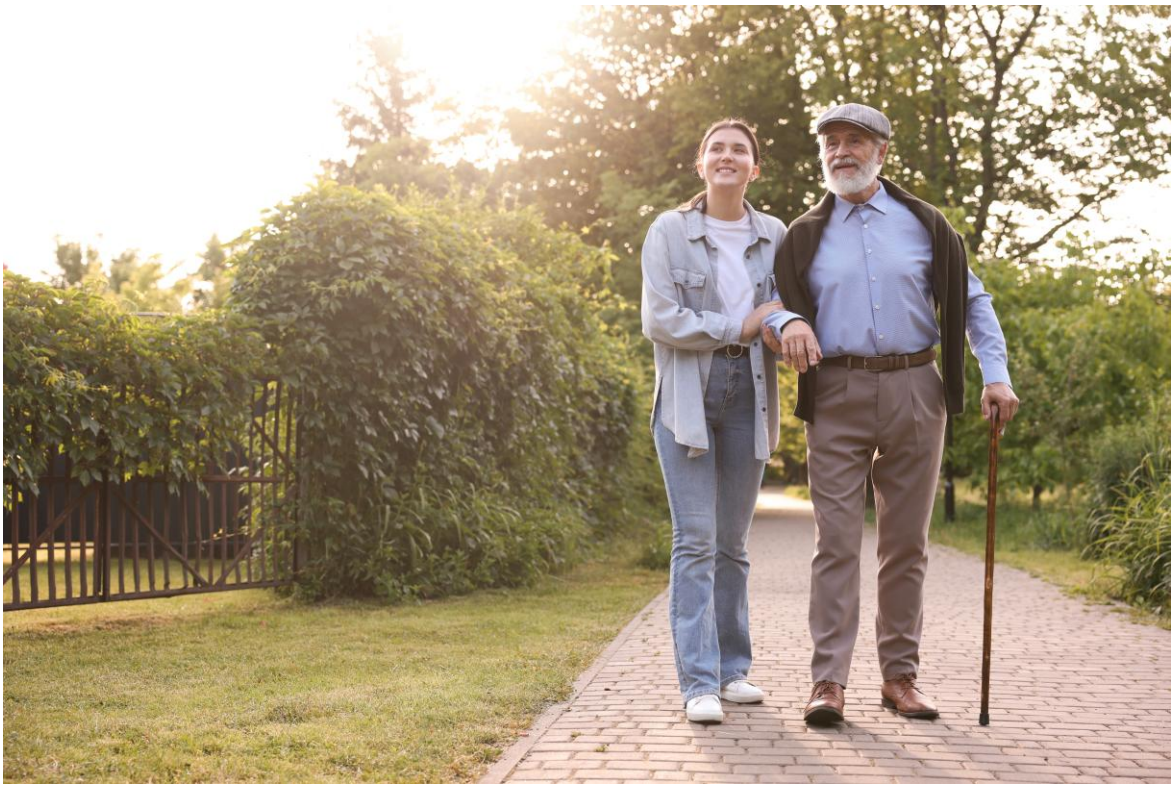
Hotus



Home care supporting the agency and rehabilitation of older people

NRF Clinical Practice Guidelines™

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The members of the guideline working group and the expert group have no interests related to the topic of the guideline from which they would benefit financially or that could affect the reliability of the guideline.

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Introduction

Services for older people in Finland are governed by legislation and national policies that emphasise needs-based provision and the maintenance and promotion of functional ability. Key legislation includes the Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons[1], the Social Welfare Act[2] and the Constitution of Finland[3].

National programmes and quality recommendations emphasise supporting the wellbeing, health, functional ability, and independent functioning of older people and enabling them to live in their own homes for as long as possible[4,5]. The Quality Recommendation to Guarantee Active and Functionally Capable Ageing and Sustainable Services 2024–2027 places particular emphasis on maintaining functional ability and preventing its decline[4]. The national action plan for rehabilitation, in turn, sets out the key principles of rehabilitation for older people[6].

The reform of the health and social services system, the establishment of the wellbeing services counties in 2023, and ageing population have increased the importance of home care. In 2024, approximately 13 percent of people aged 75 years or over received regular home care services. The proportion of home care clients has declined in recent years despite an increase in the need for services.[7]

The aim of home care is to support older people in managing everyday life and living at home through multidisciplinary practice[8]. Person-centred, systematic home care that promotes functional ability is the primary means of supporting older people to manage in their home environment[9]. This can be delivered through reablement-oriented care, in which home care professionals play a central role, as they are familiar with their clients' everyday lives and individual needs[10]. Care should be person-centred, goal-oriented, systematic, and based on the assessment of functional ability[9].

National recommendations on the assessment of functional ability and previous clinical practice guidelines published by the Nursing Research Foundation (Hotus) emphasise the promotion of functional ability and agency in home care[11–17]. This clinical practice guideline complements previous national recommendations by presenting up-to-date scientific evidence on home care that promotes agency and reablement in older people.

Purpose and aim of the guideline

The purpose of this clinical practice guideline is to present evidence on home care that promotes agency and reablement in older people, based on critically appraised scientific research, and to provide national evidence-based recommendations for use in home care and in supporting older people to live at home. In addition, the guideline describes how shared agency enables reablement-oriented home care within the shared practice environment of the older client and the home care professional.

The aim of the clinical practice guideline is to harmonise evidence-based care practices that promote agency and reablement among older home care clients and to support their consistent nationwide implementation.

Scope of the guideline

This clinical practice guideline concerns older people who receive regular home care services from a public or private service provider in their own home environment, that is, a private dwelling or accommodation and living environment regarded as their home. The guideline focuses on promoting agency and reablement among older home care clients within the home care setting.

Target groups

This clinical practice guideline is intended for all health and social care professionals working in home care who undertake nursing and care duties either independently or as part of a multidisciplinary team. In addition, it may be used by people without health or social care qualifications who support an older person in everyday life and in the home environment, such as informal supporters. In this guideline, informal supporters refer to both people close to the older home care client and various volunteers. The guideline may also be used as educational material and in curriculum development for initial vocational education and continuing professional development in health and social care.

Key concepts

Older home care client

An older person is defined, without an age threshold, as a person whose physical, psychological, cognitive, or social functional ability has declined due to age-related changes, an increase in the number or severity of illnesses, or injuries[1]. Declining functional ability and the associated need for assistance and support form the basis for receiving regular home care. An older person receiving home care has a care and service plan, which should include measures to maintain and promote functional ability in the person's own living environment[9]. In this guideline, the definition of an older person is based primarily on the individual's functional ability rather than solely on the age of eligibility for an old-age pension.

Functional ability and functional assessment

Functional ability refers to a person's physical, psychological, cognitive, and social capacity to manage activities of daily living that are meaningful and essential to them in the environment in which they live. An older person's functional ability is not merely an individual characteristic; it develops through interaction between the individual and the environment and depends, among other factors, on the safety and accessibility of the home, social support, and available services. Functional ability and the ability to manage everyday life can be supported through environmental factors, collaboration with the older person, support from other people, and health and social care services.[18]

The assessment of functional ability is a statutory prerequisite for granting services and benefits and for planning and monitoring care and services[1,2,19]. In addition to physical, psychological, cognitive, and social functional ability, the assessment of an older person's functional ability must consider the safety of the home, accessibility of the living environment, and availability of local services. The Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons calls for the use of the RAI assessment system when assessing an older person's service needs and functional ability. The assessment of functional ability provides the basis for planning care and services but does not, in itself, describe how functional ability is realised in everyday life[1,2,11,18,19]. In this clinical practice guideline, the realisation of functional ability is described through the concept of agency.

Assessment of functional ability and functional ability data as the basis for reablement-oriented home care

Reablement-oriented home care is based on consistent and reliable data on functional ability.

- The functional ability of an older home care client is assessed comprehensively in collaboration with the client.
- Reliable assessment instruments suitable for older home care clients are used in the assessment (Table 1).
- The RAI assessment system is required by law in social care services and needs assessments and may be supplemented with other instruments (e.g. the SPPB to assess mobility).
- Assessment instruments support the formulation of individual goals and plans as well as regular monitoring.
- Regular assessment using consistent instruments enables the delivery of reablement-oriented home care and the monitoring and evaluation of its effectiveness.
- In reablement-oriented home care, the assessment of functional ability forms part of home care professionals' duties and working time.[17]

Table 1. Examples of instruments for assessing functional ability in home care[16,17,20]

Area of assessment	RAI assessment instrument	Functional ability assessment instrument
Physical functional ability	Balance and mobility • 4-metre walk • Longest distance walked • Balance difficulties • Walking difficulties	Short physical performance battery • SPPB (Short Physical Performance Battery) Mobility assessment instrument • EMS (Elderly Mobility Scale) Handgrip strength
Activities of daily living	Basic activities of daily living • ADL-H (Activities of Daily Living Hierarchy) Instrumental activities of daily living • IADLCH (Instrumental Activities of Daily Living Capacity Hierarchy Scale)	Barthel Index IADL (Instrumental Activities of Daily Living)
Risk of falls	Falls during the past 30 days	Brief falls risk assessment FRAT (Fall Risk Assessment Tool) FROP Com (The Falls Risk for Older People in the Community)
Psychological functional ability	Depression symptom scale • DRS (Depression Rating Scale)	Geriatric depression scale • GDS-15 (Geriatric Depression Scale)
Cognitive functional ability	Cognitive performance scale • CPS (Cognitive Performance Scale) Extended cognitive performance scale • CPS2 (Cognitive Performance Scale 2)	MMSE (Mini Mental State Examination) MoCA (Montreal Cognitive Drawing Test)
Social functional ability	Social engagement • ISE (Index of Social Engagement) • SES (Social Engagement Scale)	SPS (Social Provision Scale)

Agency (human agency)

Agency refers to the reciprocal relationship between an individual and the environment. It is manifested in everyday activities and situations in which a person is not merely subject to their circumstances but is also an active agent who makes choices and influences their own life within the opportunities available to them[21–23]. Agency is not a permanent characteristic; rather, it is shaped situationally through the life course, experiences, interpersonal relationships, and the opportunities or constraints provided by the environment. Therefore, it may vary across situations and over time[21,24,25]. Agency differs from functional ability, which refers to relatively stable and assessable individual characteristics and capacities for functioning, including physical, cognitive, psychological and social functional ability[8,26]. The concept of agency, by contrast, emphasises an individual's opportunity to make choices and decisions about their own actions and to participate in decisions concerning them, rather than having their actions determined solely by external structures such as norms, instructions, or routines. For this reason, agency is a central perspective in person-centred home care.[8,21,22,27-29]

In home care, agency is constructed through interaction between the older person and the home care professional, described as shared agency. Shared agency emerges through joint negotiation, learning, and coordination of activities in the older person's daily environment[25]. In practice, this means that the home care professional makes situation-specific professional judgements between home care guidance and the individual needs of the older client. This strengthens the client's active participation and agency, which may be manifested as shared transformative agency in everyday practices. Shared transformative agency encompasses that home care professionals and older clients jointly question existing practices, take initiatives, and develop new ways of working to improve their shared situation.[21,25,27,30] In this clinical practice guideline, shared agency—and the shared transformative agency that may emerge in reablement-oriented home care—is regarded as a key prerequisite for home care that maintains and promotes functional ability.

Home care

Home care refers to an integrated health and social care service provided at a person's place of residence, home, or equivalent setting[2,19], comprising both home help services and home nursing[31]. Home care supports and assists people who, due to illness or reduced functional ability, require help with daily tasks and personal activities such as hygiene and nutrition.[9] Home care clients may be of different ages, including young disabled people. In this clinical practice guideline, home care services are directed at older home care clients. Home care professionals are primarily practical nurses, home care workers and home helpers, as well as registered nurses and public health nurses[9].

This clinical practice guideline uses the terms **home care professionals** and **nursing staff**. Home care professionals refer to multidisciplinary health and social care professionals working

in home care. This group includes nursing staff, which in this guideline refers to nursing professionals, such as registered nurses and practical nurses.

Home care forms part of the broader range of services provided at home. Supplementary support services of home care are often the first services offered to support the functional ability of older people. These include cleaning, meal and errand services, as well as services that promote or support participation and social interaction. Where required, home care may also include home nursing needed by the older person, and services may be provided around the clock.[32]

Reablement-oriented home care

In this clinical practice guideline, reablement-oriented home care refers to home care that promotes an older client's agency and functional ability through nursing interventions delivered by home care professionals and, where necessary, through multidisciplinary collaboration at the interface between rehabilitation and nursing.

The purpose of reablement-oriented home care is to promote an older person's agency across the different domains of functional ability and to maintain independence in daily tasks and mobility within their own living environment[33,34]. Reablement-oriented home care is based on interaction between the older person, their close persons, and professionals, in which professionals use nursing interventions to support the older client in achieving their reablement goals. Reablement-oriented home care comprises an assessment of functional ability performed with the older client, the setting of reablement goals, planning, implementation, follow-up assessments, and revision of the plan. Achieving the goals requires both the older client and home care professionals to commit to promoting reablement.[35,36]

In reablement-oriented home care, the older client's functional ability and agency are closely interrelated, as their physical, psychological, cognitive and social resources, together with the conditions of their living environment, influence how they are able to act, participate, and make decisions about everyday life in their own home[8,21,29]. Agency is manifested as a way of living and acting that has developed over the individual life course and manifests in concrete activities and the associated choices, decisions, negotiations, and forms of participation in everyday home care[21,24,28].

Models for supporting the functional ability of older home care clients are defined in various ways nationally and internationally. In recent years, the multidisciplinary reablement model has become increasingly common both in Finland and internationally. Under this model, the older client's functional ability is supported during a time-limited period based on their own goals and delivered through collaboration between nursing and rehabilitation professionals. To harmonise the concept of reablement, 82 professionals from 11 countries developed a shared international definition[33]. According to this definition, reablement is a holistic, person-centred model that takes account of the older client's needs and goals. It aims to strengthen the individual's physical and/or other functional

ability, increase or maintain independence in meaningful activities of daily living within their own living environment, and reduce the need for long-term services. The model is suitable for everyone, irrespective of age, diagnosis, or care setting.[33]

Reablement-oriented nursing delivered regularly in home care and time-limited multidisciplinary reablement interventions complement one another. Reablement-oriented nursing is a working method and practice framework particularly for nursing staff working in home care, and it is used both in home care and more broadly across nursing settings. Multidisciplinary collaboration supports its implementation.[37] In this Hotus Clinical Practice Guideline®, reablement-oriented home care is understood as continuous and systematic practice by home care professionals, comprising both regular reablement-oriented nursing in home care and periodic multidisciplinary reablement.

Recommendations

1. Reablement-oriented home care clients and staffing resources

The organisation should establish consistent procedures for identifying clients who may benefit from reablement-oriented nursing, because

- **the evidence is uncertain, but it suggests that home care professionals consider clear organisational policies and practices important for identifying clients who may benefit from reablement-oriented home care[38]. (C)**

  - Home care professionals have reported that it is important to identify, at organisational level, those older clients who may benefit from reablement-oriented nursing and refer them to reablement-oriented home care. Declining functional ability and reduced physical activity should be identified as early as possible. A clearly defined model for reablement-oriented home care and consistent eligibility criteria are key to reaching older people for whom reablement-oriented nursing is most appropriate.[38]

  - The guideline working group recommends using validated assessment instruments in national use for the regular assessment of a home care client's functional ability (Table 1). Further information is available, for example, in the recommendations published by the Finnish Institute for Health and Welfare (in finnish)*: Iäkkäiden toimintakyvyn arviointi iäkkäiden kuntoutumista edistävässä hoitotyössä, Iäkkäiden henkilöiden toimintakyvyn arviointi kotikuntoutuksessa ja Iäkkäiden henkilöiden toimintakyvyn mittaaminen palvelutarpeen arvioinnin yhteydessä* [11,16,17].

The organisation should establish structures and conditions for multidisciplinary collaboration and support home care professionals in delivering reablement-oriented home care, because

- **there is moderate evidence of home care professionals considering multidisciplinary teamwork essential to the delivery of reablement-oriented home care[37–39]. (B)**

  - Multidisciplinary home care teams have perceived the principles of reablement-oriented home care as providing a sound framework for collaboration, the use of professional expertise, and shared decision-making.[37]

- **the evidence is uncertain, but it suggests that professionals delivering reablement-oriented home care consider support in their work and a positive working environment important[40]. (C)**

  - Home care professionals have reported receiving limited feedback from managers, colleagues and older clients. Being heard was considered important, although areas for improvement were also identified. Joint meetings and joint visits to clients' homes were used to improve opportunities to be heard and multidisciplinary collaboration.[40]

  - Home care professionals have identified factors such as high staff turnover and excessive workload as impairing the delivery of reablement-oriented home care.[39]

€ **The available evidence is uncertain, but it suggests that multidisciplinary reablement-oriented home care may be a cost-effective form of support[41].**

The multidisciplinary intervention was cautiously assessed to be cost effective in relation to older home care clients' self-reported activity, satisfaction with performance and home care costs[41]. However, the independent contribution of multidisciplinary working to cost-effectiveness cannot be established with certainty.

Ensuring adequate resources for the delivery of reablement-oriented home care

Adequate resources are essential when planning and delivering reablement-oriented home care. Home care professionals have identified sufficient time and staffing resources as important factors in their work. They reported being able to meet clients' needs well on a general level, although time was limited for some clients. Resource adequacy has been described as substantially affecting documentation, support for clients' independence, and the appropriateness of the reablement model.[40] At organisational level, staffing and time resources have been reported to affect the organisation of reablement-oriented home care, the identification of clients' rehabilitation needs, and the promotion of physical activity[42].

2. Building consistent competence and an enabling organisational culture

The organisation should enable home care professionals to participate in training on reablement-oriented home care, because

- **there is strong evidence of continuing professional development strengthening home care professionals' competence in reablement-oriented home care[38,40,42-44]. (A)**

  - Home care professionals have reported that training and induction—including training in supporting clients' psychosocial wellbeing—are key factors in implementing reablement-oriented practice in home care.[40]

  - Home care professionals have reported that drawing on prior competence, including rehabilitation expertise acquired through education and work experience, supports practice in accordance with the reablement model.[40]

  - Following training, home care professionals could recognise the risks associated with doing tasks on behalf of clients and the benefits that may be achieved through reablement-oriented home care, such as improvements in older people's physical fitness and self-confidence. However, some professionals have considered the reablement approach more time consuming and unsuitable for some clients due to factors such as limited motivation or functional ability.[44]

  - Methods used by home care professionals include encouraging clients and motivating them to engage in physical activity, while goal setting and involving the social network are used less frequently. Professionals have mentioned the lack of time and the perception that some activities fall outside the professional's role as reasons for opting out of these methods. Continuing professional development can remind professionals to apply reablement-oriented home care more consciously and consistently, even when they are already familiar with the skills.[44]

  - Home care professionals have reported that competence in reablement-oriented home care and staff motivation promote physical activity among older clients. It is essential that professionals know their clients, receive training in reablement-oriented home care and have sufficient professional experience. Professionals have identified inadequate competence and motivation as barriers to promoting physical activity among older people.[38]

- **the evidence is uncertain, but it suggests that home care professionals perceive greater competence in reablement-oriented home care as increasing confidence in their own skills[44]. (C)**

  - Following continuing professional development in reablement-oriented home care, professionals reported applying a reablement approach more actively and consciously. However, some professionals found it challenging to motivate clients, for example when a client was unwilling to participate in activities.[44]

- **the evidence is uncertain, but it suggests that greater competence in reablement-oriented home care increases job satisfaction among home care professionals[43]. (C)**

The organisation should support home care professionals in adopting the mindset and working culture of reablement-oriented home care, because

- **there is moderate evidence of home care professionals perceiving the transition to reablement-oriented practices as requiring an active change in mindset[37,45,46]. (B)**

  - Members of multidisciplinary reablement teams have reported that multidisciplinary reablement-oriented home care required a new way of thinking and working, representing a change in working culture. This perspective transformed the older person from a passive recipient of assistance into an active participant. Home care professionals emphasised the importance of a shared vision both within the team and when working with older people.[37]

  - Home care professionals have expressed that reablement-oriented home care requires balancing a reablement approach with consideration of the older person's resources. They seek to support independence while also considering the older person's stamina and wishes.[47]

- **there is moderate evidence of home care professionals considering reablement-oriented home care meaningful both in their own work and at societal level[40,46]. (B)**

  - Home care professionals have applied their experiences of the reablement approach in everyday home care. As their skills and experience increased, support for older people's participation in everyday activities was strengthened. Professionals reported that changes in thinking and practice had positive effects on older people's lives and that integrating a reablement approach into routine daily work promotes lasting and sustainable change.[46]

- Home care professionals have
    - found reablement-oriented home care rewarding because it enabled them to support older people's social, physical, psychological, and emotional independence and provided experiences of success and meaningfulness. Supporting older people's independence increased staff members' professional satisfaction.[42]
    - considered the reablement-oriented home care model societally important. In their experience, the model generates savings and contributes positively to the use of societal resources. In addition, professionals regard the model as essential in the future due to the ageing population.[40]
    - reported that reablement-oriented home care manifests a change in their professional role, with nursing increasingly emphasising guidance, encouragement, and support for client independence rather than the traditional caregiving role[48].

➢ **the evidence is uncertain, but it suggests that home care professionals perceive motivation and doing activities together as supporting reablement-oriented home care[39]. (C)**

- Home care professionals have reported that observing older people perform tasks independently can at times be difficult. Restraining the impulse to help and enabling purposeful practice may evoke conflicting emotions and uncertainty about their role in reablement-oriented home care. The transition from helping an older person to enabling their activity may cause confusion, and encountering related conflicts and uncertainty may result in mixed experiences of working in reablement-oriented home care.[46]



3. Implementing Goal-Oriented Reablement in Home Care

The reablement-oriented home care process

- **Assessment of functional ability**

  The functional ability of an older home care client is assessed using the RAI assessment framework[49] and functional ability assessment instruments.

- **Goals and plan**

  Together with the client and, where appropriate, their informal supporters, home care professionals formulate individual, measurable, time-bound and achievable reablement goals and a plan based on the assessment of functional ability.

  These are

  - documented in the care and service plan
  - updated in conjunction with monitoring and reassessment of functional ability.

- **Implementation**

  Home care professionals deliver reablement-oriented home care in accordance with the plan and in collaboration with the client.

- **Monitoring and evaluation**

  Functional ability is assessed regularly, and the goals and plan are updated

  - when functional ability changes
  - after a hospital admission
  - at least every six months.

Consider interaction at every stage of the reablement process. Encounters between the older home care client and the home care professional, in which shared agency is realised, are central to promoting the older person's reablement and functional ability.

Set reablement goals in collaboration with the older home care client based on the client's own wishes, resources, and life situation, because

- **the evidence is uncertain but suggests that, in the view of home care professionals, individually defined goals support the delivery of reablement-oriented home care[37,39]. (C)**
  - Older home care clients have reported that goal setting in reablement-oriented home care may be less suitable for people with a progressive illness or those adjusting to permanent disability.[50]

- **the evidence is uncertain but suggests that home care professionals perceive individually defined goals as supporting an older client's functional ability[38]. (C)**

Deliver reablement-oriented home care in accordance with the older client's goals, because

- **there is strong evidence of reablement-oriented home care reducing older clients' need for services[51–54]. (A)**

- **there is moderate evidence of reablement-oriented home care supporting older clients to continue living at home[54,55]. (B)**

- **there is moderate evidence of older clients perceiving reablement-oriented home care as improving their quality of life[43,51]. (B)**

- **the evidence is uncertain, but it suggests that reablement-oriented home care reduces the number of older clients' emergency department visits[54]. (C)**
  - Clients receiving reablement-oriented home care rated both their overall quality of life[43] and their health-related quality of life[51] higher than clients receiving usual home care.

€ **The available evidence suggests that reablement-oriented home care may generate cost savings[53,56] and be cost effective[41] by reducing the need for home care.**

Reablement-oriented home care interventions were found to reduce the need for home care services[41,53]. In addition, the intervention produced savings in home care costs[53] or in combined home care and hospital care costs[56]. Furthermore, there is evidence of cost-effectiveness when considering older home care clients' self-reported activity, satisfaction with performance, and home care costs[41].



4. Respectful and individualised encounters

Treat the older client receiving reablement-oriented home care as a valued and equal person, because

- **the evidence is uncertain, but it suggests that older clients regard home care professionals who value them and adopt a positive attitude towards them as important to their health and reablement[57]. (C)**

Take account of the older client's medication and long-term conditions in reablement-oriented home care, because

- **the evidence is uncertain, but it suggests that older clients perceive pharmacotherapy and fluctuations in the symptoms of long-term conditions as complicating the delivery of reablement-oriented home care and the assessment of benefits achieved[58]. (C)**

Strengthen the older client's sense of safety and trust in home care professionals, because

- **the evidence is uncertain, but it suggests that older clients' feelings of insecurity and mistrust may hinder the delivery of and engagement with reablement-oriented home care[58]. (C)**

  - Mistrust of home care and home care professionals experienced by older clients hindered the delivery of reablement. Adverse experiences and care-related errors reduced engagement and undermined trust in the healthcare system, constituting a key barrier to successful reablement.[58]

Deliver reablement-oriented home care in a client-oriented manner, placing the older client at the centre of care planning and delivery, because

- **there is moderate evidence of person-centred reablement-oriented home care requiring a respectful approach responsive to individual needs, thereby strengthening older clients' experience of participation[42,59]. (B)**

5. Supporting and promoting physical functional ability

During home visits, guide and encourage the older home care client to perform individualised, goal-oriented physical exercises, such as sit-to-stand exercises and walking, regularly at home, because

- **there is moderate evidence of regular exercise training provided as part of home visits improving the physical functioning of older home care clients[60–62]. (B)**

- **the evidence is uncertain, but it suggests that individually tailored home-based exercises and training guided by home care professionals help older home care clients maintain their walking speed[63]. (C)**

Use remote exercise programmes as an option for supporting the physical functional ability of older home care clients, because

- **the evidence is uncertain, but it suggests that regular participation in home-based remote exercise programmes improves the physical functioning, walking speed, and muscle strength of older home care clients[64]. (C)**

During home visits, encourage the older home care client to be active in physical exercise and activities of daily living, because

- **there is moderate evidence of goal-oriented home care that encourages physical activity increasing the physical activity levels of older home care clients[54,65]. (B)**

- **the evidence is uncertain, but it suggests that regular, goal-oriented practice of activities of daily living improves the physical functioning of older home care clients[52]. (C)**

  - The guideline working group encourages home care professionals to consider the following approaches during home visits to support the achievement of home care clients' own goals, to enable the performance of activities of daily living to the highest possible degree of independence, and to promote clients' functioning:
    - enabling the practice of basic activities of daily living, for example during bathing, dressing, eating, and transfers
    - enabling the practice of instrumental activities of daily living, for example by facilitating participation in meal preparation, household tasks, and community errands

Encourage the older home care client to continue exercising their physical functional ability independently after an intensive period of home-based rehabilitation, because

- **the evidence is uncertain, but it suggests that older home care clients find independent exercise challenging after completing a period of home-based rehabilitation[66]. (C)**

  - Older clients reported that regaining a sense of control over their daily lives and flexibility at the end of a home-based rehabilitation period was rewarding. They recalled the home-based rehabilitation period as a busy time involving regular visits from home care professionals. However, some older clients found it challenging to continue physical exercise independently after the home-based rehabilitation period.[66]

Where possible, encourage informal supporters to support the older home care client's activity and participation in everyday activities at home, because

- **the evidence is uncertain, but it suggests that a positive attitude and support from informal supporters, together with an environment that encourages activity, promote a physically active lifestyle among home care clients[38]. (C)**

  - According to home care professionals, the physical environment can both facilitate and hinder increases in physical activity among older home care clients. They reported that making the living environment too easy to navigate (for example, moving to an apartment building) may reduce the activity levels of older people. Conversely, steep stairs, long distances, and challenging weather conditions may constitute significant barriers to physical activity and limit older people's participation in activities that are meaningful to them.[38]

€ **The available evidence suggests that supporting and promoting physical functional ability as part of home visits may generate cost savings[53,56] and may be cost effective[41].**

Interventions supporting and promoting physical functional ability were estimated to generate savings in cumulative home care costs, that is, costs accrued over the assessment period[53,56]. In addition, there is evidence of cost-effectiveness when older home care clients' self-reported activity, satisfaction with performance, and home care costs were examined[41]. Supporting and promoting physical functional ability may play a key role in generating cost savings or improving cost-effectiveness, although its independent contribution cannot be determined with certainty on the basis of this evidence.

6. Supporting agency in activities of daily living

Deliver reablement-oriented home care with a positive and encouraging approach, because

- **the evidence is uncertain, but it suggests that older clients consider an encouraging member of nursing staff and a positive atmosphere meaningful[57]. (C)**

  - Older home care clients have reported that an encouraging member of nursing staff played a central role in supporting their health. A positive manner facilitates commitment to the goals of reablement-oriented home care and creates hope. Goal-oriented practice that takes account of the older person's stamina encourages independent effort. Encouraging encounters strengthen the older person's self-confidence and sense of self-efficacy, which are often weakened following illness or injury.[57]

Use a range of reablement-oriented nursing interventions in the home care of an older client, because

- **there is strong evidence of reablement-oriented home care improving older clients' self-reported functional ability and confidence in managing everyday life[41,54,67]. (A)**
- **the evidence is uncertain, but it suggests that reablement-oriented home care increases older clients' self-reliance and independence[43]. (C)**

Explain to the older home care client what reablement-oriented home care means, because

- **the evidence is uncertain, but it suggests that older clients do not perceive performing activities of daily living as an activity that improves or maintains functional ability[68]. (C)**

  - Home care professionals have reported that some older clients are cautious about reablement-oriented interventions and primarily request practical assistance with everyday life rather than participation in reablement activities[69].

Include practising activities of daily living and everyday tasks in the individual reablement plan prepared with the home care client, because

- **there is moderate evidence of practising activities of daily living and everyday tasks as part of reablement-oriented home care improving older clients' performance in activities of daily living[52,70]. (B)**

  - When older clients are encouraged to perform activities of daily living independently, they may experience a conflict related to a preference for comfort, as this and a lack of motivation may, at times, prevent them from undertaking exercises. In addition, encouragement and guidance from home care professionals towards independence in activities of daily living may be perceived as uncomfortable or even disrespectful, which can make home-based rehabilitation challenging.[58]

  - While rising from a chair is a small action, it is the starting point for all mobility[71]. The guideline working group recommends that, during home visits, home care professionals encourage the older home care client to stand up when the client's individual circumstances permit.

- **there is moderate evidence of home care professionals perceiving reablement-oriented home care to increase older clients' independence in activities of daily living[46,69]. (B)**

€ **The available evidence suggests that reablement-oriented home care incorporating practice of activities of daily living may generate cost savings[53,56] and may be cost effective[41].**

Interventions incorporating practice of activities of daily living were estimated to have the potential to generate cost savings[53,56]. In addition, there is evidence of cost-effectiveness when older home care clients' self-reported activity, satisfaction with performance and home care costs were examined[41]. Practice of activities of daily living may play a key role in generating cost savings or improving cost-effectiveness, although its independent contribution cannot be determined with certainty on the basis of this evidence.

7. Considering and supporting informal supporters

In reablement-oriented home care, take account of informal supporters as well as the older client, because

- **the evidence is uncertain, but it suggests that informal supporters of older clients perceive reablement-oriented home care as reducing the burden associated with caring for their close person[43]. (C)**

- **the evidence is uncertain, but it suggests that reablement-oriented home care improves the physical and psychological wellbeing of informal supporters of older clients, thereby supporting their ability to cope[55]. (C)**

- **the evidence is uncertain, but it suggests that reablement-oriented home care strengthens consistent support for the older client from home care services and informal supporters[43]. (C)**



Implementation of the guideline

This national NRF Clinical Practice Guideline is intended for health and social care professionals working with older people in home care, as well as students in the field and those working in education. Furthermore, the guideline may be used by people without health or social care qualifications who support everyday life actions in the home environment, such as informal supporters.

The guideline is intended to support national programmes[6,65] and quality recommendations[4,5] and to provide a basis for decision-making and staff management by leaders in health and social care. Integrating the guideline into an organisation's or unit's operating practices promotes evidence-based practice and harmonisation of procedures. The guideline should be considered within existing structures and when developing multidisciplinary services for older people.

Implementing the guideline requires a planned, phased approach, which may include the following stages:

1. **Information and engagement:** The guideline is presented to management, line managers and staff, and the commitment of operational management is ensured.

2. **Assessment of current practices:** The organisation's current practices, competence, and resources are assessed in relation to the guideline.

3. **Developing and describing new shared practices:** Shared, concrete practices and responsibilities based on the guideline are developed and agreed (what is done, by whom, when, and how).

4. **Education and induction:** Staff competence relating to the guideline and the practices developed from it are strengthened through education, and the guideline is integrated into professionals' induction and continuing professional development.

5. **Practical implementation:** The guideline and the shared practices based on it are implemented as part of daily multidisciplinary collaboration.

6. **Monitoring and evaluation:** The implementation, delivery, and the shared practices based on the guideline are monitored and evaluated. The delivery and effectiveness of reablement-oriented home care are assessed systematically, for example, using functional ability data collected with assessment instruments, client feedback, staff surveys, and assessments of professionals' competence.

Implementation of the guideline is supported through education, participatory development, and communication within collaborative and network structures. Smooth implementation requires organisation-specific practical instructions and examples for everyday work situations. It is essential that reablement-oriented home care is understood and delivered as a shared operating model for the entire team.

Organisational management creates the conditions for implementation by setting clear goals, allocating resources, supporting staff through change, and ensuring monitoring and continuous

improvement. Evaluating practice and outcomes and using the data collected to support management are essential. For example, systematic collection and use of functional ability data enable evaluation of the guideline's implementation in practice and demonstration of effectiveness.

The FinYHKÄ implementation model™ available on the Nursing Research Foundation website may be used to support implementation of the clinical practice guideline.[72]

Benefits for home care clients

Systematic delivery of home care that promotes agency and reablement supports older clients' wellbeing, health, functional ability, agency as well as independent management of everyday life, and promotes equity in service provision. Consistent assessment practices and the use of reliable functional ability assessment instruments enable the systematic use of functional ability data, the development of practice in accordance with the guideline, and continuity of care across services. This may reduce the risk of falls, increase everyday activity, and support safe living at home.

Benefits for informal supporters

Consistent home care that promotes agency and reablement strengthens informal supporters' confidence in services and promotes their equitable inclusion. Maintaining the older client's functional ability reduces informal supporters' concerns and burden, as well as the need to participate in daily care. The experiences of informal supporters can be monitored systematically, for example through client feedback.

Benefits for professionals

Consistent practices based on the clinical practice guideline support evidence-based practice by home care professionals and strengthen their competence, thereby improving the quality and effectiveness of nursing care. Clear practices and an approach that promotes agency and reablement may improve manageability of the work. Furthermore, good functional ability and use of the older person's own resources may reduce the workload of health and social care professionals. Multidisciplinary collaboration and consistent operating models support wellbeing at work and smooth working practices. Competence and wellbeing at work may be assessed, for example, through competence assessments and staff surveys.

Benefits for society

Home care that promotes agency and reablement supports the maintenance and improvement of older clients' functional ability, which may reduce the need for home care services and postpone the need for more intensive services, such as round-the-clock care and hospital care. This generates cost savings and reduces pressure on the service system. Furthermore, it supports

the sustainability of health and social care and promotes the health of the older population and their ability to live at home.

Demonstrating effectiveness requires systematic monitoring and examination of functional ability data, service use, and costs. Overall, home care that promotes agency and reablement in older people is a key method of building an effective, cost-efficient and sustainable service system in an ageing society.

Methods

Literature search and selection of information sources

The NRF Clinical Practice Guideline is based on a systematic literature search conducted by a library information specialist on relevant databases in accordance with a search plan developed by the guideline working group.

The selection of research articles is based on inclusion and exclusion criteria specified in advance by the guideline working group. The guideline working group systematically screens the records in Covidence, first by title and abstract, and subsequently by full text. Each record is assessed independently by two members of the guideline working group. Any disagreement is resolved through consensus discussions.

From the selected research articles, the guideline working group identifies the findings central to the guideline. Thereafter, researchers at the Nursing Research Foundation produce AI-assisted translations of the findings and prepare methodological descriptions of the studies in accordance with a predefined template.

Critical appraisal

The methodological quality of the included research articles is assessed using the JBI critical appraisal criteria adapted to each study design. First, two reviewers conduct an independent quality appraisal, after which the final assessment is reached through a consensus discussion between the reviewers. The clinical practice guideline includes scientific, peer-reviewed systematic reviews and primary studies whose methodological quality is assessed as sufficient: more than 50 percent of the criteria in the relevant JBI critical appraisal checklist must be met, together with all predefined critical criteria.

Preparation of evidence summaries and recommendation statements

For each recommendation statement, an evidence summary describing the finding relevant to the recommendation statement, the methodological conduct of the study, the result of the critical appraisal, and the applicability of the research finding to the recommendation is prepared. The certainty of the evidence supporting each recommendation statement is determined by the strength and consistency of the evidence provided by the studies included in the evidence summary, acknowledging study quality and other considerations relevant to the certainty of evidence. The evidence summaries are published in Finnish on the website of the Nursing Research Foundation. In addition, the complete handbook for preparing NRF Clinical Practice Guidelines is available in Finnish on the Foundation’s website.

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