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Collaboration in nursing-home care: perspectives of care professionals – a qualitative study

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ABSTRACT

Interprofessional collaboration became more firmly positioned after the WHO highlighted its importance for better healthcare outcomes. In nursing homes, interprofessional collaboration refers to collaboration between teams of physicians/allied health professionals and care teams. Collaboration within care teams is known as intraprofessional collaboration. Determinants of interprofessional and intraprofessional collaboration have yet to be explored within the nursing-home context. Our exploratory qualitative study focused on the determinants considered important by professionals in seven nursing homes. We conducted 14 one-on-one, semistructured interviews with nurses and collaborating physicians/allied health professionals from seven teams of one care organisation. Data were analysed on thematic analysis, proceeding from an inductive approach. Five interacting determinants were identified. The core determinant was 'investing in each other', followed by 'roles, functions and responsibilities within care teams'; 'written policies for individual residents'; 'verbal coordination meetings'; and 'organisational influences'. One notable finding is the influence of intraprofessional collaboration within the care team on all determinants of interprofessional collaboration, including the role of the coordinating nurse. Future ethnographic and action research on intraprofessional collaboration is needed, including the perspective of nurse assistants, as well as on interventions aimed at improving interprofessional collaboration. We recommend training professionals to invest in each other as a skill that encourages relationships.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ The resident population in nursing homes is becoming increasingly complex and thereby necessitating the enhancement of interprofessional collaboration (IPC). IPC is important to provide optimal resident care; however, studies on determinants that affect IPC are sparse in the nursing home setting.

WHAT THIS STUDY ADDS

⇒ Five determinants are identified, with 'investing in each other' as the core determinant for achieving IPC. The quality of intraprofessional collaboration within care teams influences collaboration with treatment teams, with a coordinating nurse (European qualification framework level 4, EQF 4) providing added value.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Research should focus on developing and evaluating interventions informed by the determinants found, such as training to invest in each other as a skill, enhancing collaboration within care teams, improving organisational facilities and employing a coordinating nurse (EQF4).

INTRODUCTION

The context of healthcare is changing, with an increasingly ageing population and an epidemiological shift from acute to chronic healthcare. These trends have led to a rise in the number of patients with multimorbidity, thereby increasing the importance of interprofessional collaboration (IPC) to the provision of optimal patient care. Attention to IPC increased in 2010, after the WHO highlighted its importance in relation to better healthcare outcomes; after which IPC was integrated into professional codes and quality policies. The WHO defines IPC as follows:

> Interprofessional collaboration in healthcare occurs when two or more health professionals with different professional backgrounds provide comprehensive services by working together with patients, their families, caregivers, and communities to deliver the highest quality of care in all settings and improve health outcomes.[1]

Although the use of varied terms (eg, 'interdisciplinary collaboration' and 'professional teamwork') can lead to confusion within the field,[2] IPC entails alignment and communication between different disciplines to ensure that the care provided is appropriate for individual patients. In addition, the involvement of patients and their relatives in care has been associated with better patient outcomes.[3–5] This requires collaboration beyond the boundaries of individual disciplines to align tasks, goals and roles among a variety of professionals.[5] And it calls for care professionals to have customised education[6]

and specific skills based on three broad aspects: interaction, process and organisation.[3 5 7 8] A wide range of interventions have been developed to promote IPC, with many concentrating on communication mechanisms, although the effectiveness of these interventions has not been well substantiated[2] and the implementation of the interventions is often inadequate.[9] However, as demonstrated in the literature, IPC is a complicated process. Barriers are (inter)related to all three of these aspects. The individual influence of care professionals on these organisational components—both separately and in relation to each other—actually complicates implementation.[3 5 10]

Nursing homes are strongly under-represented in the literature on IPC, despite the need for specific research on barriers and facilitators.[9] In nursing homes, older people often live there because they face multimorbidity and geriatric syndromes, thereby requiring care which is warm, personal and adequate to meet the multiple needs. In this setting, IPC takes place between physicians and therapists, such as physiotherapists, occupational therapists, dieticians (shortened to P/Th) and care team members, mainly certified nurse assistants (European qualification framework level 3, EQF 3)—comparable to licensed practical nurses in the USA.[11 12] This is quite a different composition of professionals than hospital and primary-care settings where registered nurses are mostly in charge; the IPC literature largely addresses this relationship between nurses and physicians. The only systematic review to focus on long-term care[3] highlights the importance of realising IPC in the complex setting of long-term care, based on team performance and information-sharing between professionals.

In our situation, all P/Th are employed by the nursing-home organisation and working together in 'treatment teams'. Nursing care is being given by a care team, providing care 24 hours a day. When working collaboratively, treatment teams and care teams must reach out to each other in IPC. In the underlying study, the collaboration among the members of care teams is called 'intraprofessional collaboration' (no abbreviation). Despite scarce studies towards intraprofessional collaboration within care teams, one study suggests better care team collaboration aligns with improved continuity of care and increased IPC.[13]

All in all, the resident population in nursing homes is becoming increasingly complex, as is the necessity of enhancing IPC in nursing homes to maintain and improve the quality of care. The current lack of studies on this topic highlights the relevance of investigating the determinants of IPC between teams of P/Th and nursing care and the collaboration among care team members themselves. The aim of this study is to explore determinants that affect these forms of collaboration, as considered important by care-team members and P/Th in nursing homes.

METHOD

Design

This study is based on an exploratory qualitative research method, with the objective of investigating the perspectives of care-team members and P/Th.[14] The Standards for Reporting Qualitative Research was used as a guideline for reporting the results.[15]

Research setting

In the Netherlands, 20% of its 18 million inhabitants are 65 years or older, and about 130 000 people live in institutions for long-term care (including care homes, assisted living and nursing homes). Almost all long-term care organisations are financed by the government (with a personal contribution from the resident) and show great variation in the number of facilities and residents. In 2022, the workforce comprised, on average, 36% certified nurse assistants (EQF level 3), 26% (nurse) assistants (EQF levels 1 and 2), 9% vocationally trained nurses (EQF level 4) and 1% registered nurses (EQF level 6).[16] Physicians (often elderly care physicians), psychologists and therapists are also employed by the care organisation, accounting for 5% of the workforce.[16] 80%–90% of the residents are satisfied with the care provided and the perceived autonomy.[16 17]

Our study was conducted in one nursing-home organisation consisting of 24 facilities, accommodating 10–60 residents living in units; units are specialised in a certain type of care, mainly for residents in need of psychogeriatric care, somatic care and rehabilitation care. The composition of care teams in each unit varied in terms of number of employees and proportion of care disciplines. All care teams nevertheless consisted of four care functions[12]: nurse assistants (EQF 2, performing domestic tasks), certified nurse assistants (EQF 3, performing care tasks and responsible for and dedicated to certain residents), vocationally trained registered nurses (EQF 4, performing nursing tasks in direct resident care) and coordinating nurses (also EQF 4, performing nursing tasks in direct resident care, monitoring quality of care and fulfilling a directing and coaching role within the teams). The P/Th teams consisted of at least one elderly care physician, psychologist, physiotherapist, occupational therapist and dietitian.

Participants and sampling

To obtain the richest possible data, maximum variation was sought, and purposeful sampling was employed. Teams included stemmed from different locations. Variation in care teams was also sought in terms of resident category (psychogeriatric, somatic or rehabilitation) and team stability (changes in management and turnover within teams). After selecting the care teams, members of these teams were approached. Team members were eligible if they had at least 1 year of work experience, worked a minimum of 24 hours a week, and collaborated with others during day shifts. Variation was sought in terms of age, gender and function (nurses' educational

level), as well as with regard to the participants' perceived (dis)satisfaction with IPC and intraprofessional collaboration. Interested team members completed a form about their personal characteristics and opinions about the quality of IPC, perceived (dis)satisfaction with IPC and intraprofessional collaboration, based on a 3-point Likert scale (satisfied, neutral or dissatisfied). The researcher used this information to select care-team members in a purposive manner.

P/Th collaborating with the included care teams were invited by their department chairs. Variation in P/Th was sought in terms of job category (physicians, psychologists, physiotherapists, occupational therapists, speech therapists, music therapists and dietitians) and perceived (dis) satisfaction with IPC.

Data collection

The study was conducted by a student researcher, employed by the care organisation (RJFK). The student researcher was inspired to pursue this research topic due to several complaints and incidents regarding IPC within the organisation.

The interviews were conducted according to an interview guide. The interviews with the nurses consisted of questions about IPC and intraprofessional collaboration; the P/Th were interviewed only about collaboration with the care teams. Five topics were discussed, derived from literature on IPC,[2 7 18–20] increased complexity of care, relationships, communication, resident aspects and organisational aspects.

All interviews were conducted online and had an average duration of 45 min. After each interview, fieldnotes were made to describe the setting and the conduct of the interviewees. Notes were documented with an audit trail to increase dependability.[21 22] The last five interviews generated no new insights. Beforehand, two pilot interviews were conducted to become familiar with interviewing and to refine the interview guide to increase credibility.[21 22]

Analysis

Data were analysed inductively, based on thematic analysis.[23] Alternation between collection and analysis was applied by constantly comparing data based on new insights. In the open-coding phase, interviews were typed out verbatim, and the text was divided into fragments, from which codes were created using Atlas.ti V.22.0.11.[24] To verify the accuracy of the interviews, the first two transcribed interviews were reviewed by the research supervisor, who provided targeted feedback (AP). In addition, the supervisor co-coded one interview (AP). After performing open coding on four interviews, axial coding was deployed and processed to categories using a code tree. In the final phase, overarching themes were formed.[21 22] The conversations with the research supervisors were used for investigator triangulation (MHL, AP), to reflect on the researcher's interviewing techniques, to ensure the independence of the researcher and to gain a deeper understanding of the data. After 10 interviews, this process shifted the focus more towards the role of nurse coordinators within care teams, to verify whether the role of nurse coordinator was as essential in the collaboration as it had appeared in the prior interviews. The content of and connection between themes are supported by quotations to increase transferability.[21 22]

Table 1 Demographic characteristics (n=14)

Total N: 14		
Characteristic	**Values**	**Frequency (percentage)**
Gender	Female	13 (92.9)
Age	20–29	6 (42.9)
	30–39	4 (28.6)
	40–49	0 (0)
	50–59	3 (21.4)
	60–69	1 (7.1)
Specialty department	Psychogeriatric	8 (57.1)
	Somatic	2 (14.3)
	Rehabilitation	4 (28.6)
Function	Nurse	7 (100)
	Coordinating nurse	5 (71.4)
	Registered nurse	2 (28.6)
	P/Th	7 (100)
	Physiotherapist	2 (28.6)
	Nurse practitioner	1 (14.3)
	Occupational therapist	1 (14.3)
	Speech therapist	1 (14.3)
	Music therapist	1 (14.3)
	Dietician	1 (14.3)
Satisfied with interprofessional collaboration	Dissatisfied	1 (7.1)
	Neutral	5 (35.7)
	Satisfied	8 (57.1)
Satisfied with intraprofessional collaboration, within care team (only nurses, n=7)	Dissatisfied	0 (0)
	Neutral	2 (28.6)
	Satisfied	5 (71.4)

RESULTS

For this study, 14 participants were interviewed: 7 nurses (EQF 4) and 7 P/Th (see table 1).

Findings

Five themes emerged in this study, representing both IPC and intraprofessional aspects: investing in each other; roles, functions and responsibilities within care teams; written policies for individual residents; verbal coordination meetings and organisational influences. Notable was that nurses and P/Th regarded the same factors as

important. Many participants indicated that IPC is more important in psychogeriatric wards, as residents themselves are not able to participate in planning their own care. In addition, some participants indicated that collaboration was enforced more in rehabilitation wards, due to the treatment climate.

The interdependence of nurses and P/Th in IPC was key, collaboration between these two groups is based on the fact that each party needs something from the other. For example, nurses spoke of asking P/Th to establish or modify treatment policies, thereby resulting in treatment tasks for P/Th. Conversely, P/Th established treatment policies for residents, and care-team members used them to derive specific care tasks. The presence of such interactions implied that intraprofessional collaboration within a care team could not be considered separate from IPC: what occurred in the care team affected the collaboration of that particular team with P/Th. The mutual investment of healthcare workers in each other served to strengthen IPC, which in turn improved the alignment of policies for individual residents. The organisation determined the framework within which the collaboration could take place.

Theme: investing in each other

The importance of investing in each other was highlighted in many interviews. Participants perceived that paying attention to one another impacted their behaviour and attitudes, which subsequently had a major impact on residents. This attention was regarded as even more important to achieving quality of care than was the individual attention that participants devoted to their individual residents. The participants observed that a positive attitude towards each other and a positive relationship with each other ensure collegiality and confidence, which results in improved alignment of policies for residents. Most participants indicated that physical visibility and informal contact increased goodwill, which in turn helped to create openness and a greater willingness to communicate.

> …For example, I am in Department X, and I visit it every week. In addition, new people are added to the care team on a regular basis. When there is someone new…I'm always in the office with them and I drink coffee together and everything… (P4)

Investing in each other was identified as a part of the team culture, which consists of collegiality, addressing each other's responsibilities, honesty and appreciation.

> You can rely on each other, we can discuss, uh, things with each other. If there are unresolved issues, they are actually resolved very quickly, so actually that goes… We work with routes and sometimes one is running late or one has finished faster. Then, something is shifted, or people will just ask if they can do something for you. (N3)

Participants indicated that, to 'invest in each other', a safe and confidential environment was essential; however, this was not always present in practice, either within care teams or in relation to the treatment team in terms, particularly regarding listening to each other and being equal partners. For the individual tasks in direct resident care, participants considered all care team members equally important, as they see residents 24 hours a day. At the same time, however, some participants expressed doubts concerning whether all team members were always seen as equals.

> Right. I do sometimes have a feeling that… Sometimes it can feel a bit like a struggle…and then a recommendation comes in (from a P/Th), and the care team thinks, 'Alright, but that just won't work with this resident!'. They can say something, but it might not work at all or someone might not want that. Then I'm still sitting there with that resident… uhm… (N1)

Theme: roles, functions and responsibilities within care teams

The clarity and execution of roles and responsibilities within care teams were important to the implementation of policies established for individual residents. The extent of collaboration between the members of a care team and the P/Th depended on the function of the individual care-team member. This was related in part to the individual relationship between a P/Th and a care-team member, and in part to the tasks, roles and responsibilities of that care-team member. Certain participants noted a difference between colleagues, with some taking more initiative and others simply completing requests. Most participants, nurses and allied health professionals emphasised the role of the coordinating nurse in this collaboration. Because coordinating nurses looked beyond their own tasks and responsibilities, P/Th were likely to approach them for coordination. For this reason, they moved between various disciplines and were the binding factor between care teams and P/Th, thus contributing to IPC.

> The coordinating nurse who had been there was absent due to maternity leave…. In essence, that key role fell away, and each discipline went to work as best they could. The care team went to work as best they could. … And in the end you notice: we all do our utmost, but it just doesn't work well enough. No one took the initiative to call everyone together and say, 'Guys, this isn't working anymore.' (P5)

Theme: written policies for individual residents

Care and treatment policies for individual residents were communicated both orally and in writing. Participants emphasised the importance of written policies for three reasons: for executing policies, for adjustments and for transfers. Communication was written in electronic patients records (EPRs), and frustration arose when agreed on policies were not executed, evaluated or

adjusted. A barrier was that the EPRs for the care team and the treatment team were two different systems. Although the EPRs were connected, not all relevant elements were accessible, and often, users did not know where to find the necessary information, which meant that care teams and P/Th could not read each other's reports.

> You also have two different electronic patient records. You can't see everything… You have to rely a lot on what people give back verbally… (P7)

Participants also mentioned the importance of constantly considering whether policies established by P/Th fitted the current situations of residents. P/Th expected their written policies to be implemented to the extent they had indicated. However, if the care team members were not convinced of the success, they found it difficult to perform the required activities. Harmonisation of policies between nurses and P/Th was therefore essential. It ensured that all professionals were in accordance with one another, resulting in the best possible attention for individual residents:

> Yes, that is tricky. We then try that modified food (from the dietician). We try it, and we report it well. Then we call the dietician and say, 'This won't work. Come up with something else'. (N1)

Theme: verbal coordination meetings

Verbal coordination took place in coordination meetings, which often involved a specific visiting P/Th interacting with one nurse, using each other's expertise. Insights from these different areas of expertise were integrated and policies were formulated for individual residents. In these meetings, nurses adapted their conduct to the needs of individual P/Th. Conversely, P/Th indicated that they adapted their behaviour to the needs of nurses by explaining their decisions, although with varying levels of explanation. Whereas some P/Th stated that interventions should be explained in a clear and practical manner, others asserted that nurses did not need the explanation or to understand policies.

> Where we [P/Th] were taught in our training to do certain analyses and make certain mental steps by reasoning and weighing things. That this leads to certain choices, why we would want to do certain things…… (P5)

According to participants, regular fixed moments of coordination should be established by the organisation to harmonise all disciplines. Although spontaneous verbal coordination between nurses and individual P/Th was also necessary (eg, after a policy for a resident had been newly formulated or after a nurse had consulted a P/Th for advice). All participants indicated that the increasing complexity of care makes more fixed coordination moments necessary, given the multiple problems involved, which call for IPC:

> Well, of course we are dealing with real nursing-home care or real elder care, so we're obviously dealing with real vulnerable people with multiple pathologies and multiple problems in multiple areas. Sometimes they just need specialized help. Actually, you always have a form of delegation. So, it's not possible for one person to do all those tasks. It's a collaboration. (P6)

Theme: organisational influences

Participants identified several organisational aspects that influence IPC and intraprofessional collaboration. The vision of the management directed possibilities for collaboration by setting up frameworks of agreements and preconditions for collaboration. For example, one agreement included the content and frequency of structural coordination meetings and the type of functions and competences in care team members.

> The vision is also: … If each level [EQF of the care-team members] is allowed to make visits, they must be given time to do so … It also concerns how you view care for the elderly. That it's multidisciplinary care, and multidisciplinary care entails collaboration and consultation. That just takes time. (P6)

Preconditions mentioned by the participants included a workforce sufficient to the needs of the organisation, the availability of resources and offices, continuity (with consistent staffing of care teams and familiarity between teams and P/Th), workload, and accessible EPRs.

DISCUSSION

This exploratory qualitative study identified determinants of IPC and intraprofessional collaboration that were considered important by care-team members and P/Th in nursing homes: 'investing in each other'; 'roles, functions and responsibilities within care teams'; 'written policies for individual residents'; 'verbal coordination meetings' and 'organisational influences'. These determinants were inextricably interconnected. Throughout the collaboration, investing in each other was considered the core factor.

The first theme, 'investing in each other', was described as paying attention to one another and emphasised that collaboration also has a personal dimension and constitutes 'people work'.[5 25] This theme was identified as the core determinant for enhancing IPC because of its underlying relational character with the other four determinants. This determinant stemmed from the individual perspectives of the participants on collaboration to achieve high quality in integrated care. It was something that the care professionals achieved with a proactive attitude due to their focus and aim on the well-being of residents. Investing in each other should be regarded as an element of interaction and relationships.[7 8 26] Wei *et al* found that trust and respect were an important barrier to IPC.[5] We suggest that to actively invest in each other, paying attention to one another, might be a way to gain

trust and respect in each other. One review on IPC in institutional long-term care identifies relationships as an important component of team performance[3]; however, it assigned equal value to other aspects of IPC (eg, process or organisational aspects). In our study, investing in each other emerged as by far the central determinant of collaboration. We therefore recommend training health professionals to invest in each other, as a skill that encourages interactions and relationships. The other four themes identified in our study refer to organisational and team factors and are recognised in many studies.[5 26 27] As such, IPC in the nursing home setting does not seem to differ significantly from that in the hospital and primary care settings.

As demonstrated by the results of our study, IPC and intraprofessional collaboration within the core team could not be separated, and the quality of collaboration among care team members affected the care team's collaboration with treatment teams. The literature contains remarkably few studies on intraprofessional collaboration in relation to IPC, but points towards team culture, fragmented communication and unclear role definition.[3 5] In our study, we similarly found that role definitions were important within healthcare teams. In particular, the role of a coordinating nurse (EQF 4) emerged in this study as influential in IPC, as perceived by both nurses and P/Th. The work of coordinating nurses apparently influenced the effectiveness and efficiency of both IPC and intraprofessional collaboration. As confirmed by Körner *et al*, team-based IPC interventions are effective within the context of chronic care.[27] Future studies should examine the influence of intraprofessional collaboration on IPC, as well as on assessing the added value of coordinating nurses in nursing-home care. Implementation studies to encourage collaboration within care teams from the perspective of human aspects could focus on enhancing three behaviours: (a) speaking up about interests, values and perspectives; (b) listening to information that is shared and (c) thoroughly processing this information.[25]

This study had several strengths. Given that no new data were generated in the last five interviews, it is likely that data saturation was achieved. Another strength of this study was the content-driven conversations that took place between the researchers to capture the essence of collaboration and enhance the reliability of the results.[22] The context of our study is described in detail, with that the results can be interpreted for the situation in other nursing homes and its transferability. Although the interaction between our five emerged themes became clear, uncertainty persists with regard to the relative weight of each theme and the fragility or robustness of the connection. We recommend more in-depth research on the determinants of collaboration, taking into account the relational aspects as well. Ethnographic studies in the practice of nursing homes will help to understand the determinants of IPC in greater depth, as they aim to uncover variation across different social and cultural groups through immersion and engagement in fieldwork. Furthermore, action research may be a suitable design to optimise IPC and intraprofessional collaboration, as it focuses on changes in practice while generating implementation knowledge.

Alongside the strengths of this study, it is important to consider its limitations. The study took place in one organisation, and although it comprised 24 locations, the variation in the sample of seven teams from seven locations may not have been optimal; for example, no metropolitan team was included. Furthermore, although the inclusion process was conducted as planned to achieve variation in terms of care-team functions, the sample consisted entirely of nurses eventually (EQF 4). As a result, the viewpoints of nurse assistants (EQF 2) and certified nurse assistants (EQF-3) were not represented in this study, even though they have daily contact with residents and thus have a major impact on their well-being. Further research on the perspectives of nurse assistants is of the utmost importance. Another weakness of our study is the lack of variation in the sample with regard to the extent to which participants were (dis)satisfied with IPC. They were more positive than initially expected, given the complaints in the involved organisation prior to the study and posing the research question.

CONCLUSIONS

Our investigation revealed five determinants of IPC and intraprofessional collaboration in nursing homes, with 'investing in each other' identified as the core determinant of IPC. We, therefore, recommend training health professionals to invest in each other as a skill that encourages IPC. Other determinants included: roles, functions and responsibilities within care teams; written policies for individual residents; verbal coordination meetings and organisational influences. This study highlights the influence of intraprofessional collaboration in care teams to IPC, with the employment of a coordinating nurse (EQF 4) providing added value. Future research is needed, focusing on intraprofessional collaboration within care teams and its influences on IPC, explicitly taking into account the perspectives of nurse assistants (EQF 2) and certified nurse assistants (EQF 3). An ethnographic study is also needed to determine how IPC works in practice, and action research is necessary to develop and facilitate interventions that foster IPC.

Contributors RJFK and AP designed the study; RJFK conducted the interviews; AP listened to the first two interview; RJFK, MHL and AP performed thematic analysis; RJFK wrote the paper drafts; made the report drafts; all three authors critically reviewed the original draft and the final version and approved the final version to be published. AP was the supervisor and is the guarantor of this contribution statement.

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Patient consent for publication Consent obtained directly from patient(s).

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