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# Family functioning, health and social support assessed by aged home care clients and their family members

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**Aims and objectives.** The aim of this study was to describe aged home care clients' and their family members' experiences of their family functioning, family health and social support received. An additional purpose was to determine which factors are connected with social support.

**Background.** Increasing life expectancy and ageing of the population require consideration of the adequacy of home care services and the role of family members as care providers. The older population is a very heterogeneous group because of their variable needs and several disabilities. To ensure the quality of home care, experimental information is needed from clients and their family members.

**Design.** A survey design with convenience sampling.

**Methods.** The home care client and a family member of his/her answered a questionnaire together, including background questions, the Family Functioning, Health and Social Support instrument and an open question about support received from home care. Statistical methods were used to describe quantitative data, and content analysis was used in analysing the replies to the open question.

**Results.** Family health was noted as good, and family functioning and overall social support fairly good. An older person's higher basic education, higher age of the family member, better family health and male gender were connected with better social support received. The relationship of the older person and the family member as well as the duration of home care service use had an effect on social support received. The content analysis raised expectations related to time, planning of service, organisational factors and caring practise.

**Conclusions.** Home care clients' and families' needs for support vary, and therefore, the assessment of needs, care planning and updating are important.

**Relevance to clinical practice.** The variable support needs of older people and their family members require flexible and adaptable home services. Cooperation between all participants involved in care would promote the well-being of the older person and the entire family.

**Key words:** family nursing, home care, older people, social support

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## Introduction

Life expectancy is increasing in many countries (Larsson & Thorslund 2006). Ageing of the population has brought about concerns on how to keep older people living at home as long as possible (Borglin 2006, MSAH, Ministry of Social Affairs & Health 2011). The majority of older people live at home and receive care at community settings. Families provide most of the care and help to older people (Schumacher *et al.* 2006, White & O'Brien 2010). The

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needs of patients and families should be the starting point in nursing care (Astedt-Kurki 2010). The older population is a very heterogeneous group with different needs and resources. The ageing process differs because of a number of reasons such as health problems, functional abilities, personal resources or the amount of social support (Borglin 2006, White & O'Brien 2010). The nursing practice needs to concentrate more on families and social networks than earlier, and the speciality of a home care context should be considered when planning care (Büscher 2007). Home care clients' and care professionals' views on practical care differs, which challenges the home care services to focus on client-driven care (Eloranta 2009). Experimental information from client's and their family members is needed to target this goal.

## Background

Finland's social and health policy strategy aims at supporting people in their own living environment. Independent living, functional capacity and participation should be advanced among older people. Starting points for services include availability, equitability, effectiveness and customer orientation (MSAH, Ministry of Social Affairs & Health 2011). In Finland, formal home care has been organised through the municipal home care system and is mainly financed from the public funding. Home care consists of one or several services, such as home-help services (e.g. assistance with housework, hygiene or moving) and home nursing and support services (e.g. meals on wheels, safety phone service, night care service) (Eloranta 2009). In 2010, regular home care was given to 61,100 people, which is 6·5% of all Finnish people aged 65 and over (THL, National Institute for Health & Welfare 2011). Informal support has a very important role too, as more than one million Finnish people (one-fifth of the population) helped a relative, friend or other person close by aged 65 or more (Kattainen *et al.* 2008).

The family is a primary group and a social institution in society. It has connections to surrounding society and links persons to a larger kinship organisation (White & Klein 2008). The family may be defined in different perspectives as based on legal, biological or emotional connections between family members (Friedman *et al.* 2003, Astedt-Kurki 2010). In family nursing, the family is usually defined in the way that the patient or customer defines his or her own family (Astedt-Kurki 2010, Kaakinen *et al.* 2010).

The most valuable nursing care is performed in partnership with families (Ekwall *et al.* 2004, White & O'Brien 2010). Family care has a significant economic value and family caregivers have become an important part of the health care system. Therefore, involvement in family care has become an essential nursing responsibility (Schumacher *et al.* 2006). Previous studies have shown that hospital at home, compared with in-hospital care, appears to increase patients' satisfaction and in many cases, reduce costs (Jester & Hicks 2003, Shepperd *et al.* 2009).

### Family functioning

Most older adults' family relationships are strong and characterised by affection, caring and exchange. This exchange of help and support continues throughout life until a very old age, when the person becomes more often the receiver than the giver. The transition of life course (deaths, retirement, partnerships) has an effect on family functioning. Intergenerational relationships are important in the family life of aged people. Only a minority of aged persons have weak social ties or are isolated from family and friends (White & O'Brien 2010).

Older people's families are usually involved in caring and helping the aged family member. The majority of family caregivers are women, and the age and health conditions of caregivers or the roles of caregivers vary a lot (Schumacher *et al.* 2006). Older people's family members, caregivers, provide different kinds of support to the aged person. The most common tasks are to be involved in preventive or supervisory care, such as preventing problems, helping with practical things outside the home or following the person to a doctor's appointment or hospital. Only less than one-fifth of caregivers help the aged person with activities of daily livings (ADL's) (Ekwall *et al.* 2004).

### Family health

Family health is seen as a continuously changing state of well-being. The biological, psychological, spiritual, sociological and cultural factors have an effect at this stage. The well-being of family members is connected with the whole family's health and functioning. Therefore, an individual's illness usually changes everyday life in the family (Astedt-Kurki 2010, Kaakinen *et al.* 2010). Most of aged people in older populations are in relatively good health and have relatively good functional abilities. In any case, normal age-related changes come with ageing and health problems increase. Despite of any difficulties they experience, aged persons may describe themselves as healthier than earlier or compared with others in same age group (Larsson & Thorslund 2006). Coping with normal life activities is an important component in older adults' perceptions of health

and well-being (Miller & Iris 2002). Family caregivers play an important role in enabling aged persons' living at home (McLennon *et al.* 2010).

### Social support

Social support has become one of the central variables in human sciences during past decades. Social support explains the effect of other people being around in situations with a person coping with stressful events or challenges of everyday life. Social support can be provided by informal sources (e.g. family, relatives and neighbours) or by formal sources (e.g. community services) (Schwarzer & Buchwald 2004). In this study, social support was described according to Kahn's definition. In this theory, social support was divided into three elements: 'Affect' describes emotional support, which refers to appreciation, admiration, respect or love and creating a sense of security. 'Affirmation' includes reinforcement, feedback and influencing the individual's way of making decisions. The third element is concrete aid, such as objects or money and spending time helping someone (Kahn 1979, Tarkka *et al.* 2003).

A social network seems to improve the quality of life among older people (Hellström *et al.* 2004). According to Saito *et al.* (2005), social support has a positive effect on well-being and health status among older adults living alone. Lyyra and Heikkinen (2006) noticed in their follow-up study a strong connection between non-assistance-related support (consists, for example, of emotional closeness, a sense of belonging) and survival in older women. Among men, perceived social support was not associated with mortality.

The purpose of the study was to describe aged home care clients and his or her family members' experiences of their family functioning, family health and social support received from home care. The second purpose was to assess factors related to the social support received. Experimental information about the families of aged people and support received is needed when developing home care and family nursing.

## Methods

### Design

A survey design was used in this research with convenience sampling. Data collection was conducted between 1 February 2011 and 30 May 2011. Home care clients from two Finnish towns and their family members participated in the research.

### Data collection

Questionnaires were delivered to 200 home care clients via home care staff. Home care service teams chose clients, who were over 65 years old, received home care services at least once a week (clients of the regular home care) and had been receiving home care for at least six months, so they were able to assess the services. The older person needed to be able to assess the queries of the questionnaire (e.g. clients who had severe dementia were excluded). The client should have had a relative/nearby person who took part in the older person's care. The older person had decided by him/herself who should be her/his closest nearby. The questionnaire was completed by the aged person and the family member together. Owing to this, aged persons with different functional capacities were able to participate and answers widely described clients and their family members experiences about home care. The questionnaire, filled in together, was sent in a postage-paid envelope by mail to the researcher. A pilot study was carried out with eight participants. Scale items were not revised after the pilot study, and thereby, the pilot study sample became part of the total sample.

### The questionnaire

The Family Functioning, Health and Social Support (FAFHES) questionnaire has been developed on the basis of knowledge in three Finnish academic nursing dissertations (Astedt-Kurki 1992, Tarkka 1996, Paavilainen 1998). The scale was designed for the study of families of heart patients, and the intention has been to modify and use FAFHES among families with other long-term illnesses (Astedt-Kurki *et al.* 2009).

The questionnaire included background variables, the FAFHES instrument and an open question about the support received from home care. The FAFHES instrument consists of three total scales: family functioning, family health and social support. The scale was of a Likert-type format of 1 (strongly disagree) to 6 (strongly agree). The FAFHES instrument's reliability and validity has been tested in two studies (Astedt-Kurki *et al.* 2002, 2009). Principal component analysis (PCA) with varimax rotation supported theoretical framework. Alpha coefficients of the total scales and subscales ranged from 0·76 to 0·98 (Astedt-Kurki *et al.* 2009). The FAFHES instrument was modified on the basis of literature for the purposes of this research (Gallagher & Truglio-Londrigan 2004, Stoltz *et al.* 2004, Barrett 2005, Büscher 2007, Salin *et al.* 2009). Changes were kept to a minimum to maintain the reliability of measurement. The

family function scale was used as original, and this scale included 19 items, which described family relationships (seven items), structural factors of the family (four items), family resources (three items) and relationship outside the family (five items). The family health scale consisted of 23 items describing knowledge (five items), ill-being (five items), activities (three items), well-being (four items) and values (six items). Half of these items were modified. The third scale, social support, contained three subscales: affirmation (seven items), concrete aid (seven items) and affect (six items). Social support process is very complex and affected by many variables (e.g. context, social network, gender, age, state of health, resources) (Schwarzer & Buchwald 2004), and therefore, almost all items of social support scale needed modification.

Background items included 26 questions about the aged person and his/her family member, such as the gender, age, marital status, education and the use of home care services. Questions about the aged person's health and wellness included the amount of diseases, the need for help with three activities of daily living (later ADL) or with instrumental activities of daily living (later IADL), self-reported state of health and feeling secure at home. Additional questions for the family member were such as kinship, frequency of the family member's visits and description of the support that the family member provides to the aged person.

An open question about received support, experiences of home care and expectations of services were added to the end of the questionnaire. The purpose of this additional question was to enrich the data and to offer information for further development of FAFHES scale in the home care context. For responders, the question offered an opportunity to express wide-ranging options about home care.

### Analysis

Descriptive statistics were used to examine the demographic data. Variables of total scales (family functioning/health/social support) were first summed up and then divided by the total number of the variables in that area. When computing the sum variables, only participants with responses on all items in sum area were included. Therefore, the number of participants with valid sum scores was lower than the number of participants. The sum of the variables family health and social support were normally distributed. Other sum variables (family function and three subscales of social support) were not normally distributed. Cronbach's alpha test was used for measuring internal consistency of the sum variables. Means with standard deviation (SD) and medians with quartiles ($Q1$ and $Q3$) were used to describe family functioning, health, social support and three subareas' sum variables of social support. The significance of differences was determined with Mann–Whitney and Kruskal–Wallis tests (medians) and with $t$-test and analysis of variance (mean values). The level of statistical significance was set at 0·05 (Polit & Beck 2006).

Spearman's and Pearson's correlation coefficients were used to examine the connection between sum variables. Limits for correlation coefficients were set according to Burns and Grove (2005): 0·3–0·5 is considered a moderate linear relationship and above 0·5 is a strong relationship. A multiple linear regression analysis (enter selection) was used to find the variables explaining 'social support' (dependent variable). Independent variables were chosen among variables that indicated statistical connection with social support or were important variables based on literature. Variables that enhanced the degree of explanation were included in the final model. Statistical analysis was carried out using the SPSS statistical package for personal computers, versions 16 and 19 (SPSS Inc., Chicago, IL, USA). The open question was analysed with inductive content analysis. A unit of meaning was chosen to analysis unit. Of these answers, 57 units of meaning related to expectations were found. These were grouped under ten subcategories and in the following grouping, divided into four generic categories (Hsieh & Shannon 2005, Elo & Kyngäs 2007).

### Ethical considerations

Permissions to execute the research in home care services were requested and obtained approval from the head of the organisations in both towns. Home care clients received written information about the study, participant privacy, voluntariness, anonymity and confidentiality during the study with the questionnaire. The consent form was distributed with the questionnaire, and participants signed and returned the form with the questionnaire. Participants returned letters by mail directly to the researcher. Thus, home care staff was not able to see any answers given on the questionnaire (Burns & Grove 2005, Polit & Beck 2006).

## Results

The questionnaires were delivered to 200 home care clients and were returned by 84 voluntary older persons and their family members. One empty questionnaire was returned. The response rate was 42%, and no follow-up letters were

sent. Most of the older people were women (70%), and the mean age was 82·6 years (SD 9·0). Of the family members, 74% were women, and the mean age of family members was 60·2 years (SD 12). Two-thirds of family members were the aged persons' children (66%), 12% were spouses and other family members were siblings, friends, neighbours, etc. Of the family members, 13% lived in the same household with the aged person, and 45% of family members were working. A quarter of family members visited the aged person's home daily, 40% visited from two to six times a week and the rest of family members (45%) visited once a week or rarely (Table 1).

The aged people participating in the study had been home care clients for 0·5–35 years, on average 3·7 years (SD 5·0). A home care nurse visited 78% of the respondents regularly, and 65% received domestic home service. Frequency of formal help varied: 34% received help from one to three times a week. Of the respondents, 40% received help twice a day and more. Three questions concerned the ability to manage ADL's (getting dressed/undressed, going to/getting out of the bed and moving inside apartment), and 76% managed these things by themselves. Most respondents (85%) needed help with IADL's. Three questions concerned these functions (light housework, cooking and, for example, going to the bank) (Table 2).

**Table 1** Demographic characteristics of older people and their family members ($n$ = 83)

| Variable | Class | Older people, $n$ (%) | Family members, $n$ (%) |
|---|---|---|---|
| Gender | Male | 24 (29) | 22 (27) |
| | Female | 58 (70) | 61 (74) |
| Age | Mean | 82·6 years | 60·2 years |
| | SD | 9·0 | 12·0 |
| Marital status | Married/Cohabiting | 14 (17) | 58 (71) |
| | Unmarried | 9 (11) | 9 (11) |
| | Divorced | 9 (11) | 10 (12) |
| | Widow | 51 (61) | 5 (6) |
| Basic education | Elementary school | 61 (74) | 30 (36) |
| | Comprehensive school | 18 (22) | 26 (31) |
| | Matriculation | 4 (5) | 27 (33) |
| Vocational education | No vocational education | 52 (63) | 18 (22) |
| | Basic schooling | 9 (11) | 24 (29) |
| | College or academic | 11 (13) | 34 (41) |

**Table 2** Demographic data of home care services, older people's health and everyday life

| Variable | Class | $n$ (%) |
|---|---|---|
| Amount of home care visits | 1–3 times a week | 28 (34) |
| | Four times a week – daily | 21 (26) |
| | Twice a day or more | 33 (40) |
| Duration of home care service use (half-year accuracy) | $\leq 1$ | 20 (26) |
| | $>1 \leq 3$ | 34 (44) |
| | >Three years | 24 (31) |
| Use of home services | Domestic home service | 54 (65) |
| | Home care nursing | 65 (78) |
| | Meals on wheels | 41 (49) |
| | Cleaning service | 16 (19) |
| | Safety telephone service | 48 (58) |
| | Shopping service | 15 (18) |
| | Night care service | 4 (5) |
| Activities of daily living (ADL, manages independently) | Getting dressed/undressed | 64 (80) |
| | Going to/Getting out of the bed | 72 (90) |
| | Movement inside | 71 (89) |
| Instrumental activities of living (IADL, manages independently) | Light housework | 46 (58) |
| | Cooking | 27 (34) |
| | Dealing (e.g. banking) | 15 (19) |
| Experience of state of health | Good/fairly good | 12 (15) |
| | Moderate | 43 (52) |
| | Fairly poor/Poor | 27 (33) |
| Feeling secure at home | At all times | 34 (42) |
| | Almost at all times | 36 (44) |
| | Sometimes/Rarely/Never | 11 (14) |

## Family functioning, family health and social support

Participants reported fairly good family functioning (median 4·37, $Q1$ = 3·97, $Q3$ = 4·89). Respondents reported good overall family health (mean, 4·59; SD, 0·39). Overall, social support received from the home care services was fairly good (mean, 4·28; SD, 0·82). Concrete aid was the most reported type of support (median 4·57, $Q1$ = 4·0, $Q3$ = 5·0), while the second subarea was affect/emotional support (median 4·5, $Q1$ = 3·83, $Q3$ = 5·0), and affirmation was the least commonly reported type of support (median 4·43, $Q1$ = 3·43, $Q3$ = 4·86) (Table 3).

A strong positive correlation was found between family functioning and family health ($r$ = 0·61, $p < 0·001$). A significant but moderate positive correlation was found between social support and family functioning ($r$ = 0·30,

**Table 3** Description of the three total scales and the social support's three subareas

| Sum variable | *n* | Mean | SD | Median | Range |
|---|---|---|---|---|---|
| Family function | 69 | 4·28 | 0·74 | 4·37 | 2·05–5·68 |
| Family health | 75 | 4·59 | 0·39 | 4·61 | 3·74–5·48 |
| Social support | 70 | 4·28 | 0·82 | 4·43 | 1·95–6·00 |
| Concrete aid | 74 | 4·43 | 0·80 | 4·57 | 1·71–6·00 |
| Affect/Emotional support | 77 | 4·27 | 0·95 | 4·50 | 1·83–6·00 |
| Affirmation | 75 | 4·05 | 1·01 | 4·43 | 1·14–6·00 |

$p = 0·02$) and between social support and family health ($r = 0·42$, $p < 0·001$).

## Background variables and social support

The older persons' basic training was associated with the received amount of total social support ($p = 0·011$, $t = -2·604$, df = 68). Persons with lower education, that is, elementary school, reported less overall support (mean, 4·14; SD, 0·83) than persons with comprehensive school or a matriculation examination (mean, 4·71; SD, 0·6) (Table 4). Significant differences were found in the subareas of concrete aid (M-W $U = 311·5$, $p = 0·015$) and emotional support (M-W $U = 326·5$, $p = 0·005$). Professional education or the family member's educational background was not associated with received social support.

Participants, whose family members were younger, reported lower support than participants whose family members were older, but the difference was not statistically significant. However, a significant difference between groups was in the emotional support subarea (Kruskal–Wallis test 6·999, df = 2, $p = 0·03$). Participants with younger family members (<55 years) reported moderate support (Md = 4·33, $Q1 = 3·33$, $Q3 = 4·92$) and if family members were aged 56–65, reported emotional support was the least (Md = 4·17, $Q1 = 3·58$, $Q3 = 4·75$). Participants with older (>66 years) family members reported best received emotional support (Md = 4·83, $Q1 = 4·33$, $Q3 = 5·04$) (Table 5).

**Table 4** Background variables' relation to received social support

| Variable | Class | *n* | Sum of social support | *p*-value |
|---|---|---|---|---|
| Age of family member | ≤ 55 | 22 | 4·08 (SD 1·0) | ANOVA |
| | 56–65 | 30 | 4·30 (SD 0·75) | $p = 0·26$ |
| | ≥ 66 | 17 | 4·51 (SD 0·66) | |
| Older person's basic training | Elementary school | 53 | 4·14 (SD 0·83) | *T*-test |
| | Comprehensive school/ Matriculation | 17 | 4·71 (SD 0·60) | $p = 0·011$ |
| Relationship to older person | Child | 47 | 4·14 (SD 0·87) | *T*-test |
| | Other | 23 | 4·57 (SD 0·64) | $p = 0·042$ |
| Duration of home care service use (years) | ≤ 1 | 19 | 4·59 (SD 0·71) | ANOVA |
| | >1 ≤ 3 | 26 | 4·42 (SD 6·68) | $p = 0·018$ |
| | >3 years | 22 | 3·92 (SD 0·92) | |

Duration of home care service use had an effect on social support received. Participants who had been customers for one year or less (mean, 4·59; SD, 0·71) assessed more received support than those who had had home care service for over one years to three years (mean, 4·42; SD, 0·68) or customers for over three years (mean, 3·92; 0·92). The difference between groups was statistically significant ($F = 4·035$, df = 2, 64, $p = 0·018$). The Bonferroni test showed significant differences between the group of customers using least service and customers using the most service ($p = 0·022$). Of the subareas of social support, a significant difference between groups was found in the area of concrete aid (Kruskal–Wallis test 6·049, df = 2, $p = 0·049$).

In case the family members were children of the home care client, the amount of social support was less (mean, 4·14; SD 0·87) than other family members reported (mean, 4·57; SD, 0·64). The difference was statistically significant ($t = -2·068$, df = 68, $p = 0·042$). Furthermore, children reserved less emotional support (M-W $U = 459$, $p = 0·037$) and affirmation support (M-W $U = 424·5$, $p = 0·033$).

Participants' background data such as the aged person's age, marital status, amount of diseases, experience of health or managing of ADLs and IADLs were not significantly associated with received social support. Neither did the family members' gender, marital status, education, working, amount of visits to older person nor living in the same household have any connection.

## Predictors for social support received

Linear regression analysis (enter selection) was used to examine the connections of several predictors to social support. Independent variables were chosen among variables that indicated statistical connection with social support (duration of home care service use, the aged person's basic training, kinship/relationship to older person, family health and family function) or were important variables based on literature (age, gender and feeling of security). Variables that enhanced the degree of explanation were included in the final model (Table 6). Important predictors of social support were family health, the aged person's gender, the age of the family member and the duration of home care service use. The better the family health was, the better the

**Table 5** Background variables statistically significant relation to social support's subareas (affect, affirmation and concrete aid)

| Variable | Class | Affect Md(Q1/Q3) | Affirmation Md(Q1/Q3) | Concrete aid Md(Q1/Q3) |
|---|---|---|---|---|
| Age of family member | ≤ 55 | 4·33(3·33/4·92) | | |
| | 56–65 | 4·17(3·58/4·75) | | |
| | ≥ 66 | 4·83(4·33/5·04) | | |
| | | K-W, $p = 0·03$ | | |
| Older person's basic training | Elementary school | 4·17(3·58/4·67) | | 4·43(3·71/4·96) |
| | Comprehensive school/ Matriculation | 4·83(4·33/5·33) | | 4·71(4·43/5·18) |
| | | M-W, $p = 0·005$ | | M-W, $p = 0·015$ |
| Relationship to older person | Child | 4·33(3·38/4·83) | 3·86(3·29/4·71) | |
| | Other | 4·65(4·08/5·08) | 4·57(3·89/5·0) | |
| | | M-W, $p = 0·037$ | M-W, $p = 0·033$ | |
| Duration of home care service use (years) | ≤ 1 | | | 4·71(4·07/5·0) |
| | > 1 ≤ 3 | | | 4·71(4·29/5·0) |
| | > 3 years | | | 4·29(3·71/4·57) |
| | | | | K-W, $p = 0·049$ |

**Table 6** Predictors related to social support in regression analysis ($R^2 = 0·379$, $n = 60$, enter)

| Predictor | Regression coefficient B | SD | *p*-value |
|---|---|---|---|
| Family health | 0·942 | 0·217 | <0·001 |
| Aged person's gender | −0·387 | 0·184 | 0·006 |
| Age of the family member | 0·020 | 0·007 | 0·008 |
| Duration of home care service use | −0·033 | 0·016 | 0·043 |
| Feeling secure at home | | | |
| Almost always compared to always | −0·035 | 0·188 | 0·110 |
| Sometimes/Rarely/Never compared to always | −0·455 | 0·263 | 0·089 |

social support received. Men and older family members seemed to receive more support. The fourth predictor was duration of home care service use: the amount of support seemed to reduce in the course of time. Owing to small sample size, regression analysis findings from this study are suggestive.

### Expectations of home care services

Fifty participants had given answers to the open question. Expectations of home care services were related to time, planning of service, organisational factors and caring practise. Clients expected workers to pay attention to time-related factors, such as wish for extra time for the visits and better timing of the visits. Carer should not show to client the time pressure of her/his work, which would reduce the feeling of hurry. Another section of comments was related on the planning of service. The individuality of the aged person and her/his family as well as the need for help or care must be observed carefully when planning the home care services. Participants wished that the same home care workers would perform home visits: stability of carers would support the feeling of security and continuity of care:

> Carers should be permanent, the same! That helps in gaining a sense of security. (30)

Expectations related the organisation of home care services were more flexible services and more exchange of information between family and carers. Clients asked for more help and services, such as company for going outdoors or to hospital visits. The fourth component was home care workers caring practice. Clients wished workers would have a positive approach to work. They expected to have a dedicated primary nurse, which would affect the quality of care. Home care workers should have good professional competence, for example staff should have more knowledge about medication and better instructions for home visits.

## Discussion

### Family function, family health and received social support

Older persons and their family members reported fairly good family functioning in this study. Family relationships in most of the older people's families are strong and characterised by affection and caring (White & O'Brien 2010). Respondents reported good overall family health in this study, and a strong positive correlation was found between family functioning and family health. In regression analysis, good family health indicated a predictor for received social support. Previous studies have indicated that adequate

support will enhance well-being and health in a family (Astedt-Kurki 2010).

Early studies have shown that the majority of aged people are satisfied with home care services in Finland (Heikkilä & Lahti 2007). Results of this study are similar: participants reported fairly good overall social support received from home care. Harju *et al.* (2011) obtained a similar result by FAFHES (Mean 4·36, SD 0·99) among prostate cancer patients – thus, the context for that study was hospital. Concrete aid was the most reported area of the social support received in this research. Formal support sources have been noted to centralise on instrumental support (Schwarzer & Buchwald 2004). Stoltz *et al.* (2004) reported that mostly instrumental services are given to family carers, rather than services tailored to their individual needs. Previous research has shown that home care in Finland mostly focuses on helping with ADLs and physical needs (Heikkilä & Lahti 2007).

### Factors related to social support

Gender is connected with social support received, as men have reported higher values of support than women (Kristjansson *et al.* 2001). Perälä and Räikkönen (2000) noted that male family members of aged health care receivers reported higher levels of receiving help and support. In this study, the trend was similar, and in regression analysis, the gender was a predictor of social support. The age of the family member had a connection with social support received, especially in the area of emotional support. The older the carer was, the better the social support reported. According to Stoltz *et al.* (2004), the young age of the carer is connected with a high caregiver burden. Perälä and Räikkönen (2000) noted younger family members being more critical and unsatisfied in relation to care received. Previous studies have disclosed that older people give more positive assessments of care in comparison with younger receivers of care. In future, clients of home care will be better informed and increasingly demanding (Perälä & Räikkönen 2000, Eloranta 2009). The older person's basic education was connected with received social support in this study. Participants' education level has been noted as a source of influence in many types of tests as for example, in mental status assessment (Switzer *et al.* 1999).

Participants who had been home care clients for a shorter time reported having received significantly more support according to this study. The content analysis raised clients' expectations for better planning of home care. This included a notion of individuality, analysis of needs and stability of care providers. When an aged person enters home care service, his/her needs for help or support are assessed and a written care plan for home care is prepared based on this information. The care plan should be prepared in collaboration with the client and the legal representative or family members (The Act of Social Welfare Customer's Status & Rights's 2000, Väyrynen *et al.* 2010). The care plan should be assessed regularly and whenever the situation changes (Tabloski 2010). Eloranta (2009) noted the lack of up-to-date information in home care documentation. To ensure quality and effective care, systematic assessment of the needs and services is important. Both professionals' and clients' views should be included in the evaluation (Eloranta *et al.* 2010). The wish for stability of care providers has emerged in earlier studies, too: changing workers increase the clients' feeling of uncertainty (Olsson & Ingvad 2001, Heikkilä & Lahti 2007) and may limit the development of relationships between workers and the family (Sims-Gould & Martin-Matthews 2010).

Home care clients had expectations for home care professionals' caring practices in this study. They expected careers to have a positive approach to work. Olsson and Ingvad (2001) have studied the emotional climate of care-giving in home services and noted the emotional climate being a remarkable factor in the relationship between the client and the worker. A positive and symmetric climate supports the care-giving process. Family and staff relationships in continuing care should be based on acceptance, respect, understanding and knowledge of the interested – these are everyday interaction elements (Austin *et al.* 2009, Sims-Gould & Martin-Matthews 2010). Another expectation for practice of care in this study included one's own primary nurse and home care workers' good professional competence. These would further the quality of care. According to Perälä and Räikkönen (2000), family members reported that a named primary nurse and/or doctor would improve the continuity of care and amount of cooperation between family and staff.

In the open question, participants expressed their expectations of the home care services' organisation. Services should be more flexible, and the exchange of information between the family and carers needs more attention. Customers also asked for more help and services. Earlier studies have highlighted the importance of cooperation with the family. Professional helpers should plan and provide care for older people together with the relatives to improve and promote older people's quality of life (Hellström *et al.* 2004). Also the family's abilities to sustain some part of care should be solved and maybe appropriate ways to augment a family's supportive role should also be sought. Family members do criticise the things carers do not do, but they also acknowledge the

fact that the workers' work tasks are limited (Sims-Gould & Martin-Matthews 2010). Cooperation with the family and supporting the family member who is the caregiver would, in turn, support the care recipient (Ekwall *et al.* 2004, McLennon *et al.* 2010). Family members' individual needs for support should be noticed early enough and action taken to promote the well-being of the older person and the entire family (Salin *et al.* 2009, Sims-Gould & Martin-Matthews 2010). Home service clients expressed the expectation of increased time for home visits and better timing of visits. Olsson and Ingvad (2001) noticed that irregular schedules decrease the clients' feeling of security. Sims-Gould and Martin-Matthews (2010) pointed out that it is frequently the family member who receives the burden of these issues, such as rotating schedules or lack of continuity.

### Limitations and reliability of the study

The response rate in this study was 42%. Response rates among older age groups have been found to be less than among other people (Victor 1988). Other reasons for non-response might include the distance between the family member and the aged person or difficulties in responding to a questionnaire together. Convenience sampling was used in this research: home care teams chose clients who met the criteria for participation. Selection errors regarding the selection of care recipients are potential because several home care teams in two towns made decisions on suitable participants. Owing to these limitations, the results of this research are suggestive but useful in the home care context to advance family nursing and further home caring practises.

In this study, data were collected through a questionnaire containing a statistical instrument and open questions, which gave a rich picture about the issue. Free text answers can enrich the data and contribute useful information towards questionnaire development (Rattray & Jones 2007). Because of the small sample, regression analysis is only suggestive; however, previous research supports the findings of connections between social support and age, gender and family health.

In family nursing, considerations of data collection methods are needed. A relevant question is how to obtain information from families. This choice has an impact on the nature of knowledge obtained from the research (Astedt-Kurki 2010). Larsson *et al.* (2004) have researched patients' and family members' options in quality of care in home settings. They noticed strong perceptual congruence between patients and their family members who met every day and shared the care-related experiences. They suggested that family members' perception of the quality of care may be a valuable data source. On the basis of that notion and results from this research, in a home care context, with older people with a great amount of disabilities, concurrent data collection from older people and their family members is a considerable method.

The internal consistency of the FAFHES instrument was noted as appropriate in this research. Typically, alpha should be more than 0·7 for acceptable internal consistency (Pittman & Bakas 2010). In this study, alpha on the three scales ranged from 0·71 to 0·95. In earlier studies' instruments, Cronbach's alphas have ranged from 0·73 to 0·98 (Astedt-Kurki *et al.* 2002, 2009, Harju *et al.* 2011). FAFHES is a suitable instrument for assessing family functioning, health and social support received among aged home care clients. Additional research is required to study family nursing among a heterogeneous group of older people in different contexts of care.

## Relevance to clinical practice

The focus on home care is currently in concrete aid. More attention should be paid to variable support needs of older people and their family members. Home care services should be flexible and adaptable to ensure appropriate support for families. Quality of home care can be ensured by allocating adequate time and proper timing to home visits with primary nurses and minimal changes of staff.

Cooperation between all participants involved in care is crucial in a home care context. Especially cooperation with younger family members requires attention as well as families with many health-related problems. Care should be planned and updated in cooperation with the aged and all who are involved in the care of aged people. Care plan assessment should be performed sufficiently often and be based on each client's individual needs. Encouragement of the family members must be taken into account. Well-functioning shared care would promote the well-being of the older person and the entire family.

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## Contributions

Study design: KH, AR, PA-K; data collection and analysis: KH, AR, PA-K and manuscript preparation: KH, AR, PA-K.

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