teams aim at having room for manoeuvre and a readiness to be able to manage the challenges of the care during the transition period when a patient is discharged. The discharge teams also function as mobility-enhancing service forms between various treatment locations. Genuine customer-orientation is very important in the operation. The teams are, in many ways, independent as service forms or exist alongside hospital level care at home, but are typically municipal services. Their operation is not hospital care as such like hospital level care at home; they rather support the discharged patient with related matters such as taking care of practical matters and by being readily available all day. The mere opportunity to get help quickly seems to create the sense of safety the discharged patients need. Based on experiences, the services of the discharge teams are particularly helpful to challenging discharged patients who are in danger of becoming institutionalised because of the insecurity they feel at home (also Koponen 2003, 116-117).

The discharge teams care for the customers even for two weeks after going home, and, in case the need for treatment continues after this, the treatment can be assigned to a regional home care team. The experiences related to discharge teams are convincing: only a few supported patients return to the hospital. The teams are predicted to be responsible for expert tasks of assessing the patient's need for treatment in the future as mediators between special health care and basic health care, for instance.

The implementation of treatment at the customer's home is, from the point of view of organising services, much more than the sum total of the services. Hospital level care at home and discharge teams require a modern, multi-professional service network entity in which various actors work in co-operation. At least private service providers and organisations, societies and congregations usually work in close co-operation with municipal home care services. The local implementation of home care is currently in accordance with the broad implementation of home care that is described in Tepponen's Doctoral Thesis (2009, 136): in addition to individual care, home care services, and nursing services, home care includes services of proactive and preventive support, support services, gerontologic social work services, rehabilitation services, round-the-clock services, home care services, and intensive home care services.

To support the implementation of home care, easier consultation and co-operation practices between various actors are called for. In many places, better availability of short-term care would also promote meaningful implementation of home care. Different forms of short-term substitution services for family carers and temporary home care services respond to the needs of the customer. In home care, better availability of rehabilitation and physiotherapy are also needed.

The task of regional services management is to manage the extensive ensemble of home care services and to tailor the needed services individually for the home care customers. If the customer is not entitled to municipal services, the services management should openly use other available service options. (Mäkinen, Valve, Pekkarinen, Mäkelä 2006; Voutilainen, Raassina & Nyfors 2008). The service ensemble of home care and related cost management will become easier when the services that are offered to the customers are based on an extensive, realistic service plan. Offering customer-oriented services improves the quality of care, but also is more affordable to the society than a service that is the same for everyone (Voutilainen et al. 2008, 18). The service plan should also be able to predict the customer's future need for treatment. This proactive and preventive work can even be considered a precondition for a successful service structure change within health care.

Developing Home Care Services

The operation of hospital level care at home and discharge teams starts independently in many municipalities and without external funding. The operation is developed in close co-operation with other regional social and health care service providers. The staff is in a key position in discussions about how the implementation of care can be developed and how the quality of care can be improved. Assessment and update plans are compiled for critical evaluation of the introduced methods, and the functionality

of the services is assessed from the point of view of the all social and health care services, as well as from the point of view of the customer.

Developing home care cannot be justified with only economical reasons and even a thoroughly resourced home care is not the best solution for all patients or in all situations. Hospital level care at home has been studied particularly from the point of view of cost-efficiency and customer satisfaction. The mobile and fluctuating nature of this type of care affects the total costs so that services cannot be provided unambiguously or for a significantly lower cost than traditional care (Andersson et al. 1999; Shepherd et al. 2008). Instead, the quality of hospital level care at home that patients and relatives experience is emphasised in studies. This extends to staff who are reported to be content as well. (Andersson et al. 1999, 22; Liikka 2006, 11; Shepherd et al. 2008; Visakorpi 2002, 96). Comparing traditional hospital care and hospital level care at home is, indeed, meaningful as regards quality of treatment.

Safety of the treatment and the sense of safety of the customer should be assessed as regards all care that is provided at the customer's home. The sense of insecurity the customer feels is, in general, one of the central challenges of home care. For the family carer, then again, hospital level care at home can become relatively burdensome. Hence, this level of care is not considered suitable for patients with a serious memory disease who live by themselves or for those who are not able to commit to the treatment. Implementation of the care should always be assessed individually considering the situation of the customer and life quality factors. The quality home care customers and their relatives experience is related to the general appreciation of home care that can be considered a precondition to home care services becoming even more common in the future.

The contents of my thesis are summarised in the "Regional Model for the Implementation of Hospital level Care at Home and Further Care". Figure 1 that is related to the model is presented at the end of this article. In the model, hospital level care at home and discharge teams are implemented side by side with traditional home care within the social and health care services. When the services are implemented side by side, staff co-operation and use of treatment resources can be improved. Catering the treatment at the home of the customer is meaningful to them as well as to the service provider when the factors related to the patient's quality of life and interactive dimensions are in order. As the situation or the treatment needs of the home care patient change, the service should also be easy to be modified (Hirvonen 2010, 70–75).

In the model, home hospital care, discharge teams, and the hospital level care at home team use doctoral services in the area, service guidance, rehabilitation and physiotherapy services, and information technology services, as well as a regionally shared patient information system. Municipal services co-operate closely with other social and health care service providers. In special health care, co-operation is, in addition to actual patient work, active development of patient processes. Especially between municipalities and special health care, practices related to fluency and safety of treatment, predicting need for treatment, and consultation practices between professional groups should be developed. (Hirvonen 2010, 70–75.)

The significance of the unclear future of basic special health care to the service system of social and health care should be seen as one of the development challenges of

hospital level care at home and discharge teams. The division of labour between basic health care and special health care is also unclear as regards their regional development and maintenance. It was predicted that, in the future, the customers of health care services are ready to invest in good quality service more than before. This will potentially have an effect on the developing service environment, and it remains to be seen how significant the proportion of private and organisation sectors will become. Factors related to legislation and division of costs, at least, will have a considerable effect on the future development of health care services.

Inability to change or management issues in health care service organisations easily affect the implementation of care that resembles its creators and requires an innovative attitude, which is the case with hospital level care at home. Renewing home care requires an open-minded, experimental management method in social and health care services. The director of the development process is required to have an ability to manage the entirety of home care services, because the implementation of a new service may temporarily increase costs. The availability of competent staff will also have a significant effect on implementing the services in the totality of social and health care services. Good experiences of the operation of the services and customer-orientation may inspire the staff to work in home care. The renewing home care services will, in any case, make it possible to work on nursing tasks that are challenging and in which nurses can utilise their competence.

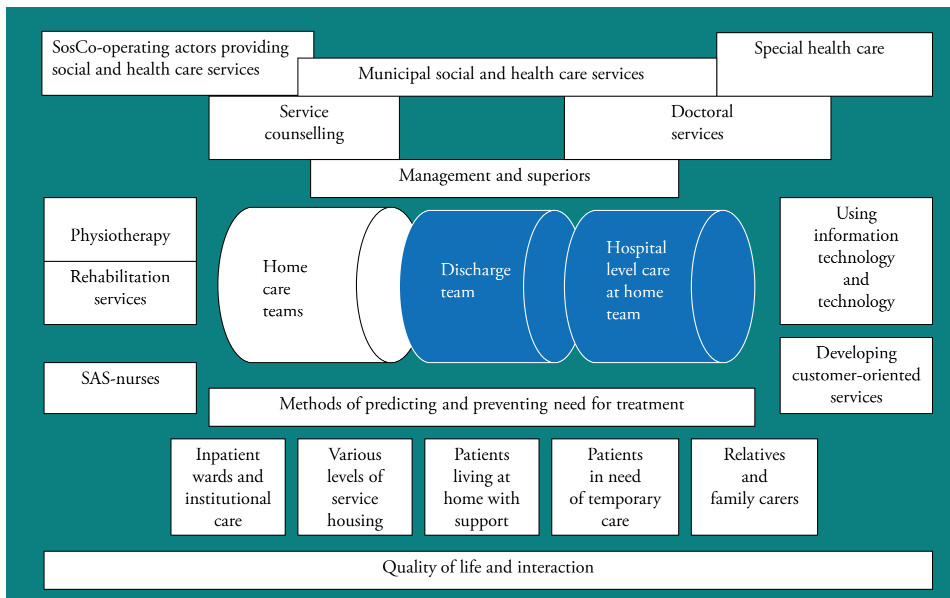

Figure 1. The regional model for developing hospital-level care at home and further care

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STARTING AN INTENSIVE HOME CARE TEAM IN JOENSUU

Kaija Lähteenmäki & Merja Kinnunen

BACKGROUND INFORMATION ABOUT HOME CARE OF CITY OF JOENSUU

The following areas of responsibility belong to the profit area of services for the elderly of City of Joensuu: services that support independent living, home care, and housing services. The profit area is managed by the director of services for the elderly and the responsibilities are managed by the leaders of the areas of responsibility.

In Joensuu, home services based on social welfare law and home treatment based on the national public health law have been combined into joint home care. Services that support independent living such as meal and security services have been separated from home care into their own area of responsibility. This area has its own staff as well as consultation and service point called "Senior Consultation Service Ankkuri".

Home care is divided into three areas: Eastern, Western, and Provincial Areas. The Provincial Area comprises Eno, Pyhäselkä, Kiihtelysvaara, and Tuupovaara. The managers are the regional leaders. The staff works in teams according to the personal carer model. In each team, there are home help and home aid persons, practical nurses, and one public health nurse. In the team for intensive home care, there are four public health nurses, of whom one is the team leader. Each home care region has a discharge nurse who receives the service requests and starts the customer's treatment process.

Security services and regular night care are bought from a private service provider. In addition, service vouchers are used in short-term care and nursing.

NEED FOR INTENSIVE HOME CARE

Tehostetun The reasons for starting the intensive home care operation were the objectives of the quality recommendation concerning services for the elderly ("Ikäihmisten palveluja koskevan laatusuosituksen tavoitteet") (Voutilainen 2007), the lack of evening and weekend nurses, and the increasing queues in both special health care and basic health care.

According to the quality recommendation concerning services for the elderly (Ministry for Social Affairs and Health Care & Association of Finnish Local and Regional Authorities 2008), there should be only 3 % of over 75-year-olds in long-term care by 2012. This means that a definitive change should occur in Joensuu as

to reducing long-term institutional care and, consequently, developing treatment of outpatients.

Home nurses work between 8 a.m. and 4 p.m.. The services provider of night care, Mummon Turva Oy, always have a nurse and a practical nurse in the night shift. Creating an operations model for round-the-clock home care and starting evening care services have been marked in the 2008 score card.

The funds budgeted for alleviating the special health care queues in 2008 had been used by the end of February. The goal was that two (2) persons/day would wait for transfer from special health care to basic health care, but, in reality, there were approximately fifteen (15) persons/day waiting for transfer. At the same time, approximately four (4) persons/day were waiting for a further care placement at the health care centre hospital either at an intensive sheltered housing or at an old people's home.

The Committee for Social Services and Health of the City of Joensuu addressed the queue situation and one of the measures for improvement was determined as development of the discharge process and founding an intensive home care team. They stated that the hospital is not the home of any elderly person; instead, hospital care should focus on acute treatment and rehabilitation. Immediate examination, treating, and planning further care, as well as early discharging were considered important in the hospital care of the elderly. Preparations for discharging should be commenced as soon as the patient is registered at the hospital.

The aim of intensive discharging should be securing round-the-clock hospital care, reducing the amount of patients queuing to be transferred from special health care to further care, and accelerating the discharge process of a health care centre hospital patient. A multi-professional team was appointed to prepare the founding of an intensive home care team.

FOUNDING THE INTENSIVE HOME CARE TEAM

There are four nurses in the intensive home care team. The selection process of these four has been under much scrutiny. The requirement is that the staff are very competent and experienced, willing to develop their work, and that they have good team work skills and are flexible. It would be good to have expertise in special health care, health care centre hospital tasks, and home care in the team.

An intensive home care team has an appointed doctor. The discharge nurses, the queue manager at Siilainen health care centre hospital, social services leaders at Senior Consultation Services Ankkuri, an SAS partner (TN: Finnish for "investigate-assess-locate), and a physiotherapist at services for the elderly are in close co-operation.

The intensive home care team is an administrative a part of Western home care. Their office is located at Siilainen health care centre hospital. The team manager takes care of rosters, statistics, compiling terms of reference, and developing the operation in co-operation with managers and home care staff. The operation area is the central city area.

THE TASKS OF THE INTENSIVE HOME CARE TEAM

Tehostetun The purpose of intensive home care operation is to produce secured, proactive and rehabilitating round-the-clock home care for the inhabitants of Joensuu who need home care after being discharged from the hospital or because of a severe illness. The operation is implemented in co-operation with a private service provider Mummon Turva Oy, from which the City purchases regular night care. The objective of the operation is to provide safe, human independent living, and managing patient queues and costs.

The task of the intensive home care team is to provide care at home for those customers who do not necessarily require hospital treatment but who need medical help. The diagnosis must be certain and the continuity of treatment must be secured. The instructions for further treatment are delivered either with the customer or by fax. The patient's consent to be treated at home is mandatory. The customer should be able to manage daily activities almost independently or the daily chores should be taken care of by a relative or other actors. Elderly patients with multiple illnesses and post-operation patients often require help in the discharge process. A rehabilitating and preventive approach guide the operation.

The customers are inhabitants of the central city area of Joensuu. The doctor makes the decision to transfer the customer to be treated by the intensive home care team. In case the customers need long-term treatment, they will be transferred to the care of their own region's home care or other specifically determined carer in two weeks time the latest.

The more specific tasks of the team are divided into the following five areas:

1) Intensive discharge process

The task is to arrange the necessary support services and home care based on assessed resources and service need in co-operation with the home care team, relatives, and a private service provider.

2) Intensive home care

he task is to arrange safe, human advanced care for those recovering from a severe illness or in terminal treatment who may not necessarily require hospital care. The care is implemented in co-operation with the participating actors and relatives.

3) Assessing the home care customer's status, and care in evenings and weekends

The task is to assess the acute status of the home care customer, provide consultation, counselling, and, if necessary, organise treatment. The objective is to prevent having to resort to the emergency department when the examination and treatment can be taken care of at home.

4) Professional support for home care staff

The task is to provide consultation and counselling for home care staff in challenging customer contacts.

5) Professional support at sheltered housing and old people's homes

The task is to provide the expert consulting or professional help of a nurse at old people's homes and sheltered housing units when they do not have an nurse available.

ACQUISITION OF INTRAVENOUS MEDICATION

The implementation of intravenous medication has been widely discussed. The discussions concern the questions where intravenous medications that are not reimbursed by Kela (the National Pension Institute) should be acquired. According to the Medication Law (1987), Section 62, medications can be distributed from a hospital pharmacy or a medication centre maintained by the municipality to public social and health care units in the municipality, however, not to outpatient customers. It has been agreed by the City of Joensuu that intravenous medication and infusions that are not reimbursed by Kela should be distributed by the medication centre of the health care centre and the costs should be allocated to treatment of outpatients according to the place of residence of the customer.

CUSTOMER FEES IN INTENSIVE HOME CARE

For one (1) temporary visit per day, the customers of intensive home care pay the fee of one home care visit and for two or more visits twice the single fee. In these cases, a payment decision will not be made for the customer. When the intensive home care is implemented in co-operation with a home care team, the customer calls are included in the payment decision made based on the income of the customer. Customer calls at intensive sheltered housing and old people's homes are included in the treatment fee of the old people's home or the sheltered housing. A payment decision according to tariff is made for the necessary support services. The customer pays for their prescription medication and products.

The customer fee includes:

- treatment provided by the intensive home care team that is based on doctor's instructions
- house call by doctor if necessary
- intravenous medication and infusions, and related accessories
- accessories for debridement: wound covers, treatment utensils, and products necessary for arranging initial debridement selected by home care for a maximum of one week, no prescription products

EXPERIENCES OF THE OPERATION OF THE INTENSIVE TEAM

Tehostetun koti The operation of intensive home care started on 11 August 2008 when a four-nurse team had been found. The operations model was developed and fine-tuned, networks were searched for, and instructions were compiled.

In August, 11 customers with intravenous antibiotics medication as treatment were discharged. The first blood transfusion was performed in the autumn of that

year. The first terminal treatment at home also started. The team had 12 terminal treatment patients during 1 August 2008 and 31 May 2009. The team was able to cater to the customer's need to "be allowed to die at home". The work was mentally demanding, but the good feedback from the relatives and peer support in the team helped to cope.

The operation was suspended due to retrenchment for the summer 2009. After the summer break, starting the operation again was draining. The discharged customers were so called monitoring customers. Visits were made to monitor the success of the discharge process, condition, medication, and to warm up food, rehabilitate, and assist the customer to bed for the night. The treatment periods were long, but remained in the agreed two weeks. If it was necessary, the customer was transferred to regular home care after the two weeks. There were the occasional intravenous antibiotic treatment. There were three to six blood transfusion customers a month.

In January 2010, a more intensive co-operation began with the first aid observation ward of the central hospital in Joensuu and the emergency department of basic health care. The idea was to accomplish good co-operation and a practical discharge model for intensive home care. The intensive home care team succeeded in discharging tens of customers without further treatment at Siilainen health care centre hospital.

In the discharge model, the discharge nurse of the intensive team visits wards at the central hospital and establishes whether there are patients from Joensuu who are ready to be discharged with the help of intensive home care. From the first aid observation ward, the aim is to discharge the patient directly either into intensive home care or to the home care team. In the inpatient wards, the task is to establish whether there are patients waiting to be transferred to a health care centre hospital. Another hospital period can be avoided by motivating and encouraging the patient to become rehabilitated. The patient will also rehabilitate faster in a familiar environment.

The aim of the discharge model is to discharge the patients on the day the request has been received. Quick discharge processes without a committed, functional co-operation network will not succeed. Co-operation with partners has been fluent.

The aid tools that the customer needs have also been accessed quickly. In addition, the Mummon Turva team providing night care has been able to make the asked night calls within the desired time-frame. Meal services have started on the discharge day so that the meal can be picked up in the kitchen of Siilainen hospital and taken to the customer during the first home call.

STATISTICS ABOUT THE OPERATION OF THE INTENSIVE TEAM

Ensimmäisenä During the first year, starting from 11 August 2008, there were altogether 167 customers of which 73 were treated by the intensive team only. There were altogether 1164 visits, approximately 233 per month. The reason for treatment was mostly an infection and the treatment was intravenous antibiotics. Six (6) customers were in terminal treatment, of which two had the opportunity to die at home. In addition, some customers were treated with intravenous fluid treatment or were

monitored after being discharged. The average treatment time was 5,8 days and the average age of the customers was 74. (Table 1.)

In 2009, there were 322 customers altogether, of which 145 were treated by the intensive team only. There were altogether 2685 visits, approximately 295 per month. The operation was suspended for three months. The majority of customers were still those treated with antibiotics, but during the operational year, altogether 16 were in terminal treatment, of which 11 died at home. The average treatment time was 6,7 days and the average age of the customers was 67,5 years. (Table 1.)

During this year, between 1 January to 30 September 2010, there were altogether 285 customers, of which only 137 were treated by the intensive team. There were altogether 2829 visits, approximately 314 per month. There were 7 terminal treatment patients, of which 2 died at home. Blood transfusions have increased as have assessment visits prescribed by the doctor on call. (Table 1.)

Table 1. Operation statistics of the intensive home care team in 2008-2010

Observation area / Time	11.8 – 31.12.2008	1.1 2009 – 31.5.2009 1.9 – 31.12.2009	1.1 – 30.9.2010
Sum total of customers	167	322	285
Own customers	73	145	137
Sum total of visits	1 164	2 658	2 829
Average visits/month	233	295	314
Terminal treatment	6	16	8
Death at home	2	11	4
Average treatment time/ day	5,8	6,7	7,6
Average age/years	74	67,5	74

EXPERIENCES OF CUSTOMERS IN INTENSIVE HOME CARE

A customer satisfaction questionnaire has not been complied yet. The customers have shared their thoughts during the home visits and particularly the relatives of the patients in terminal treatment have given very grateful feedback as death at home became possible. Not many knew about the operation in advance. Treatment at home was found a good, safe option for hospital care. Home care also activates the patient and rehabilitation is faster. The risk of hospital infections is smaller and, for a patient afraid of hospitals, intensive home care is a good option. The feedback from relatives is mainly good and they are able to participated in the care. For example, the spouse of a terminal treatment patient told that sitting next to their spouse at the hospital is rough, whereas at home one can live freely and do household chores at the same time. The problem many customers reported was that intensive home care does not accumulate the care payment limit total and is not reimbursed by Kela.

THE PROJECT'S SUPPORT FOR THE DISCHARGE PROCESS AND THE OPERATION OF THE INTENSIVE TEAM

The Developing Round-the-clock Home Care as a Regional Network Co-operation project has supported starting the team and developing the discharge process. The project has provided information and peer support for developing round-the-clock home care. The need and significance of round-the-clock home care has become clearer and stronger.

It has been possible to assess one's own operation during the network project and compare it with same kind of operation in other municipalities. The participants have also provided support and tips about various practical operations models and solutions. Other people's experiences of solutions that did not work well have also helped to avoid pitfalls.

The customer payment team that was founded during the project and a post of an expert nurse for each region (Figure 1). Customer co-ordination work was redirected from the immediate superior to the expert nurse who works as the discharge nurse of his/her own home care area. He/she receives the service requests and agrees on the treatment discussions with the customer and relatives. Based on the assessment of the customer's status and resources in the treatment discussion, a treatment and service plan is compiled, which the team starts implementing. The payment team prepares the customer payment and makes a payment decision. These structural actions have clarified and improved admitting customers to care. It has also clearly made the work of the immediate superior and the discharge nurse easier, as both are now free to focus on their own task, as compared to the previous model, in which the immediate superior completed the assessment visits and was responsible for personnel administration. These actions have also made the discharge process clearer.

During the project, the discharge process now supported by intensive home care has become faster. Customers in inpatient and monitoring wards in need of intensive hospital-level home care have been discharged directly to their homes, which was relatively rare earlier. Discharging from health care centre hospital is also possible during evenings and weekends. In addition, customers are discharged from emergency departments of basic health care directly to home care.

The project piloted the operations model of discharging during 1 February – 30 April 2010. In Joensuu, 51 respondents answered the questionnaire. After discharging from hospital, the need for home care and meal services, in particular, increased. Treatment planning meetings were regularly held once the patient was at home. Home care in Joensuu was, for the most part, able to respond to the increased demand of home care. Delays in the discharge process were mainly due to factors related to deteriorated condition. Information about the discharge of a patient was received early enough and the majority of customer had the necessary treatment instructions with them. Shortcomings and mistakes were mainly related to medication instructions.

There was extensive communication about the project and its goals. Securing independent living and fluency of the discharge process are most likely the key factors from the point of view of all actors. The awareness of personnel at different wards of the central hospital increased also about home care of City of Joensuu and intensive

home care, which can be seen as increased contacts during the discharge situations. The awareness of basic health care doctors has increased significantly.

During the development day of discharge processes on 17 February 2010, nurse Merja Kinnunen spoke about hospital-level intensive home care and the operations model of the discharge process, and discharge nurse Marja Lappalainen about the treatment folder at the homes of customers in regular home care. The results of the day were abundant, and each actor was able to discuss their operation to a large audience and received valuable information for developing the operation further.

THE CURRENT SITUATION AND FUTURE PLANS

There are four (4) permanent nurses in the intensive home care team. There are approximately 15-20 discharges every month and 250-340 home calls. Its form of operation is established and it has received good feedback from customers and partners. Increasing the amount of customers is not possible with the current personnel size.

Coping mentally and physically is one of the main questions the staff deals with in this demanding work. Treating home deaths, nursing that requires accuracy and inventiveness, working alone, and developing an operations model at the same time are a heavy load. Good team spirit, support from superior and peers, and feedback from customers have helped to carry on. Regular work counselling is an acute issue and there are plans to start the operation in November 2010.

The intensive home care team is in close co-operation with the queue manager of Siilainen health care centre hospital and the discharge team. The team's office is already located at the hospital. They are going to be transferred administratively in connection with the health care centre's discharge ward 1A, but the timetable is currently unknown. The transfer will guarantee that the challenges related to choosing the right treatment placement for the customer becomes easier, whether it will be home or hospital. In addition, acquiring intravenous medication will become easier and co-operation between the hospital and intensive home care will improve. Terminal treatment at home for cancer patients with the support of the health care centre hospital's support ward will become better secured, and then the customers will also feel safer.

There is a willingness to develop the operation based on customer needs. For successful development, it is important to know about customer satisfaction as regards the services and to listen to customer's thoughts about improving the operation. A customer satisfaction questionnaire will be introduced in order to acquire researched data about customer's experiences.

The operation of intensive home care is already better known than in previous years. The customers and the relatives contact the nurses directly; there are more contacts at the wards. The majority of customers are shared with home care. The service provided by the home care comprises, then, either services that support independent living or regular home care. The justifications for admitting customers to the care of the intensive team will have to be specified and whether customers could be transferred quicker to the care of home care teams should be reassessed.

The tasks of the intensive team have become the following:

1. Arranging and supporting the discharge process
2. Performing medical operations
   - intravenous antibiotics treatment
   - intravenous fluid treatment
   - blood transfers
   - medication
   - treating wounds
   - catheterising
   - monitoring sugar levels and monitoring insuline treatment
   - post-operative monitoring
3. Terminal treatment and death at home
4. Assessing the need for treatment when prescribed by doctor
5. Assessing the status and treatment consultation of home care and sheltered housing customers
6. Supporting and consulting home care and sheltered housing personnel

At the moment, the discharges have mainly been from inpatient wards of basic health care and special health care, and the emergency department of basic health care. Communication about the operation should, however, be constant; there are always those who have not heard about it. In general, knowledge about the discharge operation and staff competences is not wide-spread. For many, what is known comes from the time when home aid personnel travelled from house to house helping around. The awareness about the operation of the doctors who make discharge decisions is important.

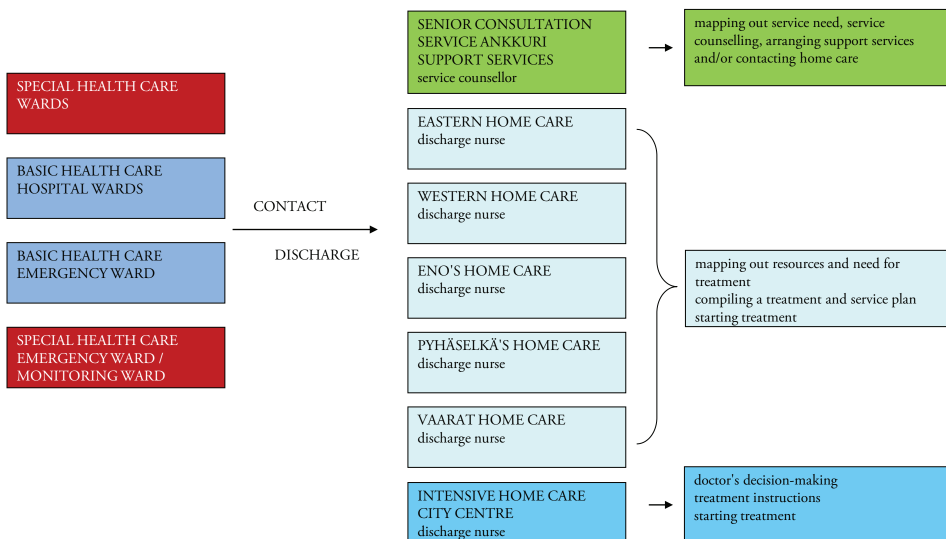

Figure 1.Operations model for discharge process in home care of Joensuu 25 October 2010

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THE STATUS OF REHABILITATION NOW AND IN THE FUTURE

Anu Niemi

The principles strongly guiding rehabilitation are customer-orientation, networking, and a multi-perspective attitude. The rehabilitation patient is not an object but a subject. Consequently, during the past few years, the idea of ’rehabilitating’ has been replaced with ’being rehabilitated’. The timing of rehabilitation is important and, unfortunately, there is an unnecessary delay in starting the rehabilitation. This delay may cause losing some of the potential to rehabilitate. According to a report by the National Audit Office of Finland in 2009, the service chains of rehabilitation do not operate optimally from the point of view of effectiveness of rehabilitation.

A successful rehabilitation process requires strong commitment from the one being rehabilitated, his/her relatives and the carers, as well as setting common goals. The goals of the rehabilitation patient may differ considerably from those set by the health care expert. Traditionally, rehabilitation has been seen as a trick performed by rehabilitation professionals. According to the current views, rehabilitation is participatory, active, and persevering. In practice, target-oriented rehabilitation requires documenting objectives and constant assessment of reaching goals. Right now, the health care legislation draft from the government to the parliaments emphasises the significance of a written individual rehabilitation plan in such a way that a claim to compile a written rehabilitation plan has been enthroned to the level of legal text. Compiling a rehabilitation plan would, at the same time, anchor the rehabilitation responsibility and follow-up. A good rehabilitation plan is compiled multi-professionally.

Drawing a line between treatment and rehabilitation is difficult. This promotes imaginary assumptions that rehabilitation requires a special operational environment. Rehabilitation performed at home is productive and it can be integrated with rehabilitative treatment. However, it is still unfortunate how often passivating attitudes of nursing personnel, but also the patient’s relatives, are obstacles for rehabilitation.

Rehabilitative everyday life refers to implementing the proactive resources of the rehabilitating patient. The cultural background of the home and the cultural differences between sexes and age groups have to be considered. The everyday environment and its possibilities have to be known. The stereotypes learned by the rehabilitation personnel of a “good rehabilitation patient” have to be recognised, and they should be avoided, while the individual needs and goals should be respected. In this way, passivating actions can be avoided. In addition, rehabilitation patients are not a homogenous group. Routine rehabilitation does not always respond to the individual needs of the patient and, in the worst case, cause unnecessary costs. The methods learned in therapy should be applicable in the everyday life. Practicing new skills should continue in the everyday life that asks eagerness towards social participation. Because of

this, to ensure continuity of rehabilitation contents and its implementation in special health care, for instance, close co-operation with the patient's home municipality's social and health care services are necessary. The main responsibility belongs to the municipality, which, in practice, means basic health care and, in a smaller scale, special health care.

Geriatric rehabilitation is planned, long-term co-operation that supports social participation of the elderly and coping in the everyday life. The core questions are patient participation in rehabilitation and affecting the patient's environment. Weakened mobility predicts a notable increase in the need for services. On the other hand, mobility and functional ability can only be maintained and improved by moving and acting. Hence, all actions in the elderly person's environment that promote health exercise are very cost-effective.

What distinguishes rehabilitation from health exercise is methodicalness. With the help of a rehabilitation expert, rehabilitation aims at finding ways to promote physical, mental, and social resources, as well as functional ability in a situation that threatens functional ability or in case the fall has already occurred.

The objectives of rehabilitation are traditionally documented in a relatively vague manner and this is why, during the home care project, solutions that help documenting the objectives of rehabilitation at a level that springs from ADL functions have been looked for. The patient information system of the region is becoming unified during 2011, which will make better data transfer possible between various organisations. To reach maximal benefit from introducing a unified data management system requires, however, learning a unified documenting system and, more than anything, a unified idea that investing in rehabilitation is worthwhile.

For developing home rehabilitation, it is positive that in the education of a practical nurse, for example, one can specialise in rehabilitation. Similarly, breaking the wall between social and health care with the organisation reform supports the multiprofessional principles of rehabilitation. In addition, a two-year labour political occupational therapist training started in North Karelia at the beginning of 2010. An occupational therapist is an expert in maintaining and realising rehabilitation for everyday functional ability. It has, indeed, been a pleasure to notice that municipalities that have invested in preventive work have used the expertise of occupational therapists in home rehabilitation of geriatric patients.

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DEVELOPING ROUND-THE-CLOCK HOME CARE AT MUMMON TURVA OY

Jorma Hartikainen

My family business Mummon Turva Oy participated in the practical piloting of the Home Care 24h project in spring 2010. For us, this meant developing home nursing. Our role was to assist the customers of the ophthalmology ward at North Karelia central hospital in preparing for an operation and with the discharging process. The aim was to ease the customer's load during the operation and to reduce treatment days at hospitals and units. We prepared for the project so that our nurses were ready to help the customer with preparations and further treatment. Mummon Turva nurses mainly focus on geriatrics, which made participating also in terminal treatment piloting a natural part of the project.

OUR GAIN

We gained good training through the project. The ophthalmology ward at North Karelia central hospital deserves our gratitude for providing further training to our nurses. In addition, the sample-taking training organised by Home Care 24h and implemented by North Karelia University of Applied Sciences gave added readiness to our employees.

Another positive consequence of the project is networking. The benefit gained from co-operation is more than competing and sitting on competence within the private and public sectors. Both can join forces and the beneficiary will be the customer. In addition to concrete profit, our business gained new contacts; we got acquainted with other entrepreneurs in the business and I was able to share my views with the decision-makers of the public sector. All health care and social services networks are important to entrepreneurs, because you never know what you find behind the next door. The best profit of the project was networking with the region's actors.

SHORT TIME

For an entrepreneur, the short piloting period was challenging. The time of piloting was spring 2010 and it lasted for three months, which proved to be far too short a time for a private actor. Creating customer contacts and also networking with the public sector requires a lot of time and persistent work. Extending business operations to home care, which was a central part of the project, is worthwhile work, but,

this time, lack of time in the pilot was an obstacle. After the pilot, the amount of shared customers and co-operation have, however, increased, which was not apparent during the pilot.

THE DIRECTION OF CO-OPERATION

The project was of good quality and showed the direction health care should take. These days, it is short-sighted to look at the actor field from the point of view of old roles and spread it to public and private sectors. They have no longer been exclusive sections, but rather support each other and build a good quality, all-encompassing service together for the customer. The winning party in overlapping services is the customer. The project proved how values such as customer-orientation, humaneness, safety, and reliability can be knitted together into a strong web. I can see that intensive home care and home hospital operation are the starting point for this new kind of customer-oriented operations model.

STUMBLING BLOCKS

When I discussed the project with nurses I know at the central hospital, I heard surprisingly often that they had not heard about the project. Communication is a difficult art form, especially in a field that is under constant pressure to change. Research and projects that concern nursing are in process so often that it is difficult to sort the wheat from the chaff. It is understandable that the projects are seen as relatively abstract ideas that do not concern the everyday of an employee. The daily basic tasks consume so much resources during retrenchments that anything extra will be easily shrugged off.

In my opinion, discharge nurses are in a key position in this project. Their attitudes play the most significant role in including a private person into the discharge process. Perhaps it is still easier to contact the city's home care as before.

SUGGESTIONS FOR FURTHER DEVELOPMENT

At the moment, service vouchers are used in home care, home nursing, and family care. As the project proceeds, I believe they might be a valid option in this kind of operation as well; the name could be discharge voucher. Our company has had good experiences with service vouchers. When the customer uses a voucher, they have an improved freedom of choice. When there are several service providers available, they can use the company that best pleases them and the voucher will not exclude municipal option, if the customer chooses that. When there are more options and competition, the quality of nursing improves.

In the piloting phase, terminal treatment and operation with the ophthalmology ward were tested. In the future, I cannot see any obstacles in expanding the co-opera-

tion to day case surgery as well. A part of hospital days could easily be abolished and the costs would be easy to verify with a simple mathematical calculation. Preparing for operations would also be possible at home in a customer-oriented way.

Communication about the companies and their services should be developed further. The companies cannot assume that information about their operation is automatically available for other actors. This also applies to public sector actors who also change and develop constantly.

TERMINAL TREATMENT AT HOME

Erja Riikonen & Tuulia Kouvalainen

We have worked in special health care for years and helped dying patients to home care. This article is mainly based on our experiences with discharging terminal treatment patients. At the end of the article, we present a summary of the discharge process to terminal treatment at home in a figure. The figure can be used as memory support in organising home care.

Terminal treatment is care for a severely ill patient, of whose treatment has been given up; the illness proceeds and death approaches. Terminal treatment is good care of the patient's symptoms that aims at alleviating symptoms, promoting wellbeing, and that emphasises respecting human dignity and safety. It is not related to a specific diagnosis. (Hänninen 2008, 12.) Good terminal treatment can be implemented at the hospital, in a nursing institute, in a terminal treatment home, or at home (Autio & Sonkajärvi 1998, 4). Although treating a dying patient mostly takes place in institutional care, the awareness about terminal treatment at home has increased. The wish to be treated at home until the end of life is more and more common. An individual should have the freedom to choose where they want to die. Life is more valuable the less time there is to live it. Because of this, it is important to attempt to respect the wishes and the will of the patient and relatives.

Successful terminal treatment at home is affected by the availability of care services in the patient's place of domicile. Basic health care should provide round-the-clock help, and the treatment responsibility would then be transferred to home care personnel and the health care centre doctor. The patient's own willingness to choose terminal treatment at home should, however, be the starting point. The willingness of relatives is also necessary, because without them, home care is not possible. Relatives are important partners in planning and implementing the treatment. Relatives and friends secure the basic needs of the patient, but home care is professionally responsible for the medical tasks and the success of the entire treatment. The preconditions for being accepted to terminal treatment at home and the decision to discharge are assessed and decided together with the patient, the relatives, and the home care personnel.

Rantasalo (2997, 21-22) describes the discharge process clearly and the following parts are also central in discharging a terminal treatment patient: assessing readiness to be discharged; making the decision to discharge; preparing and assessing the discharge; and assessing the realisation of the discharge process. A discharge plan predicted soon enough gives more time to realise the discharge process and make arrangements for home care. With a dying patient, individuality and human values are emphasised. In realising terminal treatment at home, the knowledge of the approaching death gives a different starting point for organising the care. Exceptional solutions may

sometimes have to be made for successful home care that may require flexibility and commitment from the participants. For instance, rehabilitating treatment is aimed at alleviating symptoms only.

Before the transfer to terminal treatment at home, a terminal treatment decisions by a doctor is required. The doctor must have a terminal treatment discussion about terminating healing treatments and starting a symptom-based treatment with the patient and relatives. This does not, thus, mean terminating all treatments. The discussion covers the treatment of symptoms at home and the situation of the illness, and how natural death at home can take place, and that it is both hoped for and allowed (AND = allow natural death). At the same time, a decision about waiving resuscitation and intensive care (DNR = do not resuscitate) is made. In all actions, the professional nursing staff must respect the patient's autonomy, individuality, and value of human life. The decisions are made in mutual understanding with the patient and relatives, also noticing the patient's living will.

Home care requires that the nursing staff has a patient-specific treatment plan about treating symptoms, need for assistance, and operations models. This means that the symptoms that spring from the illness and the areas of living in which the patient requires help are mapped out. Home care implementation is planned during treatment and service plan discussions, during which it is agreed with the patient and relatives how help at home is arranged; which services, aid tools, and treatment devices it is possible to get. At the same time, the practical matters are agreed on: who participate in the treatment, what they do, and when they make a house call. The discussion may included the patient, his/her relatives, an inpatient ward nurse, a doctor, and home care professionals such as a doctor or a home care nurse. In addition, special professionals such as a social care worker and a physiotherapist are included in the process if necessary.

The patient, relatives, and home care staff are given spoken and written information about the treatment of the patient's symptoms such as pain alleviation, dyspnoea, drains, infusions, and wound treatment. The patient and the relatives also need guidance about basic nursing and patient handling. The patient needs to know that he/she has autonomy as to the treatments, so he/she has the right to refuse accepting life-prolonging treatments. The doctor's participation in the consultation is important for the success of the discharge process. A patient in need of intensive care should be given plenty of time. The doctor is also responsible for preparing the necessary prescriptions and statements, for example epicrisis, or statements B and C, early enough.

Depending on the situation, a home can be provided with a lot of help or very little. It is important for the patient and the relatives to get as much information as possible about the stages of the illness and changes that may happen in the condition of the patient, and also where they can get more information, assistance, and support around the clock (Hänninen 2008, 8). The home must also have enough aid tools and instruments. In addition, a social worker should find out about the opportunities for financial support so that the patient's livelihood is secured.

Terminal treatment at home is always a demanding process for the patient as well as to the relatives, so agreeing to go ahead with it requires courage and commitment from the relative. The relative has a double role in terminal treatment at home: he/she

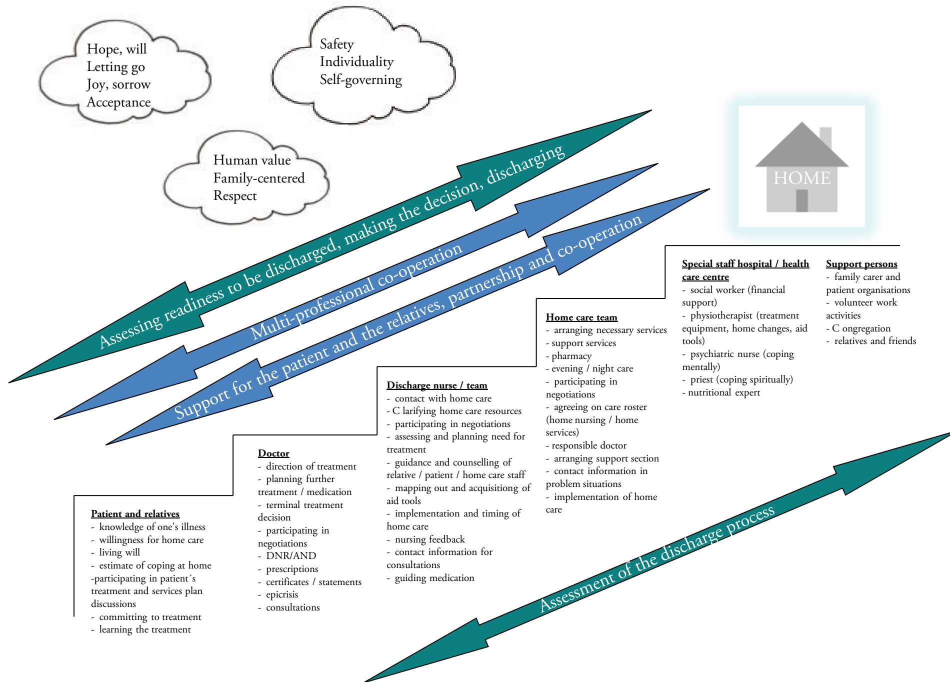

Figure 1. The discharge process to terminal treatment at home.

acts as a carer and as a relative in need of support. Home care planning should map out which relatives and/or friends are going to participate in the treatment. Prolonging the treatment or the patient's deteriorating condition may also cause exhaustion and feelings of inadequacy in the relatives. Founding a treatment circle in which the participants take turns in treating the patient, temporary inpatient ward placement, or reassessment of the treatment may ease the situation (Hänninen 2008, 8). In the terminal treatment situation, both the the patient and the relative may encounter various kinds of emotions and talking about death is often difficult. The family may need someone to talk to, counselling, and support during the entire terminal treatment process that needs to be human, delicate, and honest. If the patient refuses to talk or cannot talk about death, it must be accepted. The changes in emotions and moods of the patient and the relatives may increase fatigue. This is when a psychiatric nurse or volunteer workers from organisations or the congregation may be of assistance for the treatment circle. (Autio & Sonkajärvi 1998, 6.)

Feedback from relatives about successful terminal treatment have been encouraging. Often, the relatives have found out that treating a severely ill patient at home is possible only during the treatment process; that the inpatient ward treatment is not the only possibility. It has been important for them to get enough information and counselling, as well as professional help to manage the patient's symptoms. They have been grateful for having the opportunity for home care, for organising practical matters, for support, and for not being left alone in a very difficult life situation. They

have been grateful especially for home care of basic health care. It has been important to be able to help their relative, spend time with them, and realise their wish to spend the last moments of their lives at home. Many important discussions would not have been had during hospital care. Plans and decisions have been made at the peace of one's own home and the patient has been at liberty to express their feelings and wishes. Home care has also made everyday life easier, because visits to the hospital are experienced as hard. At the same time, it has been easier for relatives and friends to come an say hello. Knowing that it is possible to get consultation for special health care and a possibility to be transferred to the inpatient ward of one's own health care centre in case the home care becomes too heavy has brought a sense of security. In addition, advance information about the arrangements after death has been useful. Successful home care has supported the relatives in their grief work. Good memories and experiences remain and carry through life.

In some municipalities, home care has been strongly developed by creating home hospital operation, intensive care teams, and terminal treatment homes, for instance. This improves the prerequisites for good quality round-the-clock terminal treatment at home in a safe way. Good symptom-based treatment (such as pain alleviation) requires that the professional staff is constantly trained in terminal treatment and have an understanding, positive attitude. Each municipality should have at least one nurse and one doctor specialised in palliative treatment, who support the success of terminal treatment at home and participate in developing their municipality's palliative care. The possibility for home care is an important treatment option for a severely ill patient in the society's service structures reform. Expert care should be available at home, if it is the will of the patient and the relatives. If human values and financial resources meet, the equation is worth realising.

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ORGANISATIONS AS PARTNERS FOR FAMILY CARERS AND PUBLIC HEALTH CARE

Anna-Maija Pitkänen & Leena Knuuttila

RECOGNITION OF FAMILY CARERS – HEALTH CARE IN KEY POSITION

According to the definition used by Omaishoitajat ja Läheiset-Liitto ry (association for family carers and relatives), a family carer is a person who takes care of his/her family member or other relative, who cannot cope independently due to illness, disability, or other special reason for needing care. The concept is based on a relationship that has existed before the care started. Important elements in caring for close relatives are: 1) closeness, 2) care and nurturing at home, 3) the patient cannot cope individually. The concept is difficult to accept and it is not necessarily recognised even though the characteristics would exist. Evaluating one's own situation is not always easy. One is primarily a father or a mother of a disabled or chronically ill child. As a spouse, one tends to think mutual care and support are a natural part of the shared everyday life. The ageing parents' need for assistance increases unnoticed. Sometimes, it takes years of caring to realise one is a family carer.

It is good to think about caring for a close relative and recognising it from the points of view of the family and health care. It may be difficult for the family carer to talk about the topic, which is why the health care staff needs to talk about it. Recognising and considering being a family carer should be made possible for each individual. Could it be that, from the point of view of recognising a family carer, health care would be in a key position?

BALANCING NEEDS IN FAMILY CARE UNITS

Becoming a family carer changes the life and the internal balance of a family. It is important that the whole family lives a life that is as rich as possible, suitable for one's age, and has hobbies and enjoys life as much as possible. By strengthening the areas of life that are healthy and hanging onto them can help to maintain a balance despite the changed situation. If there is no balance in needs, there are two extreme risks: the needs of the family carer and the rest of the family are forgotten completely and the illness wins. The other extreme is that the needs of the patient are forgotten and the whole basis of family care is endangered. In these cases, the

family carer is, perhaps, fatigued and can no longer take care of the patient. Because fatigue can emerge in a very short time, it is important to take care of balance right from the beginning of the family care situation. The whole family needs support to make home care possible (Figure 1.).

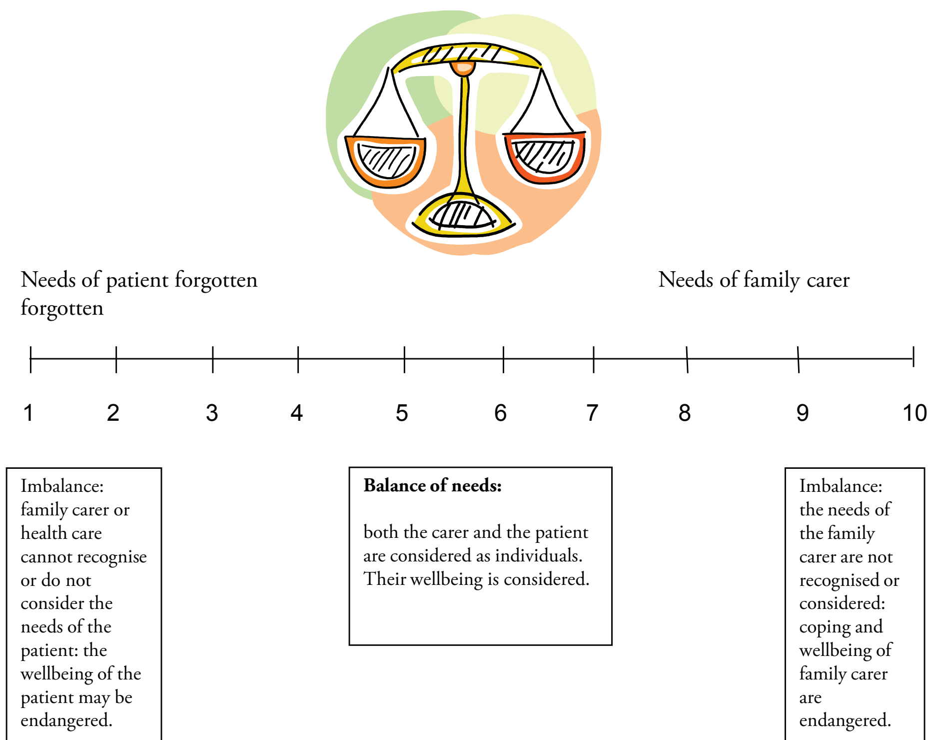

Figure 1. Balance of needs (Miisa Lamminen 2010)

Studies show that family carers are under a great risk of feeling encumbered, exhausted, and stressed. There is more depression amongst family carers than with people of the same age who are not family carers and they often feel their health is worse as well. (Mäkelä, Karisto, Valve, & Fogelholm 2010). There are references to a greater risk of falling ill and premature death of family carers. The Omaishoito yhteistyönä (Family care as co-operation) support model of dementia families shows that long-term care can be postponed and the wellbeing of the spouse carer can be increased with the help of tailored and co-ordinated services. It is significant to notice that tailored and co-ordinated services cost 5 000€ less per family/person year than services that are not. (Eloniemi-Sulkava, Saarenheimo, Laakkonen, Pietilä, Savikko & Pitkälä 2006.)

ORGANISATIONS ON THE FAMILY'S PATH

The board of an organisation that does volunteer work is responsible for the operation. Organisation activity is always based on volunteer work. It can be a service provider, but some of the organisations have laid out a traditional organisation service area. This is non-profit operation that is funded by instances such as Finland's Slot Machine Association, Ray. In these cases, the state council decides on the subsidies yearly based on applications and Finland's Slot Machine Association's proposition. The funding is laid out nationally. It can be a project funding or funding for a sub-operation that receives a more regular support. A part of the organisations operate on voluntary basis only. The task of organisations is peer and voluntary work. Most organisations have peer activity directed at relatives that offer opportunities for participating, joining, and social interaction. They are trustees and opinion leaders.

Organisation workers act as experts and professionals as well as partners of family life. Target-oriented support for family carers requires professional attitude and co-operation of professionally operating organisations. Organisation activities should join with the service network that the family is a part of. A good example of this is the organisation-based peer support model for memory disorder patients' family developed by Yhteinen Polku ("Shared Path") project by Joensuunseudun Omaishoitajat ja Läheiset ry (association for family carers in Joensuu) and Muistiluotsi (expert network) of Pohjois-Karjalan Dementiayhdistys ry (dementia association in North Karelia) who participated in the Home Care 24h project. The model describes the path of the family of a memory disorder patient form the early stages to the end of the life situation of family care. In the model, organisation-based services have been marked alongside the path of the family.

When the everyday life of a memory disorder patient is still relatively normal and the family has a need to understand the changes that come with the disorder, the experiences can be shared, according to the organisation-based model, in Muistimiitinkiryhmä (a group) or in a first information and peer activity group of those fallen ill as under 65-years-olds. These services are realised in co-operation with public and private actors as well as organisations.

As the illness progresses, the family comes to a point in which they have a need to discuss preparing for the future. The everyday life is also starting to show typical signs of a family care situation. How can one make life easier when the patient needs more and more support from another person? How can one ease the load of the family? The family can get support and assistance for this life situation from Pariskuntaryhmä (group for couples) that is realised as co-operation of both organisations and City of Joensuu.

As the illness progresses further, the changing everyday life produces more and more questions about coping. These can be answered in individual family work, for example, or at the alternate care ward with the help of a peer support group. The process of being a family carer continues even after the caring has come to an end, when support is available in a grief work group. There are support forms for all stages of the illness for the memory disorder patient's family both as organisation services

and co-operation services. Many services are networked with other actors in order to realise the co-operation.

All organisations in North Karelia have been collected to a web site (www.jelli.fi). The organisations have a lot of information, networks, and material that nursing staff and students can use. In addition, training and the working life can produce information about development needs that can be passed on to various actors. Networking is important in the operation of organisations, especially when they receive state funding and have paid employees.

PUBLIC HEALTH CARE AND ORGANISATIONS CAN SEE MORE AND PREDICT THE FUTURE BY CO-OPERATING

The objectives of Omaisten tuki (support for family carers), a subproject of Home Care 24h, are: family carers as partners, and development of the contents and methods of support for family carers. In addition, it aims at increasing the amount of supported family carers. Family carers do already participate in the life of the patient, but organised support is insufficient. To see a family carer and other actors as partners requires new thinking, a new culture. The family carers may also have thoughts of being the target of action, the ones being supported instead of active participants. The patient will have a better chance to cope at home despite the illness through the support of the family carer, which means that the support cannot be a separate area of operation on its own. The objective of support should be good assistance, treatment, and support from the family carer. In addition to professional nursing, a partner is required for successful home care. He/she will be able to manage the loaded everyday life when supported. He/she will be able, and will have strength and be motivated to deal with the patient's situation. This perspective sees the support of a family carer as a part of good overall care.

The partnership network provides the family carer with opportunities to get specific information, counselling, nursing assistance, domestic aid, peer support, recreation, and rest. For example, neurologic and cancer illnesses touch the lives of the patient as well as his/her relatives as, in addition to treating the illness, the family has to change their normal everyday life and roles, find new ways to cope with household chores and responsibilities, and do their grief work. Realising rights needs to be developed further with each individual family and various areas as a part of the care chain. The better the co-operation between various actors is, the more systematically it can be assured that the proportion of supported family carers increases. In her dissertation, Holmberg (2007) describes the experiences of family carers and finds empathy particularly significant in palliative treatment. Expressing empathy means understanding another person's thoughts and feelings, feeling compassion towards another person, and doing them good. She uses the concept 'social empathy' that comprises access to services and a form of support, information, continuity, flexibility, freedom of choice, and financial support. Empathy, which is based on compassion, refers to acceptance, respect, trust, individuality, empowerment, support, and shared experiences (Holmberg 2007).

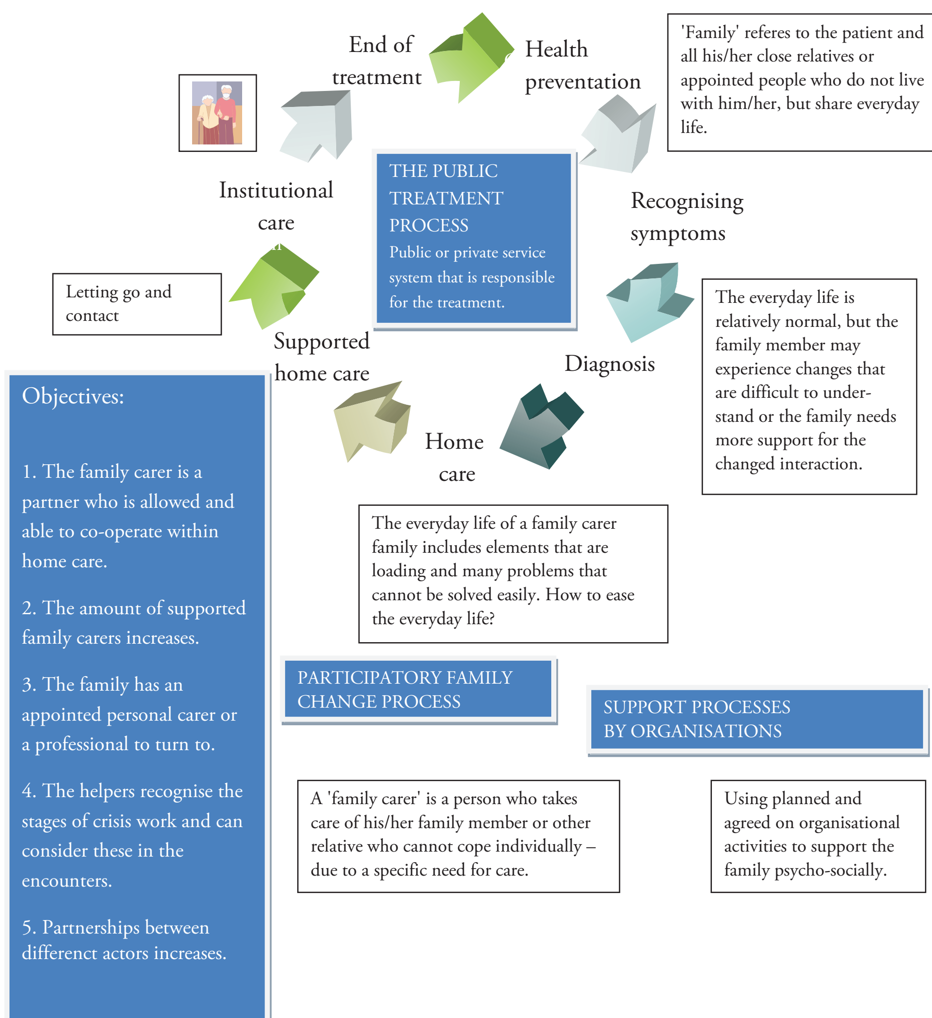

Image 2. Processes meet – co-operation needed

A prerequisite of reaching the goals of the subproject is that the care chains are modelled and that they are implemented as co-operation between municipalities, the state, private service providers, congregations, and organisations. All actors should know how their own action is placed within the care chain and how the transfer into another stage of the process happens. The action should be justified and it should be based on Current treatment recommendations ("Käypä hoito") and models of good treatment practices, for example.

When a person is in a situation in which he/she needs treatment, care, or support to manage independently due to illness or injury, the institution responsible for treatment should find out immediately what the possibilities of this person's family/relatives are to participate. An individual has the right to define his/her close relatives. If the progressing illness causes a situation in which the patient cannot cope independently, a family carer must be included from the beginning. The family is

seen as a subject, not an object. The situation and need for help and support of the family carer change as the patient's situation changes, but also as the family carer goes through his/her own crisis work. The employee should be ready to do counselling and he/she should get support in developing his/her social skills and coping. Successful interaction/co-operation does not require more resources – instead, the operational culture and attitudes require that each looks at their own thinking. Using organisation activities in supporting the family psycho-socially should proceed as planned and as agreed.

The above Figure 2. was created during the subproject on family carer support. The objectives of the family carer support team in the Home Care 24h project can be reached by co-operation. The public treatment process is the foundation of the operation and is responsible for the existing operations models, good practices, and care chains. The patient and the family carer are in a transformation process because of the long-term illness and this often requires other support than only treating the illness. Organisations function in the middle ground of the public health care process and the family using the services in their unique life situation. This support is socially valuable, economically profitable, and, more than anything, human.

The co-operation of organisations and the public system is full of potentials but also challenges. Trimming the service structure from institution-based treatment to home-based treatment will immediately raise the question of family carers and their support. From the point of view of families, joining the resources of public health care and organisations is one possibility and even a solution that makes home care possible. Clear, shared practices and openness promote co-operation and increase the sense of safety of the families. The North Karelian welfare strategy for 2015 "Yhteistä hyvää" (Regional Council of North Karelia 2007, 3) regards organisations as active actors and promoters of welfare. The goals of the strategy for 2015 are:

- Versatile and active organisation activities in the region promotes the general social and health-related wellbeing of the citizen. The operational preconditions of organisations in North Karelia region are strong.
- Public actors and organisations in the welfare sector operate in an open, partnership-based co-operation to promote local and regional welfare. New operational models have been developed for the co-operation of welfare organisations and private businesses.
- The special expertise of organisations is considered in the welfare political decision-making of municipalities, sub-regions, and the entire region

AN EXAMPLE DESCRIPTION OF THE NETWORKING CO-OPERATION OF JOENSUUNSEUDUN OMAISHOITAJAT JA LÄHEISET RY, POHJOIS-KARJALAN DEMENTIAYHDISTYS RY, AND THE CITY OF JOENSUU

Before starting the co-operation, both parties have their own tasks on the path of the memory disorder patient and his/her family. The patient and his/her family must have treatment and follow-up arranged by their own municipality's services or the private sector. The necessary support forms have been arranged to the family with the help of memory nurses of the municipality, counselling centres, and service coordination professionals. The family has access to peer support from the organisations as soon as resources without it are too small. The operation is voluntary. The needs of the family are promoted and the action makes the necessary support forms available. Professional organisation activity is networking. Figure 3. below is an example of this.

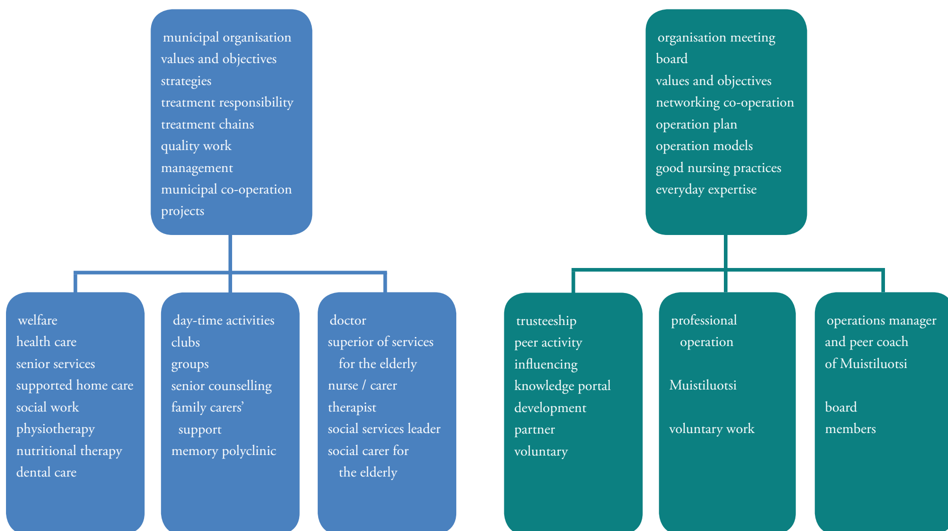

Figure 3. The actors's organisation models form the basis of the co-operation.

Figure 4 describes the life of a family in the service network in Joensuu. The green arrows describe the orientation of the family into a couples group either through the city's services or an organisation. Memory nurses evaluate the needs of the family and provide the information about the families to the planning group's selection meeting. The grey arrow describes information flow, which means, for instance, information that the couples group can work on or information about treatment-related matters to the municipal actors. The orange arrow describes the transition of the family after the group. The partnership model includes an agreement between the City of Joensuu and related organisations. Both commit to the action semiannually. In this model, the organisations have been operating with support from RAY and the municipality has not purchased the input of the organisations. The organisations have received the

support from RAY for group and peer support operation. The partnership is understood as a shared goal, similar values, clear role differentiation and rules, as well as regular co-operation meetings and trust.

The process

1) Directing to service and choosing group
2) Planning group before rehabilitation begins
3) Intervention
4) Further support and follow-up

About Figure 4. A good practices description of the model “Rehabilitation and peer support couples group for memory disorder patients and their family” has been accepted to the Internet pages of the Social Gateway (Sosiaaliportti).

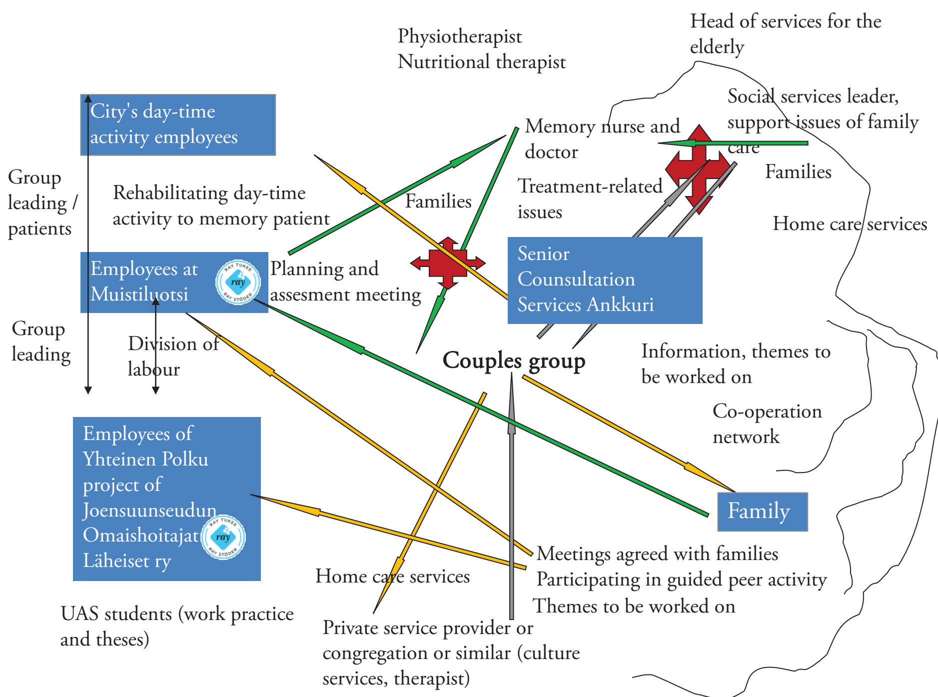

Figure 4. Description of the networking co-operation “Rehabilitation and peer support couples group for memory disorder patients and their family”

HOME CARE 24H, FAMILY CARER'S SUPPORT – A LONG WAY LONG WAY

The last stages of a memory disorder patient can be compared with cancer or a difficult heart hypofunction. It already refers to palliative treatment that can also be realised at home, which is the aim of the Home Care 24h project. Studies show that families who understand the limitations of life and know about the complications demand less straining operations (Saukkonen 2010). The family of a memory disorder patient may live years with a dementing illness. In order to make home care possible, the support must begin with the recognition of the illness and continue throughout all the stages.

Organisations as partners for families and public health care is a modern concept. As described earlier, good co-operation accomplishes more than any individual actor. Service networks are so multi-dimensional that each of us could use a moment and think how the voice of the family, the closest relative, can be heard amidst of all that.

WHAT DO I NEED AS A FAMILY CARER?

O It is worthwhile to get to know the family carers and think why it is important to work with them. Co-operation between an employee and a family member may, at any point, shift its balance so that the family member is the active participant. Form this point of view, each of us can understand why getting to know the family and co-operating with them is so important. A family carer support training day was organised during the project. The families were asked to write down experiences and other points they wanted to share with others. The wishes of one family carer could serve as discussion points for the nursing community when goals and values for the foundation of the operation are discussed:

- *I wish that my beloved family member is respected, heard, and treated like an adult.*
- *I wish that my beloved family member could see smiles on the nurses' faces.*
- *I wish that the one treating my beloved family member would be genuinely present in a meeting.*
- *I wish that the nurses think whether being busy is really always the reason why treating another person well is not possible. Can you really be <u>always</u> so busy?*
- *I wish I can give the nurses positive feedback for good care.*
- *I wish that I am truly included in the treatment of my beloved family member. That I am asked, that I am supported, that I am told about matters that concern my beloved family member.*
- *I want to be able to breathe freely, go peacefully to bed at night, and have a life of my own.*
- *I want to give time to my family, children, and spouse without feeling guilty, that I should be with my beloved family member instead.*
- *I wish my beloved family member gets good treatment so that I do not always have to fight for it.*
- *It would also be nice that someone, some day, would ask, "And how are you?"*

Nurse, colleague, family member 2010

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TECHNOLOGY SUPPORTING CARE AT HOME

Anne Heikkilä

Kotihoidon In planning home care services, it is important to consider the entire life situation of the aged as regards fluency of everyday life, social safety, and supporting functional living. The task of home care is to match services from different service providers to correspond to the individual service needs of the customer. The increase in the amount of aged people increases the need for home care services in the future. By the end of 2006, there were 395 000 over 75-year-olds in Finland (7,5% of the population) and almost 90 000 over 85-year olds (1,7% of the population). In 2035, the estimates predict that there will be 800 000 over 75-year-olds (7,5% of the population) and 250 000 over 85-year-olds (5% of the population). This means that the amount of over 75-year-olds will be doubled as compared to the current situation. The estimates say there will be over two and a half times more of over 85-year-olds in 2035. Although the functional ability of the population has improved at a general level, there has been no change for the better in the functional ability of over 85-year-olds. The need for care of the aged has not, thus, apparently been postponed. The decreased physical functional ability and various illnesses incur need for home care. (Heinola 2008.)

Aid tools have been used in services for the elderly for a very long time. Some mechanical tools are so well established that they are no longer seen as aid tools. On the other hand, there are more and more technological aid tools available. As the population ages, the age groups being born diminish and lack of work force threatens, new technological solutions and methods are, indeed, needed so that the challenges of the social and health care sector can be met. (Melkas, Pekkola, Enojärvi & Markkula 2008, 10.)

The goal of promoting the health of the elderly is independent living and an active old age that support living at home for as long as possible. In Finland, a little less than 90 percent of over 75-year-olds live at home and the proportion has remained almost the same during the 2000s. In 2005, 89,6 percent of the age group of over 75-year-olds lived at home. (Voutilainen 2007, 31.) More and more nurses are needed to care for the increasing amount of customers. At the same time, there are less graduating nurses than there are aged who retire. To support the staff and customers of home care, more new technology is needed in order to cope with the increasing amount of customers. For a long time, technology has been used in home care, for example safety wrist-bands and different kinds of measurement devices (blood sugar measures, INR quick-tests, CRP quick-tests), but new technology is developed and tested all the time around the country. Examples of new products are: various kinds of interactive televisions and motion sensors, as well as mobile devices and lock systems designed to help the work of staff, in particular.

New technology can be used as support for coping at home and for home care staff to help manage the care of the increasing number of customers. Technological applications developed around the country will be available in the near future as solutions for loneliness in the aged and lack of psycho-social support. The social participation of those bound at home due to old age or illness has been encouraged by a project entity called HyvinvointiTV (welfare television). The objective of HyvinvointiTV is to use technology that increases safety of living and the functional ability of the elderly, and that also makes social interaction possible. It produces an operating environment that applies digital television, phone technology, and the Internet that supports coping at home and independent living. Virtual eServices developed in different projects are related to supporting daily activities, self-care, and being together, as well as promoting health, rehabilitation, functional ability, safety, and mental health. Interactive visual connections will make maintaining social relationships and interaction with other people possible in the future through library reading circles and congregation events, for example (Tepponen 2009, 174).

Safety-promoting devices that measure vital functions and floors that register falling have been tried out in home care. The technological applications show that welfare technology can be used to support independent living of the elderly. The results of the current development projects should be better anchored into practice and their use should be expanded more actively to prevent and alleviate loneliness, exclusion, and insecurity in the aged (Tepponen 2009, 174).

The family carer and the patient spend 24 hours together and meaningful activities are important for their wellbeing. Positive experiences have been had with interactive visual connections in supporting personal carers and patients, for instance (Tepponen 2009, 178). Kaakon SoteInto project, that is a part of the Kaste project, is testing HyvinvointiTV for family carers and patients that is aimed at easing the work load of family carers and improving safety. The primary purpose of the system is to provide extra support and a faster contact platform to those responsible for family care. The system makes peer support between other family carers possible, as caring for the patient may be binding and moving with the patient can be burdensome and difficult. There can be more than one person online at the same time and these people can talk to each other. HyvinvointiTV increases the sense of security as those responsible for family care can be reached more easily. Visual contact also makes quicker intervention possible, as spoken reports may not convey important observations.

Home care can be made more effective by applying modern technology when the applications are not build to strengthen old hierarchies but, rather, to support co-operation networks and develop new functionalities. Mobile technology provides new possibilities such as using a mobile phone for opening doors combined with an automatic sign-in. In addition, documenting treatment data with the customer on a computer at his/her home increases the participation of the customer and decreases the time the home care staff needs to use on it (Tepponen 2009, 182).

The EU-funded InnoElli project has also tested home care technology starting from 2005. The project was piloted in Kotka, Lappeenranta, Imatra, and Turku archipelago. It improved the readiness of employees in services for the elderly to use

technology. The pilots improved their skills in interaction between technology and services. Introducing technology presumes that the staff is skilled in information and communication technology, and is able to assess the introduced technology in addition to having technical skills. The piloting environments of municipal home care and sheltered housing provided an opportunity for product development and reference to technology businesses that developed their products in a customer-oriented way. (Niemi, Riska & Joskinen. 2008.)

However, it is important that the individual is not forgotten as these new technological products enter the market. It is still important that that elderly person living at home is provided with real human contact. The hands that treat should be real, not those of a robot.

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TRAINING AND RESEARCH CO-OPERATION – STRENGTHENING COMPETENCES AND INSPIRING WITHIN A DEVELOPMENT NETWORK

Ritva Venejärvi

THE STARTING POINT OF THE CO-OPERATION

The objectives of the Home Care 24h project set a challenging starting point to project partnership, and multi-dimensional training and research co-operation. As the main funding comes from the Regional Council of North Karelia and as the administrative organisation is North Karelia University of Applied Sciences, there is a demand for using synergy benefits that are in line with project decisions and strategies, as well as providing strong evidence of research, training, and innovation co-operation in regional development. Working life -orientation, regional influence, and pioneering as the values of NKUAS create the foundation and also function as a resource for the development co-operation based on the research-based approach of the development projects and the interaction between the representatives of the work communities (North Karelia University of Applied Sciences 2007; regional Council of North Karelia 2008, 2010).

I this article, I will review the value basis, potentials, and implementation of the training and research co-operation in the Home Care 24h development process. I will describe and consider the significance of project co-operation for the development of expertise of the students who participated as partners in their thesis and work practice processes. In addition, I will discuss some thoughts concerning the joint learning experiences and atmospheres of exploring innovations during the project's field trips while exploring and searching for continuity as a whole in the training and research co-operation. The descriptions and explorations are based on feedback from students and project actors on the development process; written core questions or those that were brought out during conversations and co-operation negotiations.

ETHICAL PRINCIPLES OF TRAINING AND RESEARCH CO-OPERATION

Training and research co-operation is strongly value-bound in all its forms. In Home Care 24h, the actors have co-operated in multi-actor work community and relationship networks under constant change that cross organisational and municipal borders. Development in its various subprojects aim at reaching shared goals. The work

of the personnel co-operating and participating in the development of the social and health care field is guided by a value basis focused on human values and professional ethical principles included in professional expertise. Expectations of participation and participating extend to co-operation based on jointly agreed principles, developing together. Commitment to work, evaluating and justifying one's own work, and considering research ethical questions from a human point of view are a part of ethical professionalism and they endure on the shared development path. The networking training and research co-operation wishes to find the best actual knowledge to support decision-making and to apply best practices of evidence-based practice into the development processes of work communities. (Leino-Kilpi 2009, 361–368; Sarajärvi & Markkanen 2009, 4–10; Välimäki 2009, 19–20.)

The values and basis of ethical operation in Home Care 24h are based on customer-orientated, human, safe, and reliable action. The development processes of work communities always touch the sensitive world of the participants that needs to be approached in a delicate manner. The private world of the work community that needs to be protected and, on the other hand, the world that is open to critical examination exist side by side in development work. The work communities that commit to the project have expressed a need to and an interest in development; to strengthen the competence of their unit and project actors, to highlight its strengths and future development trends in an open way, receptive to support, and by sharing peer support to the partners. The participating businesses expect the Home Care 24h co-operation to provide them with visibility and an increasing opportunity for training and municipal co-operation. Their expectations have, naturally, been directed towards the added value of economic growth, so business-specific special competence can be considered a success factor. Developing new operational models and service innovations in an open atmosphere and confidential partnership has been the 'guiding star' of training and research co-operation.

The right to live at home or in their chosen treatment environment until the end of life of severely ill patients and aged people along with their close relatives have been the core values of new operational models. The values of Home Care 24h are experienced to exist in the everyday operation of work communities as commitment to ethical good quality development, good deeds in the everyday life of work communities, and as responsible action in training and development co-operation. The significance and importance of co-operation related to home care in the different stages of the treatment path of customers, patients, and families has, thus, been made visible in the development processes. The project has done its share in promoting a stronger positive attitude towards a home care centred attitude and as an advocate of good treatment for the elderly in the region and also at a national level.

Students have been important and valued partners as both experts and work community developers of the social and health care field today and in the future. There has been a willingness to provide learning environments and atmospheres that invite learning and make multi-faceted learning possible, and that are convenient for the students. A vision of strong competence in customer-oriented home care and expert co-operation across the borders of work communities and organisations has also been a rallying point for the training and research co-operation during the project.

CONSTRUING TRAINING AND RESEARCH CO-OPERATION

The operation of development processes must be founded on the best possible evidence so that research information, experiential expert knowledge, and information about the expectations and treatment results of patients and customers, as well as the potentials of the operational environments of the development can be brought together. Research data that fulfil scientific criteria form a solid foundation for evidence-based practice and provides the best up-to-date data available to evidence-based nursing. With the help of evidence-based practice, the quality of nursing can be promoted, and its effectiveness and cost-efficiency can be assessed. Using researched data can be direct, when the operation can be changed using interventions directed by the data or a new method can be introduced by applying the information in the data. Research data can be used indirectly according to the purpose, nature, and preconditions of the development. (Holopainen, Korhonen, Miettinen, Pelkonen & Perälä 2010, 30–45; Kankkunen & Vehviläinen 2009, 25).

The phenomena of nursing in various environments, in the care chain of the customer and the patient, are strongly connected with multi-professional competence and, in home care in particular, to multi-disciplinary networking competence across the borders. In addition to nursing-specific data, development requires multi-disciplinary applicable research data and expert information providing new viewpoints from other fields such as medicine, physiotherapy, pharmacy, social and health care economics. Experiential and practical expert evidence deemed good can be produced, collected, and used in the development or quality assessment processes of organisations. Then, research data does not fulfil the criteria of scientific data, but guides the development, if systematically implemented, towards good practices and new methods (Kankkunen & Vehviläinen 2009, 191–195).

An important finding during the field trips has been comparing well functioning practices based on benchmarking and finding new evidence-based innovations in the expert organisations. Learning during the field trip to Tampere in spring 2009 strengthened the correct direction of the development. The expert information in lecture discussions increased faith in the possibilities of development especially in challenging discharge and rehabilitation processes, the significance of home hospital operation, and in considering memory disorder patients and their relatives. The field trip to Denmark and Sweden in spring 2010 brought about an opportunity to become acquainted with the doctoral dissertation of a researcher mother about the terminal treatment of her son (Holmberg 2007). This touching learning experience inspired the family carer developers, among others, immediately to apply the levels of empathy described in the dissertation to serve as the background for studies on encountering family and relatives. The significance of systematic development was also strengthened by an expert lecture (Agger 2010) on Tom Kitwood's theory on treating elderly patients with a memory disorder. The approach is visualised in the form of a Flower metaphor and, when internalised by the entire staff, has guided this staff of a nursing home towards respectful encounters and resource-based, activating treatment. There was strong evidence on the meaningfulness of the model

and genuine humane action, and the work communities in the project wanted to apply this nursing ideology. The joint field trips have inspired and strengthened the project actors' and students' communal development spirit and experience of peer support. Joint innovation processes have also been experienced as ones responding to the expectations of the emotional level of learning and the challenges of developing competences. (Cf. Tenhunen, Siltala, Keskinen 2009, 17–20.)

Applying evidence-based practice plays an important role in strengthening students' and project actors' development and co-operation skills, and in directing the development towards innovative solutions and productive co-operation. Expectations of strengthening ethical competence is also always connected to joint thesis processes – which concerns supervising teachers as well as representatives of work communities and project actors alike. The challenges are met during the studies while developing working life skills during training and research co-operation, as well as in expert tasks. The busy everyday life of work communities does not always make research-oriented nursing culture possible. Superiors and managers of nursing are in a central position and can affect using research data as inspirers and developers of evidence-based practice in their work communities. (See Eriksson, Isola, Kyngäs, Leino-Kilpi, Lindström, Paavilainen, Pietilä, Salanterä, Vehviläinen-Julkunen, & Åstedt-Kurki 2007, 111–117, 132.)

TRAINING AND RESEARCH CO-OPERATION IN THESIS PROCESSES

In the competences of UAS level Social and Health Care studies, the requirements of the development of research competences have been considered especially in research method studies and the thesis process. Thesis commissions from the working life or other partners of the education are systematically asked for. Six (6) nursing, public health nurse, and physiotherapy students have completed their basic education theses for the Home Care 24h project. Meaningful and interesting thesis topics have been found for the students among the research topics of the development process that are also practical in their application. The completed theses are in line with the development objectives of Home Care 24h, advanced topics with creditable results.

Three (3) of the theses deal with patient experiences of severely ill patients in palliative treatment and descriptions of good care by nursing staff. The thesis "Amyotrofista lateraaliskleroosia sairastavan potilaan toivosta ja sen vahvistamisesta hoitotyössä" (The hope and its strengthening in a patient with amyotrophic lateral sclerosis) (Kauppinen 2009) deals with palliative treatment. This thesis approaches the phenomenon through patients' descriptions of experiences of hope and expectations of strengthening hope in nursing. In her thesis, Kilpeläinen (2009) studied medicine-free pain treatment of palliative patients as a multi-professional co-operation from the point of view of experiences of representatives of various professionals and development opportunities. The interview data was collected in line with the phenomenon from nurses, physiotherapists, a hospital priest, and doctors, who co-operate in pain treatment. Another thesis in the field of palliative treatment, especially in the field

of developing terminal treatment, is about the professional nursing competence of a nurse at a terminal treatment home (Myller 2009). The informants in this thesis are experienced expert nurses who work at terminal treatment homes. The results of all these theses are significant as to hearing and appreciating the patients' experiences, as well as increasing the visibility of palliative treatment and challenges in terminal treatment expert competences. The results build a foundation for a broader discussion on the future development challenges of palliative treatment.

To support the development of the discharge process in Home Care 24h, two (2) theses were completed. In her physiotherapy studies, Häikiö (2010) focuses her case study on supporting the rehabilitation process of a cerebral palsy patient with physiotherapy as he/she is transferred to home care. The follow-up period of the rehabilitation patient was six months including the interviews and functional ability measurement assessments. In addition, family participation and need for support were also considered in the descriptions. The practice-based thesis by Pelo & Sammalisto (2010) made for the special health care emergency ward is also related to developing the discharge process. The thesis describes the discharge process from the emergency ward and presents a discharge check-list for the personnel. The objective of the operation process is to secure safe transfer for the patient and continued treatment in Joensuu Intensive Home Care. The significance of the previously presented results can be seen in the larger context of the challenges of home rehabilitation potentials as the population ages and also in the necessity of developing co-operation and communication in intensive home care.

A thesis (UAS) by nurse students in the field of health promotion on the significance of home as an environment that promotes wellbeing and health will be completed in spring 2011. (Tiilikainen & Voutilainen 2010.) The interview data of the thesis has been collected from nurses who have experience in home care and that describes the health promoting significance of wellbeing and health at home.

An upper-level UAS thesis (Master's thesis) on developing hospital-level home care and further treatment was completed in the spring to support Home Care 24h (Hirvonen 2010). The results have been used in various stages of the development process, for example, in the synthesis of results of piloting operational models. (See article in this publication.) In addition, research co-operation was realised in the Master's degree studies of health care information management within Social and Health Care at the University of Eastern Finland. The Bachelor's thesis "Tieto- ja viestintäteknologia kotihoidossa" (Information and communication technology in home care) by Vilpponen (2009) was completed so that it was possible to use it in the project and formed the theoretical basis for exploring information and communication technology environments.

The thesis that were commissioned by the project work communities have also been presented to the partners during the development days. Nykänen-Juvonen & Pakarinen (2009) wrote their thesis on customer-oriented discharge processes to develop the service structures and processes of the Liperi – Outokumpu social and health care co-operation district. This practice-based thesis explored treatment and service chains, and examined the functionality of service processes as the customer is transferred from a health care centre hospital to home. A guideline folder themed

”Auta ajoissa – ohjekansio muistisairauksien varhaisten oireiden tunnistamiseen” (Early intervention – guidelines for recognising early symptoms of memory diseases) was prepared as the product of Piiroinen’s (2010) thesis commissioned jointly by Muistiluotsi of Pohjois-Karjalan Dementiayhdistys ry and Kontiolahti home care. The guideline folder is designed as a tool for nursing staff to strengthen competences in encountering memory disorder customers, assessing the changes of an incipient memory disorder, and finding support methods. The results of the theses have been received enthusiastically in work communities to be further developed for practical applications.

TRAINING AND RESEARCH CO-OPERATION IN PRACTICAL TRAINING PROCESSES

Selecting the students’ practical training and learning environments is a significant factor in professional growth and developing competences in various stages of the studies. According to Laurin (2006, 87), becoming an expert always requires authentic connection with the expert culture. This way, the student will have the opportunity to learn historically formed expert-based know-how to support his/her learning, receive feedback on his/her progress, and follow the model of the research-based, critical approach of the expert supervisor for his/her own operation and for examining the operation of the work community. This helps the student to take a step on path of research-based learning and be supported by an experienced supervisor in the development of his/her expertise and thinking (c.f. Heinilä 2009, 134–139).

Practical training in a project provides an opportunity for understanding entities in an expert community, for reflecting one’s learning, for understanding the significance of what has been learned in a broader context, and also for producing developing information. The practical training periods of nurse and public health care nurse students in the Home Care 24h project have taken place during their second or third academic year, so they have had basic skills in nursing and experiences of other types of learning environments. Trusting the responsible attitude of students and recognising one’s own learning challenges has played a central role in the co-operation. Training in a project requires enthusiasm, independence, good interaction skills, a sense of responsibility, and planning skills as to one’s own work. In addition, flexibility and openness towards change has been needed – a development project cannot provide only one clear training environment or learning traditional nursing skills. The training environments have been chosen based on the learning objectives of individual study units and personal learning objectives by negotiating and making agreements. The students have appointed home teams in sub-projects in which team leaders have functioned as key persons of co-ordination and planners of the training path together with the supervising teacher.

Important learning objectives in long-term illness nursing have been safe discharge practices, nursing cancer patients in different environments, palliative treatment, and terminal treatment in inpatient wards, home care, and Joensuu Intensive Home Care, as well as good care of the elderly in nursing homes and inpatient wards. Com-

munication and seamless information flow have been a part of the learning process. One of the instances making this learning possible in this area has been the emergency care unit of North Karelia Fire and Rescue Department. The need for support of families and family carers has also been one of the learning objectives and challenges for the students. The learning opportunities in family support have, in particular, been present with the organisation partners Pohjois-Karjalan Dementiayhdistys, North Karelia Cancer Organization, and Joensuunseudun Omaiset ja Läheiset ry. Students have also participated in the project as a part of their practical training in health promotion and preventive health care studies, during which the experiences have been significant for health and resource based learning and they have expanded their conception of health.

The students have completed successful assignments and information from these has been used in development. As training tasks, a needs assessment, for example, was made for terminal treatment homes in municipalities in Eastern Finland, a theoretical description of health promoting nursing in home care was completed, and a needs assessment of electronic documenting in emergency care was made. Some of the training assignments have been presented at the Home Care 24h development days and they are available for the partners in the virtual environment of Moodle.

The Master's students of the Faculty of Health Sciences at University of Eastern Finland have enriched the student co-operation with their competence. The training co-operation has been realised as a part of the Practical Training in Health Promotion course of the Master's Degree Programme in Health Promotion in Nursing Science and in the Teacher Training Programme in Health Sciences. These Master's Programme training modules can be completed in project environments. The co-operating students participated in the development process fully; they acted as representatives of practice and their work communities, as experts and lecturers, they have been responsible for piloting operational models, and served as peer support and co-operation partners to team leaders and project staff. The articles that describe the experiences of students Halonen and Heikkilä are a part of this publication. (See articles in the publication.)

TRAINING AND RESEARCH CO-OPERATION – STRENGTHENED COMPETENCES AND INSPIRATION?

As I was examining the previously presented viewpoints to the challenges of co-operation, several questions arose. Has the training, research, and development co-operation been according to the Home Care 24h project's values? Has the development co-operation been experienced, as expected, suitably challenging and has it provided students and other project partners opportunities for development? The operation of the development teams and the work communities to reach common goals has been exemplary and committed despite the internal changes in the work communities, several overlapping projects, and extensive change challenges of the service structure. The majority of actors have been able to participate closely, committing and creating

possibilities, and being responsible for the development of their work community. The developers of sub-projects and superiors have understandably had to conform to the change challenges of the work communities as they have actively participated. It has been possible to feel tired of "constant development" – hence, it can be concluded that the challenges of development or participation have, in these situations, been too much. Similarly, participating in development has also brought experiences of joy at work or with development! The opportunity to participate has been experienced as a form of co-operation that provides peer support and is collegial. The management practices of organisations and work communities have clearly supported reaching common goals, as well as training and development co-operation that benefits the entire project network.

A look at the training and research co-operation brings up questions about evidence-based practice in Home Care 24h. In this practice-oriented development process, many ways to spread researched information and to apply it to the development of home care practices have been discovered. Information based on expert experiences, as well as information based on customer needs and wishes, and on operational environments have been produced in theses that can be used in the development. The thesis processes have been challenging to the students, but the usability of the results and appreciation have been a source of joy for all participants. Using researched data is a multi-phase process in work communities and requires continuity, which emphasises particularly the roles of nursing superiors and expert nurses in applying and spreading this information to develop everyday practices further. The superiors are in a central position in securing the knowledge-related competence and in developing an attitude that favours research. It is also important to strengthen the opportunities of graduating social and health care professionals to use scientific data and their own research-oriented approach in everyday practices.

The thesis processes and the training processes in Home Care 24h have been rewarding for the students. They have gained varied work community competence and co-operation competence and courage to dive into new challenges. Positive encounters and appreciation mediated by a future colleague have been significant in the co-operation. Several goals to develop competences have even been surpassed. The students describe their experiences of the joint field trips as "wonderful shared learning opportunities", which thought all participants find easy to relate to. The co-operation between students in responsible positions in the project has been natural and reliable; mutual learning, encouraging towards new ideas, establishing new, personal working life connections and network partnerships. The students have experienced these opportunities as inspiring and significant for their future careers and project co-operation competence.

Careful estimates can be made that systematically implemented training and research co-operation can inspire towards development, and towards strengthening professional expertise and competences on a wide scale. Continuity is necessary for systematic training and research co-operation, and this can be further developed also in the Home Care 24h process regarding the future development challenges in co-operation.

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ON THE PATH OF A DEVELOPMENT PROCESS – SUPPORTING THE TEAM LEADERS OF A DEVELOPMENT PROJECT

Tuula Kukkonen

SUPPORTING THE DEVELOPMENT PROCESS OF TEAM LEADERS

To support the work of the Home care 24h team leaders, a process was designed that aimed at supporting the team leaders in leading the development, and at providing time and space for their reflective work during the process. To be precise, the whole process was not designed before it was started. The two first meetings were agreed on and, after that, the work continued. The aims and implementation were specified during the planning stage of each meeting. This suited the ideology of process development (Vataja & Seppänen-Järvelä 2006, 219) well, in my opinion: the development process develops in the course of time, so it would be fruitful for the supporting work to develop along the lines of this time. The gardener does not drill holes in the three trunk and plant new branches to get an apple tree of his liking – or knowledge – but rather supports the natural growth of the branches that grow from the trunk, giving only a gentle push towards the desired direction.

In this article, I will chronologically peruse the process that was created to support the work of the team leaders. The process started in February 2009 and continues until January 2011, but the time period under examination now ends in September 2010. The point of view is that of an outside expert and the object of interest are specifically the observations the team leaders brought with them, and the experiences in the progress and management of the development process. I believe that these matter to others involved in development as well. Being an outsider was, for me, being an outsider to the project as well as its contents without any expertise. In other words, I did not have any other role in the project and did not know the contents of the project better than an "all-rounder in social and health care issues". The starting point of this work was, hence, fruitful; there was enough distance for the focus of the examination. On the other hand, I was, naturally, pondering whether we would find a shared discussion space somewhere between the team leaders' reality and mine.

Hence, I found it important to emphasise the process nature of the development work. Considering that development always happens in a context and is tied to its actors. In the context of work communities, Seppänen-Järvelä and Vataja (2009) refer to this actor-dependent development with the concept 'work community based process development'. I also wanted to examine the development from the point of view of learning, as developing something new is always a learning process. The goal

was to introduce future and resource oriented thinking to the examination: building on successes and resources with the development objective in mind. Experiential learning was the pedagogic clue (see. e.g. Nevgi & Lindblom-Ylänne 2003, 94): I wanted to build the work strongly on the experiences of the participants. I also hoped that the shared working times would create spaces in which joint learning experiences would be possible.

THE TWO FIRST SESSIONS: PROCESS DEVELOPMENT AND SUCCESS ANALYSES

The two first sessions were dedicated to exploring the general questions of the development that were then connected to the project and its development challenges. The themes were:

a) viewpoints for development,
b) a wise developer produces effective development,
c) the results and effects of development, and
d) the significance of assessment in development.

Keskustelimme We discussed process development and actor-dependency, development as learning (Seppänen-Järvelä 2009, 39), the viewpoint of shared learning (Wenger 1998), the networking viewpoint to development (see e.g. Karjalainen 2006), and managing development work (Niiranen et al. 2010, 138-140). As to managing development, attention was paid to an approach that integrates viewpoints of developing basic work, development work, work wellbeing, and competences. With these themes, I wanted to emphasise the process nature of development, as well as the significance of actors' commitment, participation, and inspiration to the progress of the process. In addition, change was considered, after all, it is what development always aims at in one way of the other, as were accumulation and continuity of development. In this case, it was also necessary to touch upon the question of good practices and their transferability (Arnkil et al. 2005, 640). As to assessing the development, we focused on the self-evaluation of the process as a part of the developer's work.

For examining the development process, points of reference were sought after from the team leaders' previous development process experiences. Guided by a pre-assignment, the team leaders described a development process they had participated in. The description summarised details of the objectives, progress, and results of the process. The development processes they discussed dealt with introducing information systems; developing team work; an information campaign; planning a treatment path; aid tool activity; changing the room and employee division of a ward; and organising basic work. After the basic descriptions, they completed a "success analysis" on the processes: they analysed what kinds of successes they had had during the process, in the results, and after the process had ended. The successes were related to continued development, openness of operation, and benchmarking. When the team leaders analysed what the successes were based on, what had affected the success, they brought up secrets of success presented in Figure 1.

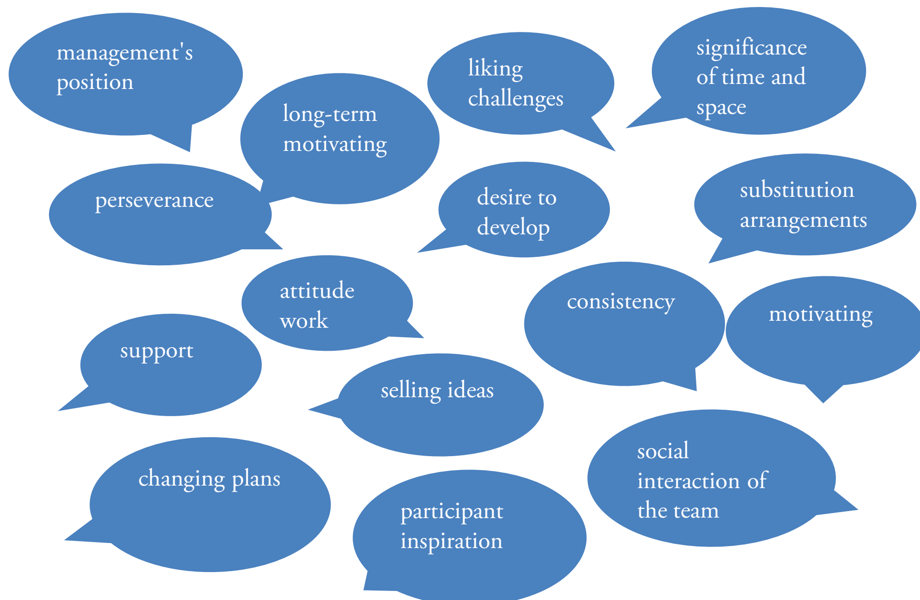

Figure 1. Team leaders' views on elements of a successful development process

The success analysis produced a diverse summary of the elements that affected success in the development processes the team leaders had experienced. It will be interesting to come back to the success analysis at the end of this development process: how will the idea be completed and, on the other hand, are there elements that proved to be less influential.

Naturally, some of the development processes were also examined from the point of view of difficulties. The challenging aspects were distributing results in a work community that works in three shifts; that the development project was given and everyone objected; lack of support from superiors; and failed timing and choice of initiating actor. In addition, sharing, continuity, and connecting with work were experienced as challenges. The development processes had brought out problems in the previous method. Communicating information had caused problems as had vitiating a process, and unlearning had also been experienced as challenging. The team leaders emphasised the importance of communication in overcoming the obstacles.

In February 2009, during discussions about the planning stage of the teams, themes that were brought up were units' commitment to development; reversing background thinking into target form; defining and focusing the central development task; sharing results of a previous project around a similar theme; and the narrative of the development. The team leaders considered the starting point of their own teams' development processes. Teaming up was still in its early stages. The development objectives of two teams were considered to partially overlap. They recognised the multitude of wishes of their teams; on the other hand, they felt that there is not much courage to write about the development objectives and that the team members get very few development ideas from their work communities. Focusing the objectives was considered

a relief. It was stated that it is good to have objectives that will be reached, but that there also needs to be objectives that are not necessarily reached; these can, however, help someone make progress. Stabilising the results of development into permanent operation occupied the team leaders at the beginning of the process.

THIRD SESSION: THE EXCITEMENT AND PRESSURES OF DEVELOPMENT

Syyskuun 2009 tapaamisen tavoitteena oli tehdä välikatsaus kehittämisprosessin etenemiseen tiimijohtamisen näkökulmasta sekä suuntautua syyskauden työskentelyyn. Kehittämisprosessin tukemiseen liittyviä tavoitteita olivat kehittämisprosessin kokemusten keskinäinen jakaminen sekä myönteisen palautteen ja kehittämisehdotusten antaminen ja saaminen. Työskentelyssä jokainen tiimijohtaja kertoi muille tiiminsä työskentelyn vaiheen. Tämän kuvauksen jälkeen jokainen tiimijohtaja kertoi tiiminsä työskentelyn kuvanneelle kollegalleen yhden havaitsemansa myönteisen asian tiimityöskentelyn nykytilasta sekä yhden tulevaan työskentelyyn suuntaavan kysymyksen tai kehittämisehdotuksen. Olen koostanut keskusteluista tehtyjen muistiinpanojen pohjalta jäsennyksen, jossa tuodaan esille myönteisiä kokemuksia ja pohdituttavia kysymyksiä nykytilasta sekä tulevia kehittämiskohteita.

Chart 1. Outline based on discussions about the state of the team work

Positive experiences of the current state	Questions about the current state	Future development areas
- networking - messages of a willingness to work together - lightness - learning process for oneself - talking about the same thing, shared focus - positive to bring the challenges of the development to the forefront - commitment - small things in the future; are really big - new partnerships - the project constantly in mind	- experiencing pressure, what should be done - the unbearable lightness of development, uncertainty, searching - the same thing developed in two teams time for development - is it going to start or should we quit - must - overloading, lay-offs - shutting down preventive work	- visibility important - communication and focus

The objective of the meeting in September 2009 was to review the progress of the process from the point of view of team leading and then orient ourselves to the work of the autumn period. Objectives related to supporting the development process were sharing experiences of the process, and giving and receiving positive feedback and development suggestions. Each team leader shared their team's situation with the others. After this description, each team leader told the colleague who described their team's situation one positive factor in the current state of the team work and one question directed to future work or a development suggestion. I have complied the discussion notes into an outline presenting positive experiences and questions about the current state and about future development areas.

FOURTH SESSION: DEFINING THE ROLE OF A TEAM LEADER

The viewpoint of the short joint session in November 2009 was learning in development. I asked the team leaders to consider the most important steps in development that had been taken and what had been learned about developing home care and also development itself. In addition, we considered what had been learned from the points of view of the operation of the development team and team leading.
The points that were raised about the experiences of developing contents included making the need for change in long-term care visible, including the viewpoints of relatives into discussions, and an outlook on constructing continuity between institutional care and home care. Discussions about pilot targets were also brought up.

The points that were raised about the operation of the development teams were realism, commitment to common development objectives, strengthening common thinking concerning the totality of the project, and outlining the objectives for 2010. On the other hand, the discussion also brought up how issues and tasks were concentrated on only a few people. The successful connection between the team leader and the team, as well as the significance of networking were noted.

In their discussion, the team leaders talked about their own role that was clearly directing towards leading the development process and team; they noted the central significance of networks in the progress of the process, "we can't do this on our own". They continued on the role of team leaders and also on making responsibilities more concrete. They also discussed that an attempt for change is not yet change; decisive, active steps are needed.

FIFTH SESSION: A PEEK A YEAR AHEAD

The aim of the session in January 2010 was to take a look at the objectives of team leading for 2010 (piloting, rooting, reporting, publications). The session was conducted by applying the "reminiscing the future" method (Arnkil et al. 2000, 162–165, 194, 198; about applying the method in customer work see Kokko 2006, 28) that focused on resources and a positive future vision. The objective was, this time, to find out and share future-oriented views about the successes of the previous year's

development process and to decide on the development objectives of the team leaders based on these. The team leaders were asked to consider the development of 2010 based on the following guidelines:

> *It is Thursday, 20 January 2011. We have gathered to a Home Care 24h project team leader meeting to take a look at the development activities in 2010. The action is mirrored to the objectives written down a year ago, that is, Wednesday, 20 January 2010. Your team reached their goals extremely well and you succeeded in leading the team beyond expectations. You are going to tell the meeting about the development in 2010 and describe the following:*
>
> - *what was done*
> - *what kinds of questions/challenges/potentials were encountered during the year*
> - *what kinds of choices and solutions were arrived at and why*
> - *what the central turning points were*
> - *which matters, actors etc. made progress and reaching goals possible*
> - *who gave you vital support crucial for the success*
> - *which things make you particularly happy*

The success drafts and preconditions to success by the team leaders are collected in figure 2.

Figure 2. Visions of success by team leaders in "reminiscing the future"

The future-oriented method proved a motivating way to concretise the project's activities that aimed at reaching the objectives of the final year. The method opened vistas to the operation of the coming year and, in addition, brought out matters related to team work and interaction between teams and team leaders. The significance of co-operation and support was strongly present, as was seeing development as a learning process and even an emotional one.

SIXTH SESSION: TURNING POINT IN PILOTING AND ESTABLISHING THE PROCESS

The aim of the meeting in September 2010 was to conduct an intermediate review of the experiences of the team leaders about developing the process and orient to the establishing stage made possible by the extended operation period. The team leaders shared their experiences in leading the development.

They felt that the operation of the teams had improved and, although they had diminished in size along the way, commitment and active participation had been a good resource. They discussed how the teams had solidified to reach the common goal and they had even felt a sense of community. The team leaders felt they had been supported in their work by the teams. The significance of team leader co-operation and interaction, as well as mutual support were discussed. An idea about an even closer peer work and support between team leaders could prove useful to the progress of the process and managing it, and to the team leaders' work.

In a way, the discussion gave an impression of a turning point in the process: the development work was progressing and the operation had become established, now it was time for a qualitatively different kind of phase that aims at continuity of results and establishing. This requires, again, new kinds of emphases and a new kind of competence. In this phase, also the expectations towards the operation of the network partners became stronger or, at least, changed: establishing the developed points presumes taking responsibility for them and combining them as a part of their own operation.

The development tools addressed at the meeting were directed at the establishing phase. The challenges of the phase were discussed through metaphors. The aim was to create memory traces about the forming of the development during its flow from the point of view of development from clearing and cultivation. The joint process path seemed clearly to have brought the actors together: although the work done by the teams is specialised around their own themes, the development is parallel and interlocked, and the experiences of team work and team leading are shared.

WHAT HAVE WE LEARNED

I asked the team leaders, the network co-ordinators, and the project workers to write down their thoughts about the support process of the development work. I asked about their expectations towards the support process, experiences and thoughts of the

jointly discussed contents, opinions about the methods, an estimate of the potential benefits to their operation, development ideas, and other thoughts about the process. I will now summarise the responses to the questionnaire completed within a unfortunately tight timetable.

The expectations for the support process are related to leading the team, getting to know other team leaders, peer support, as well as understanding one's own task, clarifying matters, and getting new viewpoints. Of the addressed contents, the responses mention the viewpoints of process development and network development. The respondents feel they have received tools for planning, developing, and assessing the reform process. It is felt that the project has become clearer and that the joint discussions have increased their understanding and decreased confusion and anxiety. It also becomes apparent that the experience of defining ones' own role and objectives has become easier thanks to the peer discussions; sharing experiences and feelings is considered significant. The project workers mention supporting team leadership, supervising the process, and supervision of work as an approach as the objectives of the process. In addition, acquiring an outsider's point of view is also seen as an objective. The project workers find the themes of team leading useful. The work is also experienced as having supervisory significance. Available peer support is also deemed significant.

The responses evaluate the methods as such that allow participation and discussion, as well as refreshing and inspiring, and using them in one's own work is also considered. Providing room for discussion and also feelings has been significant.

Development suggestions mention reserving more time for co-operation as well as support processes of team leaders and network co-ordinators. There is a definite need for more discussion – as to updating the progress of the process as well as sharing experiences and feelings.

Based on the experiences and evaluations by the participants, it appears safe to conclude that those responsible for the development process of the development project (not forgetting the project workers) who, in this case, are the team leaders and the network co-ordinator, need support to understand their own role, to discuss leadership questions of the development, to deal with questions about the development process, and to direct and focus one's own work. It is common that the work of those in charge and the their work together is focused on the content-related questions and also on operative realisation that the time and space to consider the process from the previously mentioned points of views may be minimal. The guidance of an external expert may play its part in creating a useful distance to observing: content questions will not be forgotten, but the core of the perusal are more commonly the questions related to the development process. The support process that evolves with the development process has provided good experiences in this instance, but it would be useful to plan this process as a part of planning the development process as well, and it could also produce more tightly-knit work, not forgetting the process-based nature of the work.

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WORKING AS A NETWORK CO-ORDINATOR IN THE HOME CARE 24H PROJECT

Marita Halonen

BACKGROUND

The Home Care 24h project (2008) found it necessary to have a network co-ordinator and added it to the project application. The general description of the task and responsibilities in the application was that the network co-ordinator is the contact person between the developers, actors in the palliative expert network, and the representatives of the administrative team.

The project is topical and important. During the past years, the region has seen many projects that have produced a considerable amount of additional information and good practices for nursing. The challenge has been, and still is, establishing the good practices and realising them as a part of the operation of the work communities. Network co-ordination aims at minimising overlaps and promoting the establishment of good practices into the operation of various work units.

Developing home care requires networking between special health care, basic health care, private actors, and organisations. Natural, flexible co-operation and knowing the operation potentials of one another can reduce the queue days in special health care, make basic health care more efficient, as well as quicken and promote the discharge process. Making the operation more effective results in financial gain and, from the human point of view, added value to the patient's life as home care becomes possible.

OBJECTIVES OF THE NETWORK CO-ORDINATOR

According to the dictionary of Kielitoimisto (2006) (Research Institute for the Languages of Finland) "koordinonti" ('co-ordinating') refers to organising tasks and functions, unifying into a whole, and joining (TN: translated freely). There is always a need for co-ordinating when there are dependencies between actors.

The objective of a network co-ordinator is to operate as a contact person between the developers of the Home Care 24h project, the actors of the palliative treatment expert network, and the representatives of an administrative team. The aim is to co-operate with team leaders and project personnel. The network co-ordinator is also a member of the administrative team. He/she promotes regional and inter-organisatio-

nal multi-professional co-operation and the networking of experts. The aim is to be a partner to the project developers and create something new together so that easy, modern co-operation is possible and networking skills improve.

THE TASKS OF A NETWORK CO-ORDINATOR

The tasks of a network co-ordinator are as follows:

1. Working as the network co-ordinator of the development teams of sub-projects in the Home Care 24h project
2. Using the expert network for palliative treatment and other networks supporting home care competence, and promoting networking within the development
3. Communicating information
4. Co-operating with the project personnel

The network co-ordinator joins sub-functions together, makes the project/projects known in the field of nursing, communicates information, gives advice, and participates in guiding the process. Developing and promoting the network of palliative treatment is also a particular task, as well as making the status and operation of the network stable in the region.

NETWORKS AND NETWORKING

According to Perälä and Partanen (1997), the networking of experts is desirable as, without networking, it is not possible to realise a flexible service system. By networking, the co-operation between professional groups becomes more functional, more co-ordinated, and better available for use by professional groups. The professional nursing networks and networking nurses provide one solution to the changing challenges of health care.

Nursing networks are interactive, inter-personal processes and connections, as well as development process of professional relationships that stabilise connections with other nursing employees. Networking is essentially social and hence provides a valuable framework for developing and introducing new methods to nursing. The networks are resources and tools that assist the actors in crossing organisational, professional, national or international borders. Successful networking comprises keeping in touch, keeping promises, and integrity. (Kinnunen 2001.)

The professional nursing networks are also learning environments, in which the actors can increase their professional experience and views based on the solutions made by others working in similar situations. In particular, encouraging towards re-

search-based nursing and promoting research in nursing can produce positive results in the treatment of patients. (Kinnunen 2001.)

Karila and Nummenmaa (2001) speak for networking. They have examined shared expertise, a process during which several people share intellectual resources related to knowledge, plans, and objectives. This kind of process aims at reaching something that a single expert would not be able to reach alone.

In the objectives of the Finnish Nurses Association, the basis for professional nursing networks have, in general, been related to developing nursing, improving the quality control of nursing, and examining the professional readiness of nurses. Based on Kinnunen's (2001) literature review, the purposes of networks are related to communication; discovering mutual needs and interest; developing nursing; sharing ideas, knowledge, and innovative solutions; and getting support. According to studies, networking has also supervisory dimensions in nursing.

WORKING AS A NETWORK CO-ORDINATOR

Working as a network co-ordinator has been working with interfaces and trying to see what has been done in previous projects, how these results can be used, and how the development can be continued in the current project. In project work, the aim is to avoid overlaps and to use previous results so repetition can be avoided. There are also matters that may gain in depth and launching if repeated, and sometimes repetition is needed for launching. It may take perseverance and repetitions for some processes to succeed, and real results may not be seen until after a long time.

As the network co-ordinator, I have had the opportunity to monitor and comment on the project work extensively. By doing so, I have been able to form a clear cross-section to the Home Care 24h project, which view has made it possible to comment on the work and present viewpoints from my vantage point. In addition, participating in team meetings, if purposeful and necessary, has been possible.

The operation has consisted of participating in training, development days, meetings, and team meetings. Visits to work communities have also opened up and expanded my view of the entire field of nursing. Participating in the field trip to Denmark provided me with an international point of view and increased my understanding of the multitude of methods.

Co-operation with team leaders has also been fruitful, although the opportunities to support them and ease their work load have been limited. That I was able to participate in the team meetings even now and then made it possible to get to know the project actors and get a perspective into various work communities.

FROM THE PALLIATIVE TREATMENT EXPERT NETWORK INTO A TEAM OF THE REGIONAL ASSOCIATION OF FINNISH NURSES ASSOCIATION

Developing and maintaining an expert network founded during the Palliative treatment project (2005-2007) has been developed and network meetings have been organised approximately twice a year. The network operation has been open to everyone acting in the palliative treatment expert network and Home Care 24h project actors. In the network meetings, the participants have become familiar with different work communities and shared experiences in nursing methods and practices. Recognising each other's methods and practices is important so that they can be questioned if necessary and so that questions can be asked to lower the threshold of consulting.

The network meetings discussed the long-term operational preconditions of the network and its continuity after the actual project was over. To secure the network operation in the future as well there were negotiations about grouping into a team under the regional association of Finnish Nurses Association. So, from the beginning of 2010, a team of palliative treatment has operated in the North Karelia regional association of Finnish Nurses Association.

The objectives of the palliative treatment team are to develop and promote palliative and terminal treatment competence, clarify concepts related to palliative treatment, act for terminally ill patients, share competences by educating each other in network meetings, as well as support wellbeing at work and development by active discussions and network support. The basis of the operation is evidence-based and research-based approaches. The operation of the palliative treatment expert network continues to operate side-by-side with the team during the Home Care 24h project.

Care and nursing should be based on evidence that should use scientifically researched data as much as possible and assisting methods that have produced positive results. In decision-making that concerns the patient, the best possible up-to-date researched or empirical expert knowledge should be used. This presumes co-operation between nurses, superiors, trainers, and researchers. (Eriksson et al. 2007.)

Palliative treatment refers to an extensive, holistic view of good, symptom-based treatment of terminally ill or long-term ill patients. The International Health Organisation WHO defines palliative treatment as a holistic approach that aims at the best possible quality of life of a terminally ill patient and his/her family. The amount of patients in need of palliative treatment increases constantly as the life expectancy increases. (Holli 2005.)

Palliative treatment concerns all terminally ill and long-term ill patients with conditions such as cancer, neurology illnesses, dementing illnesses, and chronic obstructive pulmonary diseases. Chronic pain patients and chronic cardiovascular disease patients may also be included in long-term illness patients.

DEVELOPING AS A NETWORK CO-ORDINATOR

As a network co-ordinator, I have been able to work with project personnel, project actors, and other participants both together and in between. It has been a challenge to have an unclear task description and a lack of clear tasks. On the other hand, despite the allocated working time resources, it has been difficult to make the extensive field of work match the given time. The task of a network co-ordinator is included in my own work as a nurse and I have had 1-12 days of resources per semester for completing the task.

Participating in the assessment of the development has expanded my views about acting in a multi-professional team and with its endless potentials. The project actors' enthusiasm and commitment towards developing nursing has been impressive. It has also been impressive to witness the organisation of an extensive project that operates in several operational environments and comprises many actors to become a functional whole.

I have been privileged to have been able to work in the vantage point of the project, developing and growing during the task. The cross-section of the project I was able to see is significant and will provide me with a readiness to multi-form project work in the future.

PLANS FOR THE FUTURE

Working in a project makes it possible to report and establish good practices. In small units, sharing and establishing project results is clearer and easier than in large, multi-unit posts. It is topical to increase communication (newspaper interviews, articles) that will help make the project and its results known.

The network operation continues as the team of the regional association of Finnish Nurses Association developing the operation as long as there is need for it and the actors feel enthusiasm towards it. The co-operation between the cancer nurses network that formed during the Käskynkkä project (2006-2009) by North Karelia Cancer Organization and the palliative treatment network will be examined in the future. Similarly, co-operation with the memory nurses network is significant.

The Home Care 24h project will leave a significant regional trace by combining various methods and actors in an extensive manner. The entire project will develop the service structures of the project municipalities and strengthen the competence of the actors, as well as co-operation between various actors. Nursing should be developed continuously in co-operation with special health care, basic health care, private sector, and organisations. Most importantly, nursing should be developed from the starting point of its basic values which are respect and love towards a human being (Eriksson et al. 2007).

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EXPERIENCES OF THE ROLE OF A STUDENT IN THE HOME CARE 24H PROJECT

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I study Nursing Science at the University of Eastern Finland's Kuopio Campus. My major is Health Promotion and as the practical training began, I was a second year student. My training is a part of the Practical Training in Health Promotion 1 and 2. I combined the health promotion viewpoint with project work as my objective. Health and wellbeing are best promoted when decisions that concern health effects and social consequences are considered at all levels and in all sectors of society. Changing social and health problems requires an even more preventive approach than before and early intervention. Promoting wellbeing and health is based on a functional, flexible co-operation between various actors such as many authorities, organisations, and private businesses. In the future, cost management will be successful only if the increase in service demand can be held back. This will be realised best by promoting health and wellbeing, as well as by preventing problems (Ministry of Social Affairs and Health 2006).

At the beginning of the training period, I already had some experience in various projects and working in them, so my aim was to deepen this knowledge and acquire a readiness to work in development in the future as well. During the training period, I was offered an opportunity to work as an area co-ordinator in the "Ehkäise tapaturmat" project (accident prevention). I felt these two projects have had a great significance in my development in project work in particular and related special features. My primary objective at the end of my training was to develop my competence in compiling different kinds of funding applications and especially having clarity about the special features an EU-funded project introduces.

Multi-professional co-operation has recently been esteemed more also in nursing development. Considering the experiences of various professional groups has been regarded as important in holistic nursing. In work communities, we need to actively listen to the employees and include them in decision-making, as well as consider justice and other ethical values. These are essential elements also in promoting the health and wellbeing of work communities. In Finnish working life, it is important to pay attention to the increasing communal management that finds everyone's work, responsibility, and participation important. Pietilä (2009) is happy to discuss a method in which managing nursing is based on a more close-knit multi-professional co-operation and health promotion than today. This shows as appreciation between professional groups and so is also reflected into good quality patient and customer work. This method would also use the competence of health care professionals better than before. We have a good nursing training that makes multi-disciplinary co-operation and social influencing possible.

During my training period, I had the opportunity to meet several individuals working in the project as well as project partners. In the development and team leader meetings, I have had great experiences of the operation of teams and how wonderful these groups have been as to innovations and inspiration to develop new activities and operational models. The discussions have been fruitful and educational. This learning I have been able to use in my own work. The operation of different kinds of networks has also become familiar and I have deepened my understanding about the importance of networks as well as multi-professional co-operation. The operational environment of the project has taken form only when compiling a piloting plan, so the understanding of the participating organisations and their operation has become clear along with it.

Co-operation with the surrounding municipalities plays an important role. They find it difficult to organise a well-operating health care system by themselves, especially in the current economic situation. The new health care law provides that sensible co-operation takes place between small municipalities, for instance, as it presents the minimum amount of inhabitants living in the area of a health care district is 150 000. (Ministry of Social Affairs and Health 2008) During my training period, I have found out rather well, in my opinion, what kind of special competences and skills co-operation between municipalities requires. I have also learned to understand what kinds of obstacles and prerequisites there are in developing co-operation between municipalities of different sizes. Project workers need to be persistent and firm in these conditions. Perhaps the most difficult part of this project work has been to be able to handle the disappointments that spring from the fact the most municipalities do not, by any means, want to or are able to participate in the project. This I have also noticed in my own work.

Guided participation is a learning situation and a process in which the individual learns skills and information that he/she can use in various situations. In this process, the skills, views, cultural habits, and values may change (Peavy 2004). Learning is a process in which new information is refined so that it becomes usable in practice, for example. I have had an excellent opportunity to learn and gather experiences in working in a project, as well as to apply this knowledge in practice immediately. I feel I have benefitted in the best possible way during these months that I have been doing my practical training in Home Care 24h.

Compiling the pilot plan for the project was also a very eye-opening experience. It was a surprise that it took such a long time. As a learning experience, however, this was an important insight, especially from the point of view that this kind of work should be given lots of time and that the use of time should also consider possible surprises such as sick leaves and other such matters that may slow down getting important information.

In guided participation, one is not required to tell what to do and how to do it, but it is rather an interactive learning process (Peavy 2004). During my training, I have experienced that my work experience and experience gained in different kinds of projects has been useful also for other actors in the project. My experience in developing home care and the so called Kotka model has been received well, and we have also been able to compare the operational models and development needs in both areas. Learning has, thus, been reciprocal as well.

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The participants in the project are the Joint Municipal Authority for Medical and Social Services in North Karelia; cities of Joensuu, Kitee, Lieksa, and Outokumpu; municipalities of Heinävesi, Ilomantsi, Kontiolahti, and Liperi; private nursing homes Apilarinne and Omena Oy from Ilomantsi, Pikkupiha (co) from Tohmajärvi, Piritta Oy from Joensuu, Kultarinki Hoivapalvelut Oy / Hoitokoti Merilä from Lieksa, Johanneskoti Oy and rehabilitation, training, and housing centre Leväniemen toimintakeskus form Heinävesi, Kanervikkola-koti Oy from Kitee, Tuuliharjun Hoiva Oy (Hyvinvointikeskus Tuuletar) from Uimaharju; night nursing provider Mummon Turva Oy from Joensuu; and North Karelia Fire and Rescue Department. The following organisations participated in the project: Joensuunseudun Omaishoitajat ja Läheiset ry, Pohjois-Karjalan Dementiayhdistys ry and North Karelia Cancer Organization. Perhehoitokoti Mielikki from Joensuu, Lieksan Pietari-apteekki (a pharmacy) from Lieksa, and various nursing and communication technology businesses were a part of the expert co-operation.

The articles in this publication describe the participants' experiences in developing round-the-clock home care in North Karelia region from different points of view. The contents comprise themes such as the structural change of social and health care services and its significance to development; hospital-level level home care and introducing intensive home care; the status of rehabilitation now and in the future; terminal treatment at home; technology in home care; and the significance of private businesses and organisations in round-the-clock home care. In addition, training and research co-operation, a student's and a network co-ordinator's experiences of development, and the progress of development and its support processes are presented.

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