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Health and social care planning in collaboration in older persons' homes: the perspectives of older persons, family members and professionals

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Providing health and social care to older persons is challenging, since older persons often have multiple diseases and a complex health situation. Hence many professions and organisations are involved. Lack of interprofessional and interorganisational collaboration leads to fragmented care. Care planning meetings before hospital discharge have long been used to overcome this fragmentation, but meetings conducted at the hospital have limitations in identifying long-term needs at home. A new model for health and social care planning in collaboration (HSCPC) in older persons' homes was introduced in two Swedish municipalities. The aim of this study was to gain a deeper understanding of the HSCPC-meeting from the perspectives of older persons, family members, and professionals. Ten care planning meetings from two municipalities were consecutively included. Interviews in retrospect with ten older persons, eight family members, and ten groups of professionals who had attended the HSCPC-meeting at home were analysed with a hermeneutic approach. Four themes emerged: unspoken agendas and unpreparedness, security and enhanced understanding, asymmetric relationships, and ambiguity about the mission and need for follow-up. The comprehensive interpretation is that the professionals handled the HSCPC-meeting mainly as a routine task, while the older persons and family members viewed it as part of their life course. Older persons are in an inferior institutional, cognitive and existential position. However, meeting together in the home partly reduced their inferior position. Findings from this study provide some general suggestions for how HSCPC-meetings should be designed and developed: attention of power relations, the importance of meeting skills and follow-up.

Keywords: care planning, collaboration, elderly, family, home care, life course, person-centred, hermeneutic, qualitative study.

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Introduction

Health and social care needs of older persons with multiple diseases are often extensive, complex and changing over time (1). Several different occupations are involved in the care, but the collaboration is not unproblematic (2–5). As care of older persons is increasingly provided outside hospitals and nursing homes, the interfaces between health and social care as well as between primary and community care have become an obstacle for an integrated care that fulfils the needs of older persons at home (6). Interprofessional care planning has been proposed to overcome the risk of fragmentation and to contribute to person-centred care (3). To achieve person-centred care and get a deeper understanding of the older person's situation, a dialogue between the older persons, family members and professionals is necessary (3, 7). Previous research has problematised interprofessional collaboration (2–5), but there is less studies on how the older person themselves, their family members and the professional experiences the interprofessional care planning meetings in older peoples home. This study will therefore highlight these perspectives.

A number of different concepts concerning interprofessional care plannings are used: advanced care planning is used to describe end-of-life care, when the older

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persons no longer can make own decisions (8). Discharge planning is used to describe the planning for the care after discharge from the hospital (9–12). Other concepts describing plannings, at the hospital or in older persons' home, are coordinated care planning (13), comprehensive care planning (14, 15), family meeting (16) and care planning (17, 18). In addition, a model for care and support planning aimed at adults with care and support needs was developed in UK in response to the requirements by the government (19, 20). The UK model has much in common with a Swedish model under development although the latter is directed only at persons with complex health problems and many providers involved. In this study we used the term health and social care planning in collaboration (HSCPC) to highlight that this planning concerned both medical and social care needs provided by professionals representing different occupations and organisations. The HSCPC was organised as a meeting that focused on dialogues between older persons, their family members and different professionals in older persons homes. Research concerning care plannings has also varied and the study foci has been; the *content* of the plan (14), the *collaboration* between health care professionals (2, 3, 9), the *meeting* (13, 16, 18, 21, 22) and older persons *needs* as expressed by themselves (12). Since planning the care at the hospital is not optimal, initiatives have been taken to perform the discharge planning at home a few days after discharge (2, 18). However, little research has focused differences and similarities between older persons', family members' and professionals' views on the care planning meeting at home.

In Sweden, organisational affiliations vary, physicians belong to primary health care, while social workers, homecare aides, registered nurses and rehabilitation therapists are employed by the municipality. As professions and organisations have their own legislations, values, responsibilities and budgets (3, 23, 24), this system carries the risk of fragmentation and lack of continuity (4, 5, 25). The integration between health and social care for older persons is challenging. In a study (23) strategies to develop integrated care in nine European countries were investigated, and it was pointed out that some strategies were provided in standalone organisations while others were cross-agency integration initiatives. The problem with improving the interface between health and social care has been described as 'one of the most prominent shortcomings in European health and welfare systems' (26). Lack of common legislation and joint budgets are barriers to an integrated service delivery (23, 26). To overcome such barriers, the Swedish government decided 2010 that coordinated individual plans should be created for persons with a complex health situation where health and social care is provided from different organisations (27, 28).

Regardless of the aims of the care plannings for older persons with multiple diseases and a complex life situation, the plannings must be based on a coordination strategy that considers both the medical and the social aspects of older persons' lives. According to the Swedish legislation about coordinated individual plans, two municipalities in southern Sweden decided to introduce health and social care planning in collaboration (HSCPC) as part of their activities. As part of a larger participatory action research project (21, 29), a new locally developed approach for HSCPC in older persons' homes was introduced. It was left to the municipalities to decide how to perform the HSCPC-meeting. Therefore each municipality had worked out its own strategy, including who should participate, who should coordinate and facilitate the meeting, how the meeting should be carried out, what issues should be discussed and where the meeting should be held. However, for the most part, their strategies were similar, for example, it was the older person who decided whether a family member should be invited or not and that the professionals that attended the meeting would normally be the GP, social worker, home care aid, community nurse and occupational- or physiotherapist. A follow-up study to discover strengths and weaknesses of the meeting and to help plan for necessary improvements was requested. As part of this, questions were raised about how the care planning meeting was experienced and how it could be developed. Therefore, the aim of this study was to gain a deeper understanding of the HSCPC-meeting in older persons' homes from the perspectives of the older persons, family members, and professionals.

Methods

In this study we chose a hermeneutic approach to gain a deeper understanding of the individuals' experiences of the HSCPC. According to the ontology and epistemology, hermeneutic philosophy claims that everything is interpreted and that the reality always is seen from various perspectives. Thus, how we interpret and understand a phenomenon depends on context and preunderstanding (30). Our preunderstanding was that HSCPC could be used to reduce the fragmentation that research has shown often characterises the care of older people. We also had a preunderstanding that the older person's own perception of their situation should be the starting point for the care planning. The chosen approach aims at allowing the reader to follow the analysis and judge the interpretations. Therefore, the findings first give a *description* of how the older persons perceived the meeting followed by a similar description of the views of the family members and the professionals. These descriptions are followed by a *comparison* and a *tentative interpretation*. Finally, a *comprehensive interpretation* is provided.

Sample and data collection

In this study, ten HSCPCs (n = 10) were followed up in two municipalities in southern Sweden. The two municipalities had introduced the new approach of HSCPC-meeting which at the time of data collection were a part of the ordinary activities and conducted regardless of this study. Older persons, family members, and professionals who participated in HSCPC-meeting were consecutively included in the study (Table 1). The inclusion criteria were that the person was ≥65 years, able and willing to take part and allowed us to interview those who had participated in the meeting. Ten care planning meetings from two municipalities were consecutively included. Fifteen older persons were asked to take part while five refrained and two of them spontaneously reported tiredness as reason. The interviews were performed between one and 3 weeks after the HSCPC-meeting. In all, ten older persons, eight family members and ten focus groups with professionals were performed. Seven older persons were individually interviewed, and three were interviewed together with a family member. The professionals took part in focus group interviews (31). As it was not possible for all professionals to attend, the focus group session were supplemented with seven individual interviews afterwards. All interviews except one individual interview with an older person were audio-recorded and transcribed verbatim by a trained transcriber. Data were collected between October 2012 and April 2013.

Individual interviews and focus groups

The interviews with 10 older persons and eight family members were performed by a researcher (MS or LV). Initially, the older persons and family members were asked to tell their story about the HSCPC-meeting by asking: Could you please tell us about the meeting so that I can get a picture of how the meeting went and what happened. Follow-up questions were: What was decided? In what way did you feel involved? In what way were you given the opportunity to take part and explain what was important to you? In what sense did it matter where the meeting took place? What has happened since then? The interviews were held in the older persons' or the family members' homes or place of work, and lasted between 18 och 69 min, (md) 41 minutes.

The focus groups with 22 professionals were led by two researchers (KB and MS), one facilitator and one observer. The opening question was: Could you please tell us about the meeting? Start when you are standing outside, ringing the door bell. The interview followed the same guide as the interviews with older persons/family members. In addition, the professionals were asked whether they had discovered anything unexpected, and whether their impression was that the older person/family member felt involved. Probing questions, such as In what way? or Could you give an example?, were used. The facilitator ensured that the themes in the interview guide were discussed while the observer ensured that everyone were allowed to have their say. The focus group interviews were held at the workplace, and lasted between 33 and 60 min, (md) 42 minutes.

Ethical considerations

As this study involved older persons with multiple diseases and complex care needs, the importance of protecting their safety, autonomy and voluntariness was taken into account. The older person decided for themselves not only their own participation but also whether their family members and professionals could be contacted and interviewed. Since many of them were fragile, the interviewer carefully observed whether the older person seemed troubled or tired and ended the interview. All

Table 1 Description of study participants

	Older persons *n = 10*	*Family members* *n = 8*	*Professionals*[a] *n = 29*
Age	65–92	Unknown	Unknown
Gender	Seven women, three men	Five women, three men	25 women, 4 men
Occupation			Home care aids 3 Managers 3 Occupational therapists 2 Physicians 5 Physiotherapists 4 Registered nurses 5 Social workers 5 Students 2
Relationship		Two wives, two husbands, three daughters, one son	

[a]Professionals who participated in two or more interviews (n = 10) are only mentioned once.

participants received verbal and written information about the study and signed an informed consent. The length of the interview was accommodated to the professionals' possibility to deposit time without taking valuable time from the patients.

Analysis

When using a hermeneutic analyse the researcher go back and forth between the parts and the whole to get a deeper understanding of the phenomenon under study. Therefore the process of understanding the texts included a number of steps (32). As hermeneutics offers an opportunity to use the preunderstanding to understand and see reality in a new way (30) the *first step* in the analysis was to reflect upon our preunderstandings. Our preunderstanding was that the professionals' different core values become a hinder for holistic care and that care of older persons is often characterised by fragmentation. This way of bringing our preunderstanding to the surface had the purpose of reflecting on ourselves as interpreters (32). As a *second step* data was read a several times to get a sense of the meaning. Our naïve reading showed that all participants spoke about the time before, during and after the HSCPC-meeting. Texts were therefore sorted into an emerging analytic structure about the time before, during and after the meeting. In a *third step*, statements from older persons, family members and professionals were described, compared and interpreted into tentative themes. *Finally*, the themes were compared and interpreted in relation to a life course perspective and to person-centred theory. All authors participated in an analytic process that moved between the naïve reading of the text, the emerging analytic structure, the descriptions and comparisons, the tentative interpretation and the comprehensive interpretations. In order to evaluate validity (33), two feedback sessions were held where professionals from the two municipalities confirmed our findings and discussed strategies to move their work forwards.

Findings

When the perspectives of older persons, family members and professionals were described and compared in order to gain a deeper understanding of the HSCPC-meeting four tentative themes emerged. Under each theme, the findings are presented in the following structure: descriptions by older persons, family members and professionals, followed by a comparison and a tentative interpretation. Representative quotes from older persons, family members and professionals are presented in Fig. 1.

Theme 1 Unspoken agendas and unpreparedness. In each of the two municipalities, the *older persons* had been invited to the meeting by a project coordinator. The invitation said that the meeting would be held in their home, and gave a brief description of what the meeting would be about. As four out of the ten meetings were 1-year follow-ups, these persons had experience from previous HSCPC-meetings. During the present meeting, older persons were seldom clear about who was who among the professionals, except for the physician who played a central role. Most came to the HSCPC-meeting unprepared, as they did not know what to expect or what to prepare for. Such uncertainty meant they had to guess what the meeting would be about and which persons or professionals would attend (Fig. 1).

Nearly all of the *family members* had participated in a number of meetings before, and they expressed that their experiences from these meetings influenced their attitudes towards this meeting. When past meetings had brought bad experiences, they now prepared to fight for their rights. To be given the possibility to prepare for the meeting was important for the family members. In the absence of a written agenda, some family members had prepared by writing down issues they wanted to discuss. They expressed that an agenda could have provided a tool for them to discuss the older person's ideas and preferences in advance. However, many family members came unprepared to the meeting.

The *professionals* had been informed about the HSCPC at workplace meetings. When a professional was absent due to illness or vacation the meeting was held despite the missing person. In some cases a person who represented that profession was invited regardless of whether they knew the older person or not. Professionals had prepared by reading medical or social records, while others had not prepared at all. Sometimes the professionals had held a meeting where they had agreed on an agenda of their own such as a suggestion they wanted the older person to accept. Sometimes surprising issues and problems were raised by the older persons or their family members, issues that the professionals had to adapt to. Although the professionals in general had been informed of what to expect of an HSCPC-meeting, some attended the meeting without this knowledge. In many cases, no chairperson to lead the meeting was appointed which contributed to uncertainty.

A *comparison* showed that there was often ambiguity about the purpose of the HSCPC-meeting and that concerns and expectations differed. The older persons and, in particular, their family members saw the invitation as a possibility to express their life situation and argue for their rights. Conversely, the professionals treated the meeting more as a routine task or, in some cases, as a possibility to push through their own, often unspoken, ideas and suggestions. *A tentative interpretation* is that being invited to the meeting raised unspoken concerns and expectations among all involved. The theme

Theme 1. Unspoken agendas and unpreparedness

Older persons: You're sort of unprepared, because you sort of don't know what they want. (Older Person, Interview 8)

Family members: No, I had never heard of HSCPC before. (…) I had no idea what HSCPC was about, but we *did* know that it had to do with your [the older person] training. (Family member, Interview 3)

Professionals: Then I experienced maybe a little bit, that I did not really know who was holding the meeting. I really did not know what place I would take. If I should just sit and wait or if I should ... push the meeting forward. (Professional, Interview 2)

Theme 2. Security and enhanced understanding

Older persons: Well, it was more comfortable to be at home and have it [the meeting] here ... I do not know, you feel so at home here. (Older Person, Interview 6)

Family members: I can see another advantage of it… that you're just here at home… it makes for a more open attitude, a more comfortable and open attitude in some ways, more comfortable in that respect … like he can be a little bit more open to it on his home turf. /…/ Yes, it feels like… Like they're so focused. (…) Yeah, here and now. They are present. Their thoughts are not as scattered in other directions. (Family member, Interview 9)

Professionals: And then she talked a lot about her walker, it was important for her to go out with the dogs and so, so I knew she used it a lot (...) So I looked while I was there, I looked when I went out, and I saw that it was really not so usable anymore, but we changed after that. (Professional, Interview 8)

Theme 3. Asymmetric relationships

Older persons: Yeah, they talked about all sorts of things, and mostly they talked ABOUT me. (…). She talked up a storm. And so I responded to what she said. I can't recall what she was asking about. (Older person, Interview 10)

Family members: Yes, they talked and talked, I was not listening all the time, either, for I do not know what they were talking about. (Family member, Interview 2)

Professionals: It is of course clearly easier for the patient that … that we come there, but at the same time they justifiably feel exposed, I can imagine. That a whole… a whole army of caregivers and the like will be coming to their home… (Professional, Interview 3)

Theme 4. Ambiguity about the mission and need for follow-up

Older persons: I don´t really know why [the meeting was held]. I think they…you know they arrange such meetings now and then. (Older person, Interview 9).

Family members: So, there hasn't been any continuous follow-up. There should have been a contact person who perhaps rang up. Yes, once every six months. "What's the situation? How are things now? Is it time for a new meeting?" Because I think that it must cost an awful lot. All those professionals sitting there for like an hour. It costs an incredible amount. But maybe someone in this group checked up. (Family member, Interview 1)

Professionals: … but it's true in principle that all the patients that HSCPC meetings are held for are, after all, elderly and multimorbid… and then you just have to adjust to the fact that there will be a new meeting where everyone comes again together after a certain period of time, whether it's in two years or, in the case of this particular patient, who has such a serious illness, then it may be as soon as just a couple of months, because the circumstances are different. (Professional, Interview 4)

Figure 1 Views of the HSCPC meeting in older persons' homes: quotes representing the perspectives of the older persons, family members, and professionals.

'unspoken agendas and unpreparedness' thus illuminates that there was feelings of insecurity among older persons and their family members but also often among the professionals.

Theme 2 Security and enhanced understanding. Almost all *older persons* appreciated having the HSCPC-meeting at home. In most cases, it did not bother them that there were many people present. Rather, they appreciated that all the professionals were there at the same time. Generally, they felt understood, and experienced it as satisfying to talk about what was troubling them and felt comfortable about meeting at home (Fig. 1).

The *family members*, for its part, appreciated to be given the opportunity to tell their story and being listened to and they believed that it was easier for the professionals to grasp the full picture in the home setting. They expressed that the older persons felt more safer and that the professionals had more time and were more focused in the home setting.

The *professionals* appreciated that the HSCPC took place at home, because it helped them get a feeling of the atmosphere. It also gave them the opportunity to make assessments in the home environment and to find ways of solving practical problems. Meeting the older person and the family member together at home also made roles and relations apparent. When the home was not adjusted for the older person's needs or disabilities, the HSCPC-meeting offered the chance to discover things, even small details that could pose problems in daily life. Such details had been overlooked at the care planning at the hospital. Meeting all together in older persons' homes made the professionals notice others' perspectives while listening and asking questions. The presence of different professions often raised new issues that a representative of another profession could address, and taken-for-granted notions became visible.

A *comparison* showed agreement between older persons, family members and professionals as all appreciated that the meeting was held at home. The older person and their family member felt safe and were given the possibility to explain their situation and the professionals got an opportunity to capture the situation. A *tentative interpretation* is that arranging the meeting in the older person's home was advantageous for all parties as the home created trust and as, through interdisciplinary discussions, the professionals discovered new aspects concerning older persons' needs as well as concerning their own profession. The theme 'security and enhanced understanding' thus illuminates that arranging the meeting in the home setting contributed to enhanced understanding of the older persons situation and contributed to enhanced interprofessional understanding.

Theme 3 Asymmetric relationships. While a majority of the *older persons* were pleased that all the professionals attended the meeting, problems in joining the conversation were expressed. They felt they could not always speak for themselves, and sometimes felt unable to defend their own interests. If the balance swung towards providing too much information rather than facilitating a dialogue, the older persons had feelings of not being involved in issues regarding their own situation, and some were not fully aware of what had been decided (Fig. 1).

The *family members* noted that the older persons sometimes were tired and had problems in joining the conversation. If those who attended the meeting lacked the mandate to take decisions, the meeting felt pleasant, yet meaningless. The family members expressed that they had been listened to but some expressed that it had been difficult to keep up with the discussion.

The professionals were well aware of the importance of dialogue. They tried to adapt their language and tempo to the older persons, but realised that they sometimes forgot this when there were many issues to discuss and important decisions to be made. They did however believe that the older persons and family members had felt involved. One reflection was that some frail older persons would have benefited from a meeting with fewer professionals, or if the family member had attended the meeting alone, as a representative of the older person. Although they considered it positive that all professionals were represented, they saw a risk that the older person felt exposed. In cases when the professionals already had a suggestion they wanted the older person to accept they realised that they sometimes had neglected to ask for the older person's and the family members' views on the matter.

A *comparison* showed that all parties commented on the importance of allowing the older person and family members to be heard, but the pace was sometimes too fast for them, and the professionals noted that the decision-making was occasionally based primarily on their own suggestions. A *tentative interpretation* is that although the meeting at home was appreciated, and although the professionals wanted to adopt the meeting to the older person's ability and strength, this was difficult to achieve. The theme 'asymmetric relationships' illuminates that the meeting was insufficient to equalise asymmetric relationships.

Theme 4 Ambiguity about the mission and need for follow-up. The *older persons* expressed surprise over the possibility to arrange a meeting in their own home and appreciated in particular that the GP came. Most of them could not give an account of what decisions had been taken and did not mention the need of a follow-up.

However, one older person who was dissatisfied with the decision took an own initiative to have it changed (Fig. 1).

The *family members* expressed astonishment over how it had been possible to arrange a HSCPC with representation from a number of professions. However, they meant that such a time-consuming and costly meeting required a person to be appointed to follow-up, as well as some kind of check-up shortly after the meeting. As changes in health are often fast and unpredictable they needed someone to turn to when something unexpected occurred.

Among *the professionals* there were only a few discussions of the need for a follow-up or for assigning a responsible professional after the HSCPC-meeting. They expressed that the professionals should trust that all decisions would be carried out, and that no follow-up was needed. However, some expressed that in special cases, when the HSCPC concerned older persons with a complex health situation or when something was unclear and required clarifications, there could be a need for a follow-up by phone. A *comparison* showed that the family members were well aware of the difficulty of arranging a meeting with all relevant professionals. They therefore considered that the HSCPC should be followed up and revised. Conversely, the professionals tended to see the matter as closed when the HSCPC-meeting was over and the documentation completed. The *tentative interpretation* is that there was un unfulfilled need for someone to turn to after the meeting. The theme 'ambiguity about the mission and need for follow-up' therefore illuminates obscure expectations about the goal of the meeting. While older persons and family members considered the meeting as a means to improve the long-term life situation, the professionals tended to view the meeting more or less as a goal in itself.

Comprehensive interpretation and discussion

Our comprehensive interpretation is that the HSCPC-meeting was part of the life course of the older persons and their family members. Time is an important parameter of the life course perspective where events and experiences in the present situation are understood within the person's own biography. With a life course perspective, a person's life is seen as a series of events where events in the past affect the present situation (34). In this study, the older persons and their family members had an inside knowledge of how the previous life had manifested itself and about the events that had led to the current situation. In addition, most of them had experienced a number of meetings with health and social care professionals before. How these meetings had turned out influenced whether they felt confident that something good would come out of the present meeting or if their confidence was lost. However, the life courses of the professionals differed significantly from those of the older persons and family members. For them the present meeting was only a brief part of the working day, in which one meeting follows another. Thus, there was a risk that the meeting for the professionals easily became more or less a routine task. In spite of this, meeting all together in the home setting brought insight into the older person's life course as the home with its furniture, paintings and pictures illuminated parts of the older persons' biography and therefore increased humility and a gave a better understanding of them as persons. The social world become more clearly intertwined with the health problems in the home environment. There was, however, a lack of awareness among professionals that the older persons' and family members' experiences were not based solely on the present meeting, but also on experiences from other kinds of meetings and on their expectations of future support from health and social care.

The professionals' daily practice is concerned with answering questions and coming up with solutions to problems. In contrast, the core of a HSCPC with a person-centred approach is that the older person, the family members, and the professionals from health and social sectors all listen to each other before entering the process of problem solution. Hence, providing conditions for the older person to participate in the dialogue is essential and partnership is therefore a central concept in person-centred theory (7, 35). Although the professionals expressed a strong desire to reach a partnership by involving the older person and their family members in the dialogue and decision-making, this goal was obstructed by the existence of power relations. According to Kristensson-Uggla (36), persons in need for health care are in an inferior position that is threefold; institutional, cognitive and existential as they enter an organisation that is hierarchic and in which they become inferior to the professionals (institutional disadvantage), do not have access to the same knowledge as the professionals have (cognitive disadvantage) and are vulnerable due to multiple diseases (existential disadvantage). To achieve a true partnership, professionals need to counteract the imbalance in power between patients and professionals (ibid.). Arranging the HSCPC-meeting in the older person's home could be understood in terms of attempts to reduce the institutional disadvantage, as the environment represents an autobiographical memory connected to a persons' identity and security in place (37). Thus, the home represents continuity, routines, and identity (38). This became evident to the professionals when they used the home environment to understand the older person better, to see how they functioned in their home, and to find out their needs in daily life. To get the most out of a meeting, meeting skills and four meeting-roles are essential: the leader who keeps the discussion to the agenda, the time-keeper who keeps the participants aware of time without

exhausting the older person, the recorder who capture the significance of the discussion and, the facilitator who promotes a climate where everyone can have their say (39). These roles must always be attended to. But this is not enough, it is often necessary to designate a resource person who knows the older person well and acts as an advocate during the meeting and as a contact person after. The role as an advocate includes, when necessary, to address other aspects than the relative does, in order to make the care planning process person-centred (20).

Older persons' and family members' uncertainty about the purpose of the meeting led to a cognitive disadvantage (36) vis-à-vis the professionals. The meeting was initiated by the professionals who had knowledge that older persons and family members lacked. Ambiguity about the purpose of the meeting can create problems if the older persons, their family members and the professionals have different views of what the meeting is for. If the professionals have an agenda that is unknown to the others, there is a risk that the older person will agree to suggestions they have not had time to think through. Hence, professionals need to come prepared, but go in open-minded and with a listening mind, and take the power relations into consideration during the process. A meeting that provides greater insight and humility about how others think and reason provides conditions for, as Gadamer puts it, a fusion of horizons (30) and can thereby reduce institutional, cognitive and existential disadvantage (36), enhance knowledge transfer (3), interorganisational trust (40), and interprofessional collaboration (41).

Limitations

The credibility of the present study refers to quality in interviews and interpretations (42). Although the interviews were held in close connection to the meeting, and although one inclusion criterion was that the older persons should be able and willing to tell their story, some had trouble remembering details from the meeting. The fact that the elderly themselves had to give permission for a family member to participate in the study may have led to a preponderance of close relationships which may have given a distorted picture of high agreement between older persons and their family members. When the older person and the family member were interviewed together, there was a risk that family members had an agenda of their own, and this was taken into consideration by the interviewer. However, our impression was that family members acted as a support and as the older person's advocate and therefore contributed to the interview when adding and confirming details. Although a few professionals were unable to attend to the interview, a majority provided concrete images of the meeting and reminded themselves of how they had experienced the meeting, with feelings of uncertainty and insights of not having fully succeeded to involve the older persons and family members.

The researchers preunderstandings is always a risk of bias (43) and for reducing a study's confirmability (42), but Gadamer (30) argues that preunderstanding could also be used as an asset in the analysis. Initially, the analysis confirmed much of our preunderstanding. However, the preunderstanding changed when the text was analysed in a dialectical relationship between the whole (the meeting) and the parts (the older persons', the family members' and the professionals' perspectives), and a new understanding arose: the advantages and challenges of performing a HSCPC, the importance of considering the life course perspective and, as part of person-centred theory, the challenge of equalising the threefold disadvantage of the care receiver.

Transferability of findings may be questioned, in cases where the Swedish way of organising care of older persons differs from other countries. Nevertheless, a high level of abstraction facilitates transferability. However, we believe that our main findings are situated on a level of abstraction so that the findings can apply to other kinds of meetings conducted in older persons homes: there is a risk of unspoken agendas, the home setting facilitates security and enhanced understanding but might nevertheless be insufficient to equalise asymmetric relationships and that there is a need to establish follow-up routines and designate a contact person.

Conclusion and clinical applications

This study reveals that HSCPC is a process that must be learned by both the professionals and the organisations themselves. Like the UK care and support model (19), a HSCPC need to 'ensure everyone involved in leading, facilitating, writing and reviewing care and support plans is trained and supported to deliver these elements in consistently person-centred, person-led ways' p. 39. As HSCPC involving several people and organisations is a costly process, it should not be used as a routine approach. However, as staff, it could be challenging to adjust not only to another person's life course but also to slow down from the ordinary work pace in order to be truly present during the HSCPC-meeting. This is an aspect to take in account when planning for HSCPC in the organisation. In order to ensure that the meeting fulfils its intentions, there must be a coordinator to prepare the meeting, an agenda that is known to all participants, a chairperson with meeting skills, a follow-up and an appointed person for keeping in contact afterwards. Finally, when person-centred care is intended, it is of utmost importance to realise that a HSCPC is part of older persons' life course, that their perspective must always be taken into account and that the older persons must be seen as a partner in planning the care.

Therefore, a HSCPC should start by requesting the older person's own narrative and expectations.

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Author contribution

Malin Sundström, Pia Petersson, Margareta Rämgård and Kerstin Blomqvist designed the study. Malin Sundström, Linda Varland and Kerstin Blomqvist collected the data. All authors analysed the data and prepared the manuscript.

Ethical approval

The study was approved by the Regional Ethical Review Board in Lund, Sweden, ref. 2012/472.

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