Palliative teams’ collaborative practice with employees from hospital departments and municipal care

Katrin Hove
Medical supervisor and cancer nurse, Department of Economics /Budgets and Analysis, Helse Møre og Romsdal HF
Katrin.Mork.Hove@helse-mr.no

Frøydis Vasset
Associate professor, Department of health. Faculty of Medicine and Health science, Norwegian University of Science and Technology (NTNU)
fv@ntnu.no

Abstract
The purpose is to investigate how palliative teams collaborate interprofessionally with professionals/patients from different occupations in hospital departments and municipal health care services. Background: Previous research has argued that interprofessional teams support the continuity of care, research-based decision-making, advanced care planning, and high-quality care for palliative patients. Method: Qualitative methodology with four focus group interviews was utilized in four hospitals in central Norway, and there were 26 informants: nine doctors, eight nurses, three physiotherapists, two social workers, two priests and two occupational therapists. Results: The informants described factors that were perceived as either facilitators or barriers in interprofessional collaboration with hospitals and municipalities. Together with employees from hospitals and municipalities, the informants could develop a more comprehensive view of the patient’s holistic needs. Discussion: The informants highlighted that patients were followed up by the team. They described their mission to contribute as raising the competence level in other professions and care services. Different professionals with palliative skills could facilitate both health professionals and patients. The physiotherapy profession was especially useful because it emphasized the rehabilitation factor. This study found that patients were referred to the team late in the disease process. Conclusion: Palliative teams want to collaborate with other health institutions, so the palliative patients receive comprehensive, holistic and coordinated care. There is different availability and varieties of palliative care in municipalities. These differences can be a challenge in interprofessional coordinated and holistic health care services.

Keywords
health professionals, hospitals, interprofessional collaboration, municipal health care, palliation

Introduction
Both in Norway and internationally, political guidelines require collaboration in all health care services (1-3). This implies that health care professionals should work together to benefit patients (1-3). The World Health Organization (WHO) has been the driving force for interprofessional education and has set several goals for collaboration in practice (4). The reform in education for welfare (2) has led to several policy requirements for collaboration between institutions and health professions, improving quality and efficiency in health care. It is emphasized as fundamental that all participants develop a common understanding and goals for providing good comprehensive care to patients.
Collaboration requires coordination among health professions and involves a mutual and binding adaption of different work tasks. It intends to ensure a flow in the working process so that patients, relatives and different health professions experience coordinated and holistic care. Collaboration is informal contact based on a positive attitude, trust and mutual interest in collaboration. Collaboration involves both management responsibilities and administrative functions (5). The Norwegian Board of Health Authority’s (6) inspection shows that collaboration in patient care and transformation transposition frequently fails, especially the transfer of information. A white paper (7) underlined the lack of collaboration, user involvement and interaction between municipality care and hospitals.

Another white paper (8) refers to interprofessional services as a useful form of collaboration. Coordination reform (1) introduces various forms of cooperation and states that interprofessional teams can contribute to comprehensive treatments and better continuity in patient care. Palliative teams can help employees in municipalities in terms of medication and treatment procedures. Then, the patient can stay in their home as long as possible. Even with public regulations, there are still some challenges in interprofessional collaboration on patient pathways (9,3).

Organizing palliative care

High levels of interaction and user involvement are described as working methods in palliative teams (10). Palliative patients often have complex illnesses that involve many different health professions. The Norwegian Directorate of Health (10) states that an ever-increasing population of elderly people will, among other things, lead to increasing numbers of cancer patients. Modern cancer treatment means that many patients live longer with cancer, increasing the need for palliative care and treatment (10,11).

The palliative ambulatory team (with different professionals) is the hospital’s interprofessional competence base in palliative care. In Norway, the palliative team is a part of the hospital setting and a key link between the patient and different health professions and departments. This team can make home visits and provide consulting and advisory services with extensive competence in palliative care and treatment (10). NOU (Norwegian’s Public Investigation) (11) claims that there are major differences in the organization of palliation in municipalities. Support from a palliative team to doctors and home nursing creates security and can be crucial to obtain good palliative care at home. A white paper (7) argues that there is a need to strengthen palliative competence among municipalities. The employees at the hospital and those who provide in-home nursing lay the foundation for interaction through direct communication between the team and different departments. Doctors are described as key professionals, but they participate to varying degrees (11). The NOU notes that there is insufficient knowledge of how care in municipalities should best be organized for patients with complex palliative needs.

The purpose of this study was to investigate how palliative teams collaborate interprofessionally with patients and professionals from different occupations in hospital departments and municipal care.

Palliative teams’ collaborative practice with hospital departments and municipal care

Collaboration and interprofessional approaches are important components for providing comprehensive and coordinated patient care (3). Research (12-15) emphasizes that successful collaboration in health care addresses several aspects of the interaction, organization and environment.
In 1954, Allport’s theory (16) highlighted that people collaborate, learn from, respect and appreciate participants from other professions/institutions, and this theory showed that interprofessional learning affects the quality of patient care and treatment. Professional knowledge and collaboration are the support pillars of a profession.

Studies show challenges related to interaction during patient transfers between levels in health care. Palliative teams are described as central collaborative bodies and links between hospitals and municipalities in interactions regarding palliative patients (13,14,17). Sandsdalen and colleagues (18) highlight that cancer patients experience the palliative phase as well coordinated, and they acknowledge that health professionals work together as a team. Another study (18) found that greater professional breadth is needed to achieve more active care, especially for patients in nursing homes.

There is a need to investigate models for effective interprofessional collaboration, according to researchers (17,19). Another study (14) shows that knowledge, willingness and ability to collaborate interprofessionally characterize interactions involving cancer patients. Reflecting on interactions that work well for users will provide valuable knowledge that will improve interactions where they do not currently work. Interprofessional palliative teams represent a key interaction strategy to achieve advanced care planning (20).

Chasen and colleagues (14) points out that ambiguity around the roles of health professionals can lead to barriers in providing effective care to patient groups other than cancer patients. This study emphasizes the need for more effective and coordinated interprofessional collaboration to improve palliative care as well as for patients with conditions other than cancer. Gardiner and colleagues (21) underlined many examples of good cooperation between health care providers but still recommend further research to gain the perspectives of health care professionals and patients regarding palliative care interaction.

The research question: What experiences do palliative teams have in interprofessional collaboration with patients and professionals from different occupations in hospital departments and municipal care?

**Method**

**Design**

Based on the research question, a qualitative design was used. This design was inspired by the phenomenological approach. Creswell (22) emphasizes that the human characteristics and experiences of the phenomenon are emphasized in this design. Phenomenology seeks to describe the lived experiences of a phenomenon and gain a deeper understanding of the phenomenon (22,23). Focus group interviews were conducted with health professionals about their experiences of collaboration with other professionals/patients in hospitals and municipal care.

**Sample**

Four focus group interviews were conducted at four hospitals in Norway. The inclusion criteria were that the informants worked in palliative teams and had at least one year of experience with this work. The study was approved by the clinic leader and the team’s department manager. They received written information about the planned study. The team manager selected a day, the place and the informants who could participate in the interview. The four focus group interviews are mentioned using the letters A, B, C, and D in the results section. There were between four and ten informants in the focus groups (Table 1); 26 informants altogether.
Table 1: The informants from teams A, B, C, D.

<table>
<thead>
<tr>
<th></th>
<th>Doctors</th>
<th>Nurses</th>
<th>Priests</th>
<th>Social workers</th>
<th>Physiotherapists</th>
<th>Occupational therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>C</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>D</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Data collection
The good group dynamics led to reflective discussions that provided reliable and useful information. These focus group interviews have the advantage of creating and providing access to rich information in a timely manner via group dynamics. The focus group interviews were conducted, transcribed and analysed by both the first and second authors and were conducted in 2017. This method is particularly suitable for discussion and learning about experiences, attitudes and points of view in an environment where many informants discuss and reflect on issues (24). This approach may also result in new topics about the types of conversations among the members of these types of teams, which may also be better for patients. Participation was voluntary, and full verbal information was provided. The interviews were supported by a moderator, and a co-moderator participated during the interviews. We conducted these interviews in workplaces, and the interviews were recorded on a Dictaphone. We used a semi-structured interview guide to ensure that key topics were highlighted while focusing on the open dialogue. The interviews lasted between 30 and 55 minutes.

The disadvantage is that there may be some information team members do not reveal. There will often be some dominant people in such groups. Some individual interviews or questionnaires could provide more detailed information.

Ethics
The study was approved by the Norwegian Center for Research Data (NSD), with project number 51218. The information letter and consent form were distributed and reviewed before the start of each interview. It was emphasized that participation was voluntary and that the informants could withdraw at any time without giving a reason.

Analysis
We used Giorgi’s (25) analysis strategy to analyse the transcribed interviews and to code text systematically. The four stages of the analysis strategy are as follows:

1. Overall impression. The transcribed material was thoroughly read by both the first and second authors, alone and together, several times, to form an overall impression.
2. Preparation of meaningful units. The data were divided into meaningful units with different colour codes. We arrived at two main themes: Positive experience with interprofessional collaboration with other health cares and challenges regarding collaboration with other health care providers.
3. Extraction and condensation of the text. This process contributed to the development of these two meaningful units with three sub-themes (see Table 2).
4. Summarize the meaning of the text. A critical understanding of the text highlighted the relevant quotes and provided the essence of the interviews.
Results
The results are divided into two main parts: positive experience with interprofessional interaction with health care and challenges of interprofessional interaction with health care. The responses from the informants are mostly centred around routines and bureaucracy problems.

Table 2. The themes and sub-themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1</strong></td>
<td></td>
</tr>
<tr>
<td>Positive experience with interprofessional</td>
<td>- Collaboration with hospitals and municipalities</td>
</tr>
<tr>
<td>collaboration with health care</td>
<td>- Strengthens the competence of transfers to other health care</td>
</tr>
<tr>
<td>- Collaboration with hospitals and</td>
<td></td>
</tr>
<tr>
<td>municipalities</td>
<td></td>
</tr>
<tr>
<td>- Strengthens the competence of transfers</td>
<td></td>
</tr>
<tr>
<td>to other health care</td>
<td></td>
</tr>
<tr>
<td><strong>Theme 2</strong></td>
<td></td>
</tr>
<tr>
<td>Challenges with collaboration and health</td>
<td>- Availability of the collaborative relationship</td>
</tr>
<tr>
<td>care</td>
<td>- Different offerings in patients’ municipality</td>
</tr>
</tbody>
</table>

Positive experience with interprofessional collaboration in health care

- **Collaboration with hospitals and municipalities**
All informants wanted the patient at the centre of all work. What was the most important for the patients? (A). The informants pointed out that patients referred to palliative teams had an advantage because the team interacted with their home municipalities (D). They also emphasized that it could be fundamental for patients to have a conversation with the team’s social workers because the social worker focused on situations around the patient and not just on the sickness. This was a matter of understanding different health professionals’ competence, contributions, and abilities to provide good health care.

Informants reported that they must respect and know something about other institutions and professionals: what they can offer, accepting them as they are, with the skills they have, was highlighted by one informant (C).

The informants collaborated with municipality care, that is, home nursing, nursing homes, doctor’s offices and physiotherapists, but they also noted that laypeople are important occupations (C). All participants said that cancer nurses and cancer coordinators in the municipalities were key resources for coordinating processes in palliative care. There was a lower threshold for contacting the palliative team at this time, than in previous years. Nurses have been in dialogue with us all the time, and doctors have been more absent (A). The informants also pointed out that in some situations, a nurse from the municipality would call them when they had a challenge concerning palliative patients.

- **Strengthening competence transfer to other health care**
The team members emphasized that increasing the skills of other professionals was the main goal of palliative collaboration. We should be consultants, supervisors and advisers and make other professionals and families to work the best possible way (A). The team members said that they also did some teaching involving the interaction around single patients. Participants emphasized this teaching with resource networks, with educated cancer nurses in hospital departments, and with in-home nursing and nursing homes. The informants expressed that they had a flexible attitude and wanted to understand other professionals’ workdays and work challenges. They wanted to challenge other professionals to be good helpers.
Challenges with collaboration and health care

— Availability in the collaborative relationship

Sometimes you could feel like “hair in the soup” when you got to hospital departments (D), one informant told us. Nevertheless, they experienced increased understanding and collaboration with hospital departments, mostly because the patients, after coordination reform, were in the hospital for a short time.

The informants stated that patients were sent to the team very late during the illness. We want to come into the palliative work earlier (A). The informants also wondered Who is sitting and deciding when the patient should be referred to the palliative team? (A). The informant discussed and reflected that it was often the patient who did not want to go to the palliative team because they looked upon us as a last resort (A). We have a marketing job (A) said another. The informants expressed that getting people with the right skills was a huge challenge (A). I wanted to take care of the social cohesion. Nevertheless, it was difficult to find who in the municipality could take the sequence further (A). An informant stated It wasn’t just for a physiotherapist to provide direct information to anyone in the health care system (C). The health care system is a bureaucratic system where the team often must go through the municipal administrative apparatus with information and questions. Thus, the written information that was sent to the departments became very central to patients’ needs for other professionals (C).

— Different offers in the patient’s municipality

The informants underlined that there was scarcity of resources, including short-term stays in the institution. Communication can be a bit on and off (D). It may be a little person dependent. In many situations, we lose good competence, and it is unfortunate (A). Knowledge and follow-up questions should be at the system level and not at the person level (A). Another informant said that the challenge is when the doctor is “a little disconnected” for various reasons, and nurses express their despair because they can’t talk to the doctor (D). The informants also stated that it was a challenge that some patients did not have any relationships or consultations with their doctor in recent years. It was stated that when the patient is at home, the team is not responsible for them, but they try to be solution-oriented (D). The emergency service often becomes a very bad solution (D).

Discussion

The purpose of this study is to investigate how palliative teams collaborate interprofessionally with patients and professionals from different occupations in hospital departments and municipal health care.

Positive experience with interprofessional collaboration with other types of health care

This study highlights that the patients who came to the palliative team benefited from their help. Different professions with various and complementary palliative skills could facilitate, coordinate, and connect professions and could make plans for good care based on the patient’s wishes and needs. Another study (20) shows that interprofessional palliative teams have a key interaction strategy to achieve advanced care planning. The palliative plan was described as a key component by the informants. A written palliative plan formalized and provided common objectives for patient-centred care.

The informants stated that it was fundamental to emphasize patients’ wishes, which was
important to them. They emphasized the fact that there were several members of the team who could contribute to good solutions when the patients had special needs. Different professionals with palliative skills could help both health personnel and patients who stay at home. The physiotherapist and social workers were especially mentioned for these patients. Physiotherapists working on rehabilitation had a positive mental effect on the users. The social worker could arrange for financial aid, housekeeping, family help and other personal tasks. Other research and Allport’s theory also supported the conclusion that patient care through interprofessional interaction is useful (3,9,12,15–17). Different professional roles represent a variety of helping skills and contributions to the patients’ comprehensive needs.

The impression is that interprofessionalism should be a key principle for better interaction and user involvement. This is in line with other research and theory emphasizing that people interact, learn, respect and value employees from other professions and health care service. Additionally, they show that interprofessional collaboration can affect patient safety and quality of health care (7,15,26). Interprofessionalism may also increase knowledge about a patient’s disease and the need for holistic help (26). As a survey (21) emphasizes, there are several examples of good collaboration between service providers, for example, avoiding excessive burdens on specialized palliative care, using cost-effective services, supporting decision-making staff and boosting positive attitudes towards palliative care. Optimal effects on patient care are achieved when health care professionals work together and can also reduce the duration of patients’ hospital stays, according to Minimol Kulakkottu (27). Another factor is that the palliative team gains more extended knowledge as a result of working interprofessionally.

The informants showed genuine involvement in their patients’ daily lives and concern about sending them to certain nursing homes because they did not always have good experiences with all institutions or professions. There may be a lack of professional and economic resources and competence in some Norwegian municipalities, which can again affect patient care (1,2). Those who work in palliative teams have experience and sufficient time to do the palliative work. They have resources and space to immerse themselves in the lives of different patients they are going to help and thus become better acquainted with professionals and patients in hospitals and the municipality. They work in a comprehensive way with both professionals and patients and follow up on many patients for a long time. The team can therefore build a close relationship with both patients and their health professionals. The Directorate of Health (10,11) describes the hospice philosophy and palliative profession as focusing on the holistic care of all human beings.

It is essential that the partners know something about what the palliative team can offer. Our participants described good collaboration with the hospitals, where they understood various ways of working and were available to invite the involved departments to collaborate. Good cooperation with the patient’s home municipality was central. The teams made home visits in the municipality and invited municipality workers to meet them. It was fundamental to attract more professionals, such as doctors and physiotherapists, to the patients in the municipality to provide the patient with the most comprehensive services at home. White papers (1,7) highlight the importance of palliative team support to provide good palliative services at home. Several studies (13,14,16-18) have reported that palliative teams are perceived as important components of the interaction between hospitals and municipalities for palliative patients. Another study (19) claims that palliative patients often receive better updates and knowledge than other patient groups. A compelling reason for this can be palliative teams’ involvement in disease processes. It may be the various professionals who
interact in this process and, as Allport (16) highlights, where the respect and appreciation of others intersect. Other important factors, such as the suitable introduction of public documents (1,2) and public emphasis, may also be an element for good collaboration.

The informants experienced and reported a flexible attitude towards other health professions and departments. This was a matter of compensating, adapting and understanding other professionals’ workdays. They had a lower threshold for contact and a better dialogue and an interaction with their partners, probably because of the teams’ ideology about holistic help. The team experienced a change in that there was a lower threshold for family doctors to contact the palliative team. This may be because doctors who have good, earlier experiences with palliative teams have flexible attitudes. These findings indicate that the palliative team created relationships with its partners. The central element of relationship building is also emphasized by developing constructive solutions to challenges and increasing service quality (28-30).

Our informants had participated in the establishment of resource networks where resource nurses from municipalities and hospitals met for teaching and exchanges of experience about collaboration. The team looked at themselves as consultants/advisors. Transferring advice and recruiting collaborators was considered one of their most important tasks. This corresponds with the Directorate of Health’s (10) guidelines for palliative work. The informants described the palliative plan as a key component in palliative care; they need common goals and objectives for patient-centred care and organizational efficiency. Bjørke et al. (29) and the project Collaborative Practice About Boundaries (CAB) found that the transfer of knowledge, practical competence and collaboration cannot be brought about by theoretical studies alone. It needs physical meetings, relationships, learning by experiencing and reflecting with others. The team itself had regular meetings with the regional palliative competence centre, with teaching, reflection and exchange of experience around different patient situations.

The palliative team could make plans for different challenges that could occur in palliative procedures. This finding has also been shown in other interprofessional/institutional papers (1-3,31). Team members have different and complementary skills and can offer broad knowledge and experience in palliative care. The description by the informants corresponds with a study (20) emphasizing that interprofessional palliative teams are a key interaction strategy to achieve advanced care planning. It is not known whether the teams spent more time on courses or seminars, but they had regular meetings with the regional palliative competence centre, with teaching, reflection and exchange of experience around different patient situations.

Challenges with collaboration and employees at hospital departments and municipal care
The informants claimed that patients were referred to the palliative team late in the patients’ illness. The informants would have preferred to contribute earlier, not just in the terminal phase of patients’ life. This is in accordance with the Directorate of Health (10,11,32) and WHO (4) guidelines for palliation, which should be a part of and follow the entire course of treatment. They also thought that different patient groups should be included. The informants saw that they could help to improve this by marketing themselves because many patients associated the palliative team with the near-death stage. This is not what the informants wanted. If a physiotherapist contributes to an early meeting, without the patient’s knowledge, the patients may get a sense of rehabilitation and then hope for a better life. Physiotherapists may also help with patients’ muscle stiffness and pain (33). The pro-
Professionals in the municipal hospital should also be marketing the palliative teams’ ideology for current patients.

One of the teams stated that they were not always welcome in hospital departments for unknown reasons. A department may experience unpleasantness in response to the team’s better understanding of the palliative patient’s holistic health, and the department itself does not have sufficient expertise. The same team felt that it was difficult to find accessibility in terms of competence in some municipalities. The meetings between the palliative team and health care providers must be arranged through the administrative apparatus. This municipal system is perceived as rigid and does not often facilitate interactions. The informants reflected this in the interviews, and it seems important for them to inform other health professionals in an informal way. Several studies (28-31) indicate that this information is key to this form of work. Communication with employees in the municipality can depend on individuals. That is, one or two employees were central and indispensable in all palliative work, but not all municipalities have such a strategy. When it was difficult to have verbal contact with professionals, good written documentation was necessary.

The services for palliative patients could be in various municipalities. This was often due to the scarcity of resources, such as institutional places, and the low availability of professionals, such as physiotherapists. In Norway, some municipalities are small and have poor finances (1). This may be a contributing cause of this lack of professionals. Small municipalities far away from central districts often have problems with professional expertise, which may result in a lack of health care for palliative patients.

Research writes that interprofessional relationships are rarely discussed during the care pathway (27). The informants wanted a decent interprofessional system in the municipality to take care of this competence. It should not be person or profession dependent. A white paper (7) points out that there is a need to strengthen palliative competence in municipal care. The informants stated that family doctors should be more involved in all palliative work. Public documents (1,7,11) indicate that family doctors should have a key role in all collaborations around patients. There are major differences in doctors’ competence and commitment to follow-up with palliative patients, informants stated. Weak doctor-patient relationships with their family-doctor may be a reason for these differences, as well as promises regarding confidentiality and doctors’ workloads.

The informants stated that they tried to solve some situations with practical judgement. At the same time, it emerged that they had the most interaction directly with the home care. Meetings with the doctors were most common when there was a special need for the patient. This corresponds to public documents (7,11) showing the same result.

Limitations and strengths of this research method
The present study is not generalizable but offers valuable insights and understanding about the phenomena of interprofessional collaboration in palliative teams and health departments. Perhaps a larger survey could provide more generalizable information. Despite the small sample size, we derived rich and contextualized information from the teams about factors that were perceived as either facilitators or barriers in teamwork. Our findings indicate that further and more comparative research could test and build upon these initial findings.
Conclusion
The study can contribute to increased knowledge of how interprofessional interactions are experienced. The study reports several good and less-favourable experiences of interactions with hospital departments and municipal care. There are still some challenges in the municipalities, such as a lack of competence and resources in relation to patients’ needs. Patient services vary from municipality to municipality and may be person dependent. Collaboration with family doctors can vary. The study indicates that joint meetings, relationship building, and networking between professions and different health care providers are important factors for interprofessional interactions, in terms of both teamwork and interactions with other health care services, such as municipal care.

References
6. Helsetilsynet 2016. The information was inadequate and was too late. Summary of National Surveillance in 2015 with collaboration on the printing of patients from specialist health services to the municipality; 2016.


