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Complex caring needs without simple solutions: the experience of interprofessional collaboration among staff caring for older persons with multimorbidity at home care settings

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Complex caring needs without simple solutions: the experience of interprofessional collaboration among staff caring for older persons with multimorbidity at home care settings

Background: Older persons with multimorbidity being cared for at home often have complex needs which cannot be met by one single caregiver. Interprofessional collaboration is therefore considered necessary if care is to be organised according to the needs of the older person. To achieve coherent health care, municipalities and county councils need to develop their collaboration.
Aim: The aim of this study was to illustrate how various professionals belonging to homemaker services, home care services in municipality and hospital-based home care services experience collaboration in caring for older persons with multimorbidity.
Method: A hermeneutic approach was used. Eleven informants participated in the study and were individually interviewed.
Findings: The findings show that collaboration between players comprises various types of experiences which influence not only the staff who are involved in collaboration but also the outcome of the collaboration itself. The informants' experience of collaboration was defined by distrust and trust and by insecurity and security. To focus on patients' needs and to develop the collaboration further, it was important for informants to take the relations into account and have a reflective and questioning approach. This attitude resulted in a feeling of trust and security, and a flexible and critical approach without boundary drawings between basic and specialised care.
Conclusion and relevance of practice: Complex situations cannot be solved with simple models. Instead, a flexible approach appears necessary with focus shifting from structures to interpersonal relations and interactions. Therefore, the different professionals have to work as a transprofessional team where close interactions, flexibility and improvisation are keys to success. The transprofessional team approach is suggested to have the potential to take the competence of all staff into account when high-quality home health care to older persons with multimorbidity is to be provided by multiple caregivers.

Keywords: multimorbidity, interprofessional collaboration, hermeneutic, hospital-based home care services, home care services, older persons.

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Introduction

Home health care has become more common during the last decades. Developments in medicine and medical technology have made it possible to care for older persons with multimorbidity at home. Shorter lengths of stay in hospital have also contributed to home health care becoming an alternative arena for care. However, home health care usually implies collaboration between different healthcare professionals and healthcare provider organisations with a risk for fragmented care and lack of a holistic view.

To achieve coherent health care without fragmentation it is important to understand the collaboration within and across organisations. However, in Sweden, the division between specialised and basic home health care for older persons with multimorbidity may contribute to further fragmentation of care.

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Background

Swedish health care has undergone major changes over the last twenty years. The Elderly Reform Act of 1992 transferred overall responsibility for nursing and health care for older persons from county councils to municipalities (1). The aim was to better coordinate resources by putting them under a single organisation (2). Properly functioning home health care of older persons with multimorbidity often requires a considerable investment of effort both from hospital and primary care under the county council and from home health care services and homemaker services under the municipality. The shared responsibility for home health care is complex with several professional categories and different healthcare organisations being involved in patient care. This gives rise to new challenges for the healthcare system (3), and according to Doessing et al. (4), a key challenge in care coordination is to both reduce and embrace complexity. Collaboration and financial liability within the Swedish healthcare system are regulated by various statutes, intended to ensure efficient transfer of information (5) and routines for collaboration between healthcare professionals and between healthcare organisations (6).

Older persons often suffer from multiple illnesses with complex healthcare needs. This leads to the probable need of a combination of medical and social measures from different care providers (7). Older persons are overrepresented with respect both to the frequency of hospital admissions and the length of stay (8). Hospital care is often suboptimal and directed towards specific diseases with well-defined symptoms, resulting in patients' overall needs not being met (9). Person with complex caring needs require support and care with an overall perspective which specialised and hierarchically controlled organisations rarely can achieve (10). Therefore, it is considered necessary that relevant organisations develop accurate collaboration in order to create cohesive home health care relevant to the needs of the older person with multimorbidity (11).

To ensure safe and high-quality home health care for older persons with multimorbidity, it is imperative with effective interprofessional collaboration as well within and between organisations. It is suggested that an effective interdisciplinary teamwork has a more positive influence on patient outcomes than other quality improvement strategies (10). Depending on context, the definition of a team is unclear. Team researchers in health care define teams as being complex, adaptive, dynamic processes that exist in context and perform over time (12, 13) However, teamwork involves at least two health professionals, having a common or tangential goal for health care, which includes assessing, planning, performing and evaluating patient care with the defining attributes of interdependent collaboration, open communication and shared decision-making (11).

Thylefors, Persson & Hellstrom (14) have described three models for organising and performing teamwork in which there are discrepancies according to roles, coordination and leadership (see Table 1).

Interdisciplinary collaboration has been defined as an interpersonal process that leads to achieving goals that could not have been reached by a single team member (15). Bronstein (15) has in his model identified five components for interdisciplinary collaboration: interdependence is the reliance on other professionals in order to accomplish a task; newly created professional activities refers to collaborative acts that accomplish more than independent acts; flexibility refers to deliberate occurrence of role-blurring, with professional roles changing due to existing needs; collective ownership of goals refers to all team members sharing responsibility for success; and finally, reflection on process refers to reflecting and talking about the process, including feedback to improve outcomes.

Healthcare professionals' personalities and professional boundaries may influence the quality of teamwork, the quality of care, and as a result, also the quality of life for patients and their families (16). Uncertainty regarding teamwork may result in local interpretations (17) and lack of teamwork may therefore be considered as the main problem even though organisational structures and issues may be contributing. Individual healthcare professionals enter the team collaboration process with their own perspectives based on organisation, field of activity and profession. Their approach must therefore take into account as well differing goals and ideas on problem-solving as differing degrees of engagement in the process

Table 1 Team models; roles, coordination and leadership (14)

Multiprofessional	*Interprofessional*	*Transprofessional*
Team roles are specialised and everyone concentrates on own tasks.	Team roles are specialised but everyone is expected to interact.	Team roles are specialised, but everyone must be prepared to complement and replace each other when needed.
Coordination is based on supervision or standardisation.	Everyone has to coordinate their own activities.	Coordination is achieved by close interaction, flexibility and improvisation.
The team leader functions as a traditional manager.	The team leader functions as a coach.	The team leadership varies with the situation; the team is self-regulated.

(18). The process is not always the result of previous calculations but becomes clear through gradual interplay in a specific environment. The team members can in this case freely choose how to manage various forces and factors influencing the process (19). According to Vangen & Huxham (20), the basis for a well-functioning team collaboration is a climate of trust which needs to be continually nurtured. Despite this knowledge, health care is still organised on the principle of boundary drawing with focus on division of roles and responsibility.

In southern Sweden, there is collaboration between professionals in primary health care, municipality home care services (MHCS), municipality homemaker services (MHMS) and hospital-based home care service (HBHCS) for patients in home health care. The division of responsibilities between the MHCS and HBHCS is regulated on the basis of a functional boundary between basic and specialised care. This division means that HBHCS has the responsibility for and also carries out all specialised home health care. Specialised care could either mean having full responsibility for the medical care or having responsibility for certain aspects of care, for example blood transfusions. The division however is often considered not to be conducive to safe and high-quality care for older persons with complex caring needs and is still an area with many shortcomings (21).

To gain an understanding of factors that promote or inhabit collaboration, professionals' experience of interprofessional and interorganisational collaboration is imperative. The experience of professionals may thus contribute to identify shortcomings in caring for older persons with multimorbidity.

Aim

The aim of this study was to illustrate how various professionals belonging to homemaker services, home care services in municipality and hospital-based care services experience collaboration in caring for older persons with multimorbidity.

Methodology

Our choice of research approach is based on the phenomenon to be studied, considering the perspective of ontology and epistemology. Collaboration is a complex phenomenon that cannot be viewed independently of its context, as both the parts and the whole are of significance. The knowledge sought is new aspects of the phenomenon of collaboration which cannot be analysed through already known aspects but should instead be analysed through unprejudiced interpretation. These opportunities are provided within hermeneutics where the focus is on understanding and interpretation within a given context. Within hermeneutics, the informants' experience is used as a tool to improved understanding of the social, cultural, political or historical context in which these experiences occur (22).

Context and data collection

In Sweden, health care is provided by two organisations, municipalities and county councils. This means that when older persons are taken care for in their homes, different professionals from different organisations have to collaborate (Fig. 1).

The study took place in the south of Sweden and the informants (n = 11) were recruited from both municipalities and county councils (Table 2). No general practitioner (GP) from primary health care was invited to participate in the study because they do usually function as medical consultants to the municipality nurse, while physicians at the HBHCS have a more active role in patient care.

Before the recruitment process, managers within the municipalities and HBHCS were informed about the study. They then nominated possible informants with experience of collaboration in caring for older persons with multimorbidity. These potential informants were then approached via email with information about the study. Those who expressed interest in study participation were given an appointment for an interview. Five of those contacted declined to participate. Reasons given were as follows: work time pressure, long time since working with this type of patients or not interested. Two men and nine women with several years of professional experience participated in the study, their age ranged from 40–60 years.

The interviews were carried out between October 2012 and January 2013 by the first author (AL) and each informant was interviewed once at a place selected by the informant. They all chose some quiet area in their own workplace. Before the interview started, written and oral information was given. Written consent was then obtained and informants were informed about their right to withdraw at any time without stating a reason.

In all interviews, the informants were encouraged to describe their experience of situations where they had been involved in interprofessional collaboration. Thus, the unstructured interviews were initiated by the question: 'Can you tell me about your experience of interprofessional collaboration in caring for older persons with multimorbidity?' During the interview, the initial question was supplemented with questions such as 'What do you mean?' and 'Can you explain a bit more?' The first two interviews were initially conducted to test the quality of the initial question but as they gave rich and detailed information they became included in the study. The recorded interviews lasted between 38 and 58 minutes, and were transcribed shortly after the actual interview.

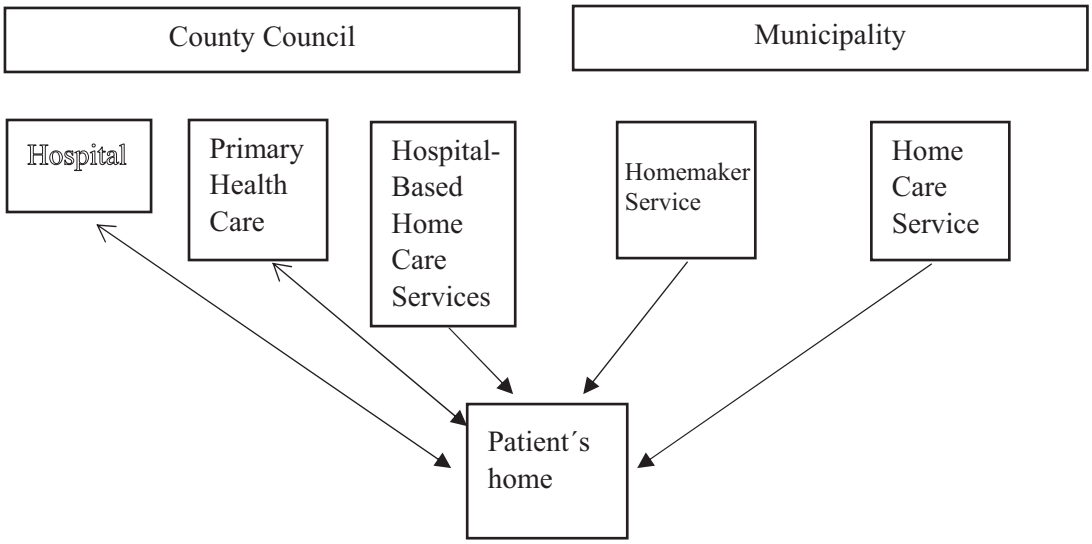

Figure 1 Illustration of the Swedish healthcare organisation. Professionals from two healthcare providers and from different organisations have to collaborate when older persons with multimorbidity are in need of home health care. Hospital-based home care services (HBHCS) are involved in the care when the person needs advanced care, while home care services (MHCS) are responsible for basic care. The care in the municipality is up to the nurse level, while the responsible physician is in primary health care.

Table 2 Place of work and professional category of informants

MHCS[a]	Occupational therapist (n = 1)
	Registered nurse (n = 1)
	Medically responsible nurse (n = 1)
HBHCS[a]	Physician (n = 2)
	Registered Nurse (n = 4)
MHMS[a]	Care Administrator (n = 1)
	Enrolled nurse (n = 1)

[a]MHCS, municipal home care services; HBHCS, hospital-based home care services; MHMS, municipal homemaker services.

Data analysis

The material was transcribed and analysed using a hermeneutic method (23). When all the interviews were completed and transcribed, the analysis phase begun. All the material was read by two of the authors (AL & PP). The first stage was a narrative reading to give an overall sense of the material. A first impression was that the informants strove to create clear boundaries, both with respect to their partners in collaboration and with respect to the actual tasks. This impression led in a second stage to search for expressions of meaning in which the informants recalled situations which had delimited them or situations in which they deliberately had drawn limits or boundaries themselves. During this search we found other expressions of meaning and our interpretation is that the informants tried to find solutions rather than boundary drawings. During the entire process, both individually and together, a constant oscillation between the parts and the whole resulted in further interpretation of the phenomena. The existential interpretation illustrates how the informant experiences the collaboration which influences not only the involved staff but also the outcome of the collaboration itself. Thus, in this study, the hermeneutic analysis expanded the meaning of the parts by understanding the whole.

Ethical considerations

The study was carried out according to the Helsinki declaration (24) and ethical guidelines for nursing research in the Nordic countries (25).

Strategies to make the interview situation confident for the informants were to let them chose the place for the interview. The interviews were also conducted as a familiar dialogue. All the informants felt confidence and enjoyed to share their stories. The first author has long experience from HBHCS and the informants were informed about this in the information letter. Despite this the informants shared both negative and positive experiences.

According to Swedish law no ethical approval was required for the study since only staff members were included in the data collection.

Findings

The findings show that the informants desired a holistic approach in caring for the older person with multimorbidity. However, the findings also showed that collaboration was about distrust or trust and feelings of insecurity and security, aspects that had an impact on the informants' approach to interprofessional collaboration.

To collaborate is to feel distrust or trust

Collaboration is about being part of a continual social interaction. The informants expressed their feelings of continually being part of a process in which both distrust and trust were factors which aggravated or facilitated collaboration and their own work.

Many of the informants had a feeling of distrust when their competence was not asked for anymore. Both municipal and HBHCS staff based their daily work routine on teamwork in their respective organisation. Interprofessional collaboration between the two organisations was in opposition to the usual work routine with a holistic approach on patient care. One example is a situation when the HBHCS physician felt delegated to the role of a prescriber instead of being part of a team. This situation was perceived as being against professional responsibility for follow-up and thus became a source of frustration. Staff from the municipality felt that unwieldy working routines between the two organisations could be an obstacle in contributing to efficient patient care.

> Well I think that if we've taken care of a patient for 5 or 6 years and then HBHCS gets involved, they just take over completely and we're just onlookers. We could have contributed so much ourselves. (Inf B – MHCS)

Experiences of distrust were described by most of the informants. Informants from the municipal described that they felt their competence and knowledge of the patient was not requested. Their impression was that the HBHCS staff took care of the specialised work, while municipal staff were left to take care of the rest. They also thought that tasks were not always assigned according to competence or patient's need but according to what the HBHCS staff had time for or what they considered to be basic care.

> We feel that HBHCS want help from the nurses from the municipal home care just when it suits them. They say that they have complete responsibility for the patient but then want help from our nurses for small or boring tasks, they suddenly say it's too far to drive… (Inf C - MHMS)

Distrust could also stem from past events involving other person. One informant from HBHCS was unexpectedly confronted by distrust while trying to establish collaboration with staff from the municipality.

> I rang her district nurse after I'd been there and she was very negative towards me. Collaboration wasn't the sort of thing she had any positive experience of and actually she was very unpleasant. I had never met her before and the question of collaboration had never arisen. So I told her that I understood that something wasn't right and asked her to tell me what it was. (Inf I - HBHCS)

Mutual trust arose when there was a common ambition to focus on the patient's needs and when the competences and patient knowledge from both sides were taken into account. Mutual respect was evident even though the informants had their own competencies and professional perspectives as starting points. There was also an understanding that assessments were difficult and complex and that both the patient's medical and nursing needs had to be assessed in order to attain a good holistic view.

The informants from the municipality showed great trust in the HBHCS staff and perceived their broad competence and teamwork with physicians, counsellors and clergymen were valuable for the patient. Informants from HBHCS appreciated this trust and tried to share their general knowledge of specialised care so that it could benefit other patients. Staff from HBHCS also felt trust in the municipality's knowledge of the patient's entire situation, including previous care. Staff from HBHCS would, for example, always try to make common home visits in order to make maximal use of obtained knowledge in assessments and decision-making.

> Then I ask the district nurse and I ask the patient and family and the assistant nurse to get a coherent - whole image of nursing aspects from those who see them at every visit - every day. — With an overall picture, it is easier to avoid hospitalizations and prevent in time. (Inf G - HBHCS)

While trust strengthened focus on the patient, lack of trust weakened patient focus when interpersonal relations influenced collaboration. The informants' experience of trust was an important component within the confidence-building collaboration process.

To collaborate is to have a sense of insecurity or security

The informants expressed both insecurity and security. Several informants from the municipality and HBHCS experienced insecurity when a clear policy on the division of responsibility and on the specific sharing of financing were lacking. It also emerged that policy documents were interpreted differently over time and there were no clear solutions that could be applied to individual cases. Discussions held at meetings between the two organisations could not always be translated to the level of the individual informant who therefore had difficulty in finding the correct approach, which took a lot of time and energy.

> As I see it the problem with collaboration is that it gets too complicated – too many discussions about individual patients – after all these years with meetings between organizations they still can't find a solution – if everything went OK with seven patients and then collaboration ran into trouble with the

> eighth I could understand that but now there's trouble with all eight – it wastes a lot of time and energy. (Inf E - HBHCS)

Although there was a call for policy documents it also emerged that these documents were irrelevant without meaningful meeting points and relations within the collaboration process.

Sharing responsibility for the patient was felt to be insecure in certain situations and among several professional categories. Doctors at HBHCS found it difficult to get in contact with the GP, an important step in clarifying medical responsibility. There was uncertainty concerning responsibility for insulin prescriptions and whether the GP really wanted to collaborate or just get rid of a problem. The district nurse felt insecurity when the patient had medications prescribed by different doctors. Problems arose when different medication lists were contradictory or the actual medicine was not accessible.

> I also see in other patients when we have been more people and it has become very messy and so. So what I think I'm missing a lot, is more collaboration with HBHCS — (Inf K - MHCS)

There was also uncertainty surrounding the administration of medicine in different pill organisers sometimes leading to the patient not receiving medication since the home care service had not received sufficient information. Different documentation systems unable to communicate with each other compounded the problem. A consequence of shared responsibility was that a lot of staff could be involved and uncertainty arose as to where information about the patient could be found and how responsibility was to be shared.

> So we get a lot of information about this patient from a lot of different people but it feels like these patients are the ones we know least about – they're sort of outside the main framework – everyone feels a bit insecure, who was there last and what am I supposed to do now? (Inf D - HBHCS)

Informants from the municipality felt insecure about how much responsibility HBHCS would take and how they could find this out. This sometimes led to discussions in front of the patient which sometimes occurred at the discharge planning conference.

> Sometimes they recommend a temporary placement just because that isn't their responsibility and then they argue with each other. That shouldn't happen in front of the patient but it really does happen in planning conferences and that makes my blood boil. (Inf C - MHMS)

However, when HBHCS assumed the whole responsibility uncertainty was reduced and it was easier to see the patients' overall caring needs.

> Actually HBHCS have helped us towards an all-round approach and made us feel more secure, they've got various professional categories and experience of meeting people at home when everything is just chaotic. It feels like we just don't have that capability, especially with primary care working on their own and us on our own'. (Inf A - MHCS)

When tasks surrounding the patient were shared out on a continuous basis in the best interests of patient and staff without focusing on which organisation was responsible, care of the patient ran smoothly without focus on financing. This was seen, for example, when HBHCS gave a blood transfusion and collaborated with the district nurse to get blood samples. New problems could be tackled irrespective of how responsibility was divided. The enrolled nurse felt secure when she could communicate her observations to the nurse and receive adequate help. Breakthrough pain, dyspnoea in COPD and repeated blood transfusions were mentioned by several informants as being well suited to treatment at home in collaboration. HBHCS could, for example, have responsibility for the treatment of pain which otherwise may have resulted in hospital admission.

> The staff perhaps feel more secure... the patient isn't bothered who treats the pain but the staff feel secure that they know where to phone. (Inf E - HBHCS)

A feeling of security among staff was crucial but the intention was to give the patient safe and high-quality care at home instead of hospital admission. Security also meant that staff from HBHCS felt it was positive when the patient's district nurse took part in introducing HBHCS to the patient. At the same time HBHCS felt they could convey a sense of security to the district nurse through their specialised knowledge.

Interpretive comprehensive understanding

The first impression in the analysis was that the professionals wanted to draw boundaries at the same time as they had a desire for a holistic approach in respect for the needs of the patient. This contradiction was a challenge in the interprofessional collaboration process. Important components in this process were feelings of distrust or trust and insecurity or security which have a decisive influence on interpersonal relations. To focus on the patients' needs and further develop the collaboration it was important to take the relations into account and have a reflective and questioning approach. This attitude resulted in feelings of trust and security and in a flexible and critical approach without boundary drawings between basic and specialised care.

Discussion

The aim of this study was to illustrate how different professional categories within MHCS, HBHCS and MHMS experienced collaboration in caring for older persons with

multimorbidity and complex caring needs in home health care. The findings show that collaboration between caregivers contains various types of experiences which influence not only the staff involved in collaboration but also the outcome of the collaboration itself.

To attain coherent care the various competencies possessed by the staff must be fully utilised. Moreover, interpersonal relations need to be characterised by trust and security. In the absence of trust and security, distrust and insecurity can take central stage. The findings show that when the informants took advantage of each other's competencies to focus on the needs of the patients, a relationship characterised by mutual trust was created. On the other hand, there were informants who felt that their knowledge and competence was not made use of which led to distrust and a feeling of working on the sidelines and not together. To succeed in interprofessional collaboration, interdependence on other professionals in order to finish a task is one of the components illustrated by Bronstein (15).

Informants' experiences illustrate that positive effects do not come automatically when a great deal of knowledge is concentrated in one group. The group's development and collaboration are crucial in determining whether the final outcome is positive. This can be described by using Runsten's (26) theories on collective capability in knowledge intensive working groups. He proposes that the outcome in such groups in large measure depends on the networking behaviour of the participants. Important factors for the participants are confidence in each other's knowledge, being able to reflect, being attentive and being considerate. This is described by McDonald (27) as a dynamic way of working, establishing personal relations with trust and respect being more important than the balance of power in order to have focus on the patient and an overall view of the patients nursing and medical care. Building relations based on trust is a long-term process and can be difficult to achieve when individuals belong to different organisations and the composition of the group is not given beforehand. If there is no scope for or interest in developing relations, then the balance of power will receive most of the focus.

In order to make collaboration work well, the professionals need to be flexible, otherwise frustration grows and collaboration has a limiting effect on the quality of care. The informants emphasised that the patients' complex conditions led to difficulty discerning which symptoms should be treated by whom. They attempted to manage this uncertainty by finding structural solutions which clarified division of responsibility for different tasks. According to Hjern (10) and Augustinsson et al. (28), the healthcare system of today is so complex that there is no predetermined route to meeting the patient's needs. The fragmented healthcare system leads to various tasks and responsibility being shared among various individuals in different organisations. This division creates ambiguity and vagueness. Previous ways of working presupposed a defined body of knowledge and a predictable future. This point of departure leads to organisational management based on a simple model. A more flexible approach is however needed to allow scope to tackle problems and obstacles, and to make use of opportunities which arise in the unique situation and which can actually strengthen the collaborating process. With this perspective it is possible to improve team functioning with an interprofessional or transprofessional approach rather than with a multiprofessional approach (14). This approach can take advantage of everyone's skills in the unique situation and provide opportunities to a safe and high-quality home health care with focus on the patients' needs.

For this development, focus needs to be on relations and actions rather than organisational structures. Consistent with Bronstein (15), the findings show how relations can develop when the needs of the patient are in focus through a reflective and questioning approach to the agreed division of responsibility. A simple telephone conversation or common discussions about how to best help and support each other can greatly facilitate a flexible collaboration. This approach makes it easier to conduct collaboration on the basis of common decisions as to how the patient's needs can best be fulfilled. For the older persons with multimorbidity, this can mean that despite different caregivers and a financially fragmented healthcare structure, appropriate measures can be chosen to satisfy the individual's need of meaningful and coherent health care. It is important to make use of the unique information possessed by the individual staff members since this can be a decisive factor determining the exact nature of the collaboration. Successful collaboration will lay the foundations for a coherent chain of care. A coherent chain of care according to Ahlgren (29) means moving focus from organisational questions to questions about integrated health care.

Methodological considerations

This study is based on information from a small number of informants. All worked with care of older persons with multimorbidity in home health care and represented different professionals and organisations in the care chain. Five persons declined to participate, but on the basis of the spread of ages, various professionals and long work experiences among those eleven informants who participated, it was considered to be enough to get both the breadth and depth from the data collected. The persons who decline to participate represented different professionals and organisations who were invited to the study.

Even if the sample was small and collaboration depended on context, the result showed that the informants had experiences which can be seen as generally applicable in situations where individuals need to collaborate.

One of the authors (AL) works at HBHCS which means that preunderstanding must be taken into account. Regarding study credibility, all the material was read through by two authors independently of each other (AL, PP). The other author (PP) had no experience of HBHCS; therefore, the question of preunderstanding was handled by a continual critical discussion between the authors during the analysis and interpretation phases.

Conclusion

In conclusion, the informants in this study have communicated valuable knowledge making it possible to illustrate collaboration between individuals in different organisations collaborating in the home health care of older persons with multimorbidity. Instead of drawing boundaries, it should be accepted as the complex work it is, constantly influenced by its environment, expectations, roles and cultures. The situations the participants have described bear witness to this complexity and the absence of simple solutions which solely is based on regulations and structure. To keep the patients' needs in focus, the key lies to interdependence between the individuals in the organisations. Therefore, the different professionals have to work as a transprofessional team where close interactions, flexibility and improvisation are keys to success.

Relevance to clinical practice

The findings of the study can be a starting point in gaining a better understanding of how collaboration can be developed by shifting focus from structure to interpersonal relations and interactions. When everyone's competencies are harnessed to gain an overall view, the patient's needs become the focus of collaboration and fragmentation of care can be avoided.

The findings offer knowledge about the complexity of collaboration when caring for older person with multimorbidity in home health care. To achieve coherent health care where focus is on the needs of the patient, a change of mindset is necessary. The goal of collaboration cannot be reached using simplified models such as dividing patients' needs into basic and specialised care. Instead, findings show that theory of complexity with respect to personal interactions can be conducive to focusing on the needs of the patient. An interprofessional or transprofessional approach to teamwork collaboration has to take the competence of all staff into account when home health care to older persons with multimorbidity is to be provided by multiple caregivers. This is suggested as an approach with potential to provide high-quality and safe care to a vulnerable population.

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Author contributions

Anne Larsen and Pia Petersson designed the study and analysed the data; Anne Larsen collected the data; Anne Larsen, Pia Petersson and Eva Broberger prepared the manuscript.

Ethical approval

The study was carried out according to the Helsinki declaration and ethical guidelines for nursing research in the Nordic countries. According to Swedish law, no ethical approval was required for the study because only staff members were included in the data collection.

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References

1 Socialstyrelsen. Ädelreformen - Slutrapport (Elderly Reform -Final report). Fritzes offentliga publikationer: Stockholm. [Swedish]. 1996.
2 Thorslund M. Det nygamla gränssnittet; äldrevården och dess omorgansiation (The new-old interface; elderly care and its organization). In *Vem styr vården? Organisation och politisk styrning inom svensk sjukvård,* (Blomqvist P, ed), 2007, SNS Förlag. [Swedish], Stockholm,. 104–31.
3 Rämgård M, Blomqvist K, Petersson P. Developing health and social care planning in collaboration. *J Interprof Care* 2015; 29(4): 354–8.
4 Doessing A, Burau V. Care coordination of multimorbidity: a scoping study. *JOC* 2015; 5: 15–28.
5 SOSFS 2005:27. Samverkan vid in och utskrivning av patienter i sluten vård (Co-operation in connection with registration and discharge of patients in hospital care).
6 SOSFS 2011:9. Socialstyrelsens föreskrifter och allmänna råd om ledningssystem för systematisk kvalitetsarbete (The National Board's regulations and general guidelines on management systematic quality work). Stockholm: Socialstyrelsen. [Swedish].
7 Meinow B. Capturing Health in the Elderly Population. Complex Health

problems, Mortality and the allocation of Home-Help Services.: Stockholms University; 2008.
8 Condelius A, Edberg A-K, Jakobsson U, Hallberg I. Hospital admissions among people 65 + related to multimobidity, municipal and outpatient care. *Arch Gerontol Geriatr* 2008; 46: 41–55.
9 Larsen T, Falk H, Bångsbo A. Onödig slutenvård av sköra äldre. En kunskapsöversikt (Unnecessary hospitalization of frail elderly, a systematic review) 2013.
10 Hjern B. Samverkan - inneord eller en utmaning för den svenska modellen (Collaboration - the words or a challenge for the Swedish model). In: Axelsson R, Bihari Axelsson S, editors. Folkhälsa i samverkan mellan professioner, organisationer och samhällssektorer Lund: Studentlitteratur. [Swedish]; 2009. p. 33–57.
11 Sims S, Hewitt G, Harris R. Evidence of collaboration, pooling of resources, learning and role blurring in interprofessional healthcare teams: a realist synthesis. *J Interprof Care* 2015; 29: 20–25.
12 Junger S, Pestinger M, Elsner F, Krumm N, Radbruch L. Criteria for successful multiprofessional cooperation in palliative care teams. *Palliat Med* 2007; 21: 347–54.
13 Ilgen D, Hollenbeck J, Johnson M, Jundt D. Teams in organizations: from input-process-output models to IMOI models. *Annu Rev Psychol* 2005; 56: 517–43.
14 Thylefors I, Persson O, Hellstrom D. Team types, perceived efficiency and team climate in Swedish cross-professional teamwork. *J Interprof Care* 2005; 19: 102–14.
15 Bronstein L. A model for interdisciplinary collaboration. *Soc Work* 2003; 48: 297–306.
16 Arnaert A, Wainwright M. Providing care and sharing expertise: reflections of nurse-specialists in palliative home care. *Palliat Support Care* 2009; 7: 357–64.
17 Finn R, Learmonth M, Reedy P. Some unintended effects of teamwork in healthcare. *Soc Sci Med* 2010; 70: 1148–54.
18 Mandell MP, Steelman TA. Understanding what can be accomplished trhrough interorganisational innovations. Public Management Review. 2003;5(2).
19 Furenbäck I. Utveckling av samverkan - ett deltagarorienterat aktionsforskningsprojekt inom hälso- och sjukvård (Development of collaboration: A participatory action research project within Swedish health care). 2012, Nordic School of Public Health, Gothenburg.
20 Vangen S, Huxham C. Nurturing collaborative relations. *J Appl Behav Sci* 2005; 39: 5–31.
21 Fratiglioni L, Marengoni A, Meinow B, Karp A. Multipla hälsoproblem bland personer över 60 år. En systematisk litteraturstudie om förekomst, konsekvenser och vård (Multiple health problems among people over 60 years. A systematic study of the incidence, consequences, and treatment) SOU 2010:48. Stockholm: 2010
22 Polit D, Beck C. *Nursing Researh: Generation and Assessing Evidence for Nursing Practice*. 2008, Lippincott Williams & Wilkins, Philidelphia.
23 Gadamer H-G, Weinsheimer J, Marshall DG. *Truth and Method*. 2004, Continuum, London.
24 World Medical Association. Ethical principles for medical research involving human subjects. *JAMA* 2013; 310: 2191–4.
25 Northern Nurse's Federation. Ethical guidlines for nursing research in the Nordic countries Vård i Norden. 2003; 23(4): 1–19.
26 Runsten P. Kollektiv förmåga. En avhandling om grupper och kunskapsintegration (Collective ability. A dissertation on groups and knowledge integration) Stockholm Sweden: Handelshögskolan; 2011.
27 McDonald J, Jayasuriya R, Harris M. The influences of power dynamics and trust on multidisciplinary collaboration: a qualitative case study of type 2 diabetes mellitus. *BMC Health Serv Res* 2012; 12: 63.
28 Augustinsson S, Petersson P. On discharge planning: dynamic complex processes – uncertainty, surprise and standardisation. *J Res Nurs* 2015; 20: 39–53.
29 Ahlgren B. Mutualism and antagonism within organizations of integrated health care. *J Health Organ Manag* 2010; 24: 396–411.