

Research and Theory

An interprofessional team approach to fall prevention for older home care clients 'at risk' of falling: health care providers share their experiences

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Abstract

Background: Providing care for older home care clients 'at risk' of falling requires the services of many health care providers due to pre-disposing chronic, complex conditions. One strategy to ensure that quality care is delivered is described in the integrated care literature; interprofessional collaboration. Engaging in an interprofessional team approach to fall prevention for this group of clients seems to make sense. However, whether or not this approach is feasible and realistic is not well described in the literature. As well, little is known about how teams function in the community when an interprofessional approach is engaged in. The barriers and facilitators of such an approach are also not known.

Purpose: The purpose of this qualitative study was to describe the experiences of five different health care professionals as they participated in an interprofessional team approach to care for the frail older adult living at home and at risk of falling.

Methodology: This study took place in Hamilton, ON, Canada and was part of a randomized controlled trial, the aim of which was to determine the effects and costs of a multifactorial and interdisciplinary team approach to fall prevention for older home care clients 'at risk' of falling. The current study utilized an exploratory descriptive design to answer the following research questions: how do interprofessional teams describe their experiences when involved in a research intervention requiring collaboration for a 9-month period of time? What are the barriers and facilitators to teamwork? Four focus groups were conducted with the care-provider teams (n=9) 6 and 9 months following group formation.

Results: This study revealed several themes which included, team capacity, practitioner competencies, perceived outcomes, support and time. Overall, care providers were positive about their experiences and felt that through an interprofessional approach benefits could be experienced by both the provider and the patient and his/her family. Findings from this study suggest that research needs to be conducted to further explore the issues faced by this group of care providers and potential client outcomes.

Keywords

care for the elderly, frail elderly, multidisciplinary care, interprofessional, falls

Introduction

Engaging in interprofessional collaboration is often a challenge for practitioners who are located in acute care settings for a variety of reasons, some of which include the hectic pace, the rapidly changing health status of the patients, and the size of the health care

team. However, in the community where team members are often required to work in isolation and travel from one client's home to the next to provide direct patient care, the challenges are equally as challenging. It is in the community that health professionals encounter some of their most complex and challenging patients—the frail older adults.

In the community setting, older adults who are prone to falls due to chronic conditions require an integrated approach to care because, it is impossible for one discipline to adequately identify and address all of the client care issues and risk factors of falls [1, 2]. Care must be organized and coordinated over time, among providers and across settings [3]. To ensure interprofessional collaboration, time must be taken to develop the team to ensure that each member understands their own role as well as the roles of the other team members and that together they share a common vision and goal when developing the patient's plan of care. Ultimately, the goal of interprofessional collaboration is to ensure positive client outcomes.

The purpose of this sub-study, using an exploratory descriptive design, was to describe the experiences of two distinct newly formed interprofessional teams as they participated in a randomized controlled trial. The aim of the trial was to determine the effects and costs of a multifactorial, interprofessional team approach to fall prevention compared to usual home care for older home care clients 'at risk' of falling. Further details regarding the trial can be found elsewhere [4]. All members of the team were familiar with one another and had worked together in the past. The need for this exploration was identified following commencement of the randomized controlled trial and once the two teams responsible for delivering the intervention had been developed. This sub-study commenced 3 months into the larger randomized control trial.

Literature review

As the health care system faces additional financial constraints, now more than ever, policy makers are examining how to best provide care for the frail older adult. It is believed by many that an integrated model of care can ensure a coordinated, cost-effective approach. Some models of integrated care, specific to this population, are described in the literature [5, 6]. Integration is defined by Kodner and Spreeuwenberg as, "a coherent set of methods and models on the funding, administrative, organizational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sections" [6, p. 3]. It is within service delivery that the interprofessional team and teamwork is described and this is the focus of the current study. Kodner and Spreeuwenberg [6] provide a unique perspective on integrated care. They describe a patient-centric view which looks at health care integration with a specific focus on the patient and particular patient populations. They suggest that this view enhances patient care and promotes system efficiency. The ultimate goal of adopting a patient-centric view is to be able to engage

in effective decision-making using various resources to ensure that patients with complex, chronic care needs are able to receive quality care [6].

Interprofessional collaboration has been purported to be the key to an effective and efficient health care delivery system. The goals of this approach related to client care have been described as; enhanced quality of care, system efficiency, client satisfaction, increased functional health, and adherence [7, 8]. Additional benefits have been described for those that participate in interprofessional collaboration. These include, but are not limited to, enhanced communication among team members, clarity of professional roles and responsibilities, a common vision, effective teamwork [9], and coordination of action plans [10]. Brown and McCool [11] note that the overall effect is one of greater efficiency and effectiveness, enhanced continuity and coordination, less duplication of services and less waste.

Several key elements are essential to interprofessional collaboration. First, there is an expectation that those involved will have a high-level of collaboration [12–17], coordination, and communication [18–22]. Second, team members will share the common goal of finding solutions to complex client issues [13, 21, 23]. Third, mutual respect and trust [13] that transcends professional boundaries and stereotypes [21, 24] must be present. Finally, decision-making, knowledge and expertise must be shared among team members [25–27] in a flexible and open environment [27].

One key element in interprofessional collaboration in any setting is communication. Communication is a theme discussed throughout the interprofessional literature [27–30]. A qualitative study conducted by King and Ross [23] that involved community-based services in two different boroughs in England found that effective communication and positive relationships had an impact on a team's ability to engage in collaborative projects. Through interviews and focus groups with the participants (district nurses, community staff nurses, managers, team leaders, social workers, home care organizers, home care assistants and social care coordinators) they noted that the various services involved had different ways of communicating and that they each faced challenges. They found that there were times when information was not passed along from manager to home care organizer and that they found themselves gathering information from other sources. The members of the team also described patchy communication and misunderstandings. While lack of communication can be a barrier to interprofessional collaboration, there are benefits that come with effective communication. Two benefits described in the literature are positive working relationships between team members and the tearing down of professional silos [23].

A second theme in the literature relates to role. Research suggests that role clarity is a key element that determines whether or not interprofessional collaboration is successful [28, 31]. Whether in the community or in the acute care setting the need to ensure that all members of the team are clear about their role is critical. King and Ross [23] in their study of integrated community care in the UK discovered that some role ambiguity is not destructive to the team and may actually be helpful in allowing the team members to adapt, develop, or reconstruct their roles to ensure that the team works effectively. However, too much ambiguity can lead to the corrosion of a team as members become defensive about their traditional identities and roles. This may, in turn, reduce efficiency and cause confusion and disillusionment with the collaborative process [23, 32].

In the acute care setting and to a lesser degree in the community, studies have been completed that suggest that members of the team who perceive that they have less power are less co-operative in teams and/or less positive about interprofessional collaboration [33–36]. Molyneux [27] conducted a qualitative study to explore how and why co-operative and positive relationships and practices developed within one interprofessional health care team in England. Through the use of interviews and focus groups with team members (occupational therapists, physiotherapists, speech and language therapists and social workers) she discovered that the formal power (status) of the health care team members played a key role in whether or not the team functioned effectively. Where there was a perception of balance within the team and where there was equal status, the team appeared to function well. With this perception of equality came trust and confidence in one another, which helped to establish a non-threatening environment. Both Cott [33] and Rutherford and McArthur [35] discovered that the status of team members inhibited those with a lower status from participating in the decision-making process.

The evidence suggests that due to the multifactorial nature of falls, early interventions which incorporate an interprofessional approach [36] using a variety of strategies [37] will have the greatest impact on the prevention of falls [38, 39] specifically among high risk groups [6] and those persons with chronic conditions [40, 41]. Two recent reports on client safety in Canada suggest that a key strategy for enhancing client safety and decreasing the number of adverse events (such as a fall) is the development of partnerships among individuals, service providers and organizations [1, 2]. This is related to the finding that due to the multifactorial nature of falls, no single discipline alone can identify and address all of the risk factors of falls [42]. The most effective approach is to achieve consensus as a team through post-fall problem-solving [36].

Recent evidence suggests that preventable and amenable adverse events (such as a fall) are associated with one or more deficiencies in the system of care such as ineffective communication among care providers [43, 44]. Adding to the complexity of providing care for the frail older adults living in the community is the need for health care providers to travel extensively. They often work in isolation from other providers and frequently communicate in an asynchronous manner through e-mail and/or voice-mail. Seldom do these individuals have the opportunity to interact with one another face-to-face as they are located in various locations throughout the county. Working with these limitations may have an impact on interprofessional collaboration. As noted in the literature, co-location of the health care professionals can improve communication and relationships [45].

Much of what is written in the literature regarding interprofessional collaboration in the community setting describes how this model of care should be implemented. However, less is known about how teams actually engage with one another when planning and implementing a coordinated, interprofessional approach to complex patient care when practicing in the community (outside of long-term care settings). Even less is known about the barriers and facilitators faced by these providers and the perceived outcomes of engaging in a team approach.

Methods

An exploratory descriptive design [46] was utilized to answer the following research questions: 1) how do interprofessional teams describe their experiences when involved in a research intervention requiring collaboration for a 9-month period of time?; 2) what are the barriers and facilitators to teamwork?

Setting and sample

This was a collaborative project between researchers in the McMaster University, System-Linked Research Unit and Decision-Makers, Managers, and Practitioners in the Hamilton Niagara Haldimand Brant, Community Care Access Center and the Mississauga Halton Community Care Access Center. A purposeful, convenience sample was employed that consisted of two teams made up of Community Care Access Center Case Managers, Physiotherapists, Occupational Therapists, Registered Nurses, and Registered Dietitians from four community agencies: Hamilton Niagara Haldimand Brant Community Care Access Center, Mississauga Halton Community Care Access Center, Halton Region Health Department, Community

Rehabilitation were included. There were a total of nine participants among the two teams. This sample included practitioners with 1–30 years of experience ranging in ages from 39–60 years. Seven of the nine participants held an undergraduate degree, one held a graduate degree and one received training in a hospital. All of the participants were involved in providing direct client care. All participants were female and had worked together for 6 months prior to the commencement of this study and had worked together in the past. When asked whether or not they felt that they had adequate knowledge and training for this population (frail older adult) four stated that they ‘mildly agreed’ while five stated that they ‘strongly agreed’. For an overview of the team demographics refer to [Table 1](#).

Context

As with any qualitative research project, it is important to describe the context and how the participants fit within that context. This sub-study was part of a randomized controlled trial, the aim of which was to determine the effects and costs of a multifactorial and interprofessional team approach to fall prevention for older home care clients ‘at risk’ of falling [4]. The goal of the trial was to reduce falls and fall-related injuries and to enhance health and quality of life and reduce demand for expensive healthcare resources. The intervention arm of the study involved 54 subjects who received a median of 19.5 home visits and 3 telephone contacts by members of the interprofessional team over the 6-month follow-up. When broken down, these contacts consisted of a median of 3 home visits and 1.5 telephone contacts by the CCAC case manager, 6 visits by the nurse,

4 visits by the occupational therapist, 6 visits by the physiotherapist and 0 visits from the registered dietician, social worker and pharmacist. Subjects randomized to the intervention group were discussed in weekly team meetings a median of 6 times over the study period. Each individual team was involved in weekly case conferences over a period of 6 months led by the case manager during which time their client’s risk of falls was discussed along with the client’s progress towards the care goals. In addition, the team discussed the results of their initial and ongoing assessment of risk along with the client’s involvement in the plan of care. All the health care professionals of both teams (all 9 members) participated at the same time in a standardized one-day educational session taught by the principal investigator. During training, emphasis was placed on the importance of working in collaboration with clients, families and other health care professionals. In addition, each member was trained in developing a single accessible fall prevention plan to address modifiable fall risk factors and other factors influencing health using a variety of evidence-based strategies [4].

The current study involved those health care team members (9 in total) who participated in the intervention arm of the randomized controlled trial described above. It is important to note that ‘usual’ practice for these practitioners would be to independently go to a client’s home, complete their own assessment and fax, e-mail, or phone in a report to the case manager. Care providers would only come together on an ad-hoc and piecemeal basis if the need for a meeting was identified by either a member of the health care team, the patient or family member.

Data collection

Four focus groups (2 per team) 60–90 minutes in length were conducted at two points in time (6 and 9 months following group formation). Each focus group was tape-recorded and transcribed verbatim. All of the focus groups were conducted at a mutually agreed upon location that was private and quiet. Burns and Grove’s [47] recommendations were followed to encourage the free exchange of ideas. In order to promote comprehensiveness and focus an interview guide was developed that reflected the research questions.

Data management and analysis

N-Vivo 8, a qualitative research software program, was used to manage the data. Data collection, analysis, and interpretation occurred simultaneously and followed the recommendations of Miller and Crabtree [48]. To ensure credibility, the researcher and two additional independent research assistants were involved in the coding,

Table 1. Overview of demographics

		Number of participants Total = 9
Occupation	Registered Nurse	2
	Physiotherapist	2
	Occupational Therapist	2
	Nutritionist/Dietician	1
	Case Manager	2
Main role	Direct client care	9
Years in profession	1–20 years	3
	21–30 years	6
Years in community work	1–9 years	3
	10–20 years	3
	21–30 years	3
Age	39–50 years	4
	51–60 years	5
Education	Undergraduate	7
	Graduate	1
	Hospital Trained	1
Sex	Female	9
	Male	0

analysis, and interpretation of data to promote the rigor of the study. An editing organizing style was used to search for meaningful words and phrases [49]. Each of these individuals independently reviewed and analyzed the focus group transcripts. Codes were assigned to segments of the text and subsequently themes were developed by grouping the various codes. The reviewers then compared their identified themes and developed a summary of themes based on consensus decisions. As part of the audit trail memos were kept by the researcher to document ideas and to track decisions made throughout the analysis. To increase rigor, member checking was used during this study. Participants were asked to clarify concepts and the researcher's emerging ideas at the end of each focus group.

Ethics

This study was conducted in accordance with the Tri-Council Policy Statement, 'Ethical Conduct for Research Involving Humans' [50]. Ethics approval for the study was obtained from the Research and Ethics Boards at McMaster University and renewed yearly as required. All participants provided written informed consent for participation.

Results

Several key themes emerged that helped to illuminate the issue of interprofessional collaboration for community health care providers. These themes included; team capacity which included roles and climate; practitioner competencies which included communication, collaboration, information gathering and sharing. In addition, participants mentioned the need for organizational support to engage in collaborative activities. Ultimately, they described how they believed that working collaboratively resulted in both a positive and less than positive experience for the clients and their families. Participants also described both barriers and facilitators to interprofessional collaboration within each of the aforementioned themes. The element of time was also described as a contributing factor when engaging in interprofessional collaboration. Figure 1 provides a visual overview of these themes.

Team capacity

Team capacity is defined as the team's ability to work together towards a common goal (positive patient outcome) in a collaborative, effective and efficient manner. Capacity was influenced by the individual roles that were played out in each team by the various health care professionals. The team's capacity was greatly influenced by each member's understanding of their

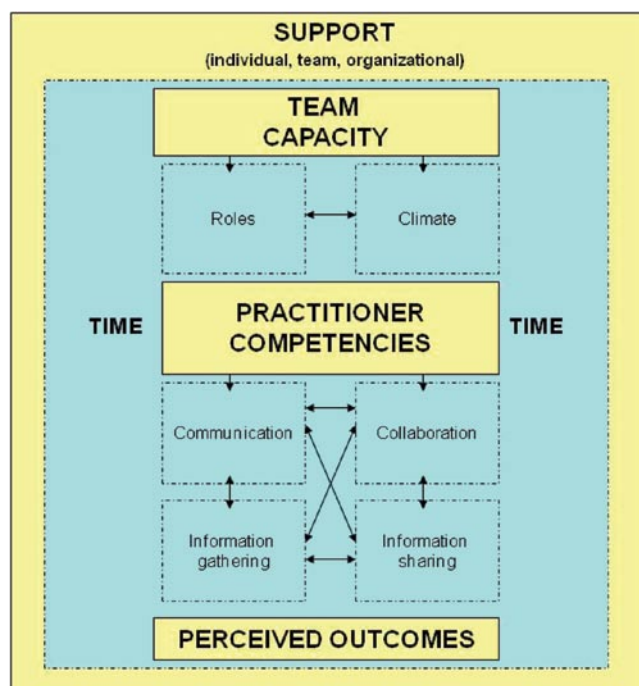


Figure 1. Overview of themes.

own role and responsibilities and those of other team members. An attitude of acceptance helped to build capacity as members of the team began to learn about the similarities and differences in their roles. One positive contributing factor related to team capacity was a prior knowledge of each other prior to the research project. Participants' revealed that they had worked alongside their team members in the past, but had not fully grasped the extent of their roles. This was partially due to the fact that they seldom met in person or communicated directly with one another. Once the team members understood the various roles they began to utilize each other to ensure that client needs were met. Taking the necessary time to engage in activities that promoted role clarity was an important element in building team capacity and trust within the team.

Roles

The professional roles that were referred to by both teams were occupational therapy (OT), physiotherapy (PT), nutrition, medicine, pharmacy, and nursing.

"I got more knowledgeable about OT and PT services and you know just listening to them talk about equipment that they recommend for clients. I can identify different walkers now and I certainly have a better understanding of them in a working sense. I think it's improved my relationship with Community Care Access Center and when I refer other clients they are more receptive to my opinion."

“What I am enjoying about this group is that I am learning about all the different disciplines. I didn’t know a lot about the public health nursing so it was really good to learn about the different roles, and more specifically to clients in what they do so it is really positive for the community. And then physio, OT, and nutrition when they collaborate together. I learn more about what they actually do, especially with their different testings.”

However, not all participants understood their role or how it related to others. This lack of understanding was seen as a barrier to interprofessional care. One participant stated:

“Typically, I am the last through the door [of the client’s home] because you guys [other health care professionals] have been given more of a priority in some ways. I know I’m not gonna suggest home safety and I’m not going to do the exercises, so I don’t know, I’ve often felt like I’m not sure about my own role, so it’s hard to sell myself sometimes.”

Climate

Climate was described as a central theme and is defined as the working environment created by the team. During meetings participants described a climate that allowed them to ‘work through issues’, to remain, ‘more on top of it’. They noted that there was a climate that accentuated their ‘common bond’ and ‘common ground’. The practitioners also spoke of a climate that allowed them to bring their expertise to the table and to have an opportunity to learn from each other. In order for the interprofessional team to work towards the common goal of reducing falls for the frail older adult it required a supportive, trusting, comfortable climate. Weekly conferences provided participants with a time when they could talk openly about the client and their care plan. In addition, participants spoke of feeling free to talk about problem issues such as ‘dealing with a challenging doctor together’.

“I think that is the one thing so different for us, that we get this sanctioned regular meeting time where we can talk, and sometimes it’s nice to be able to talk about clients with other people who know who you are taking about, who can commiserate with whatever issues you can come up with and help you brainstorm around you know different ways of approaching things.”

Participants valued a climate that promoted the development of personal relationships. They mentioned the opportunity to, ‘know each other personally’, ‘know each other better’, to become ‘comfortable with each other’, and to ‘share personal trauma’. They also described how it was, ‘great to actually know who I’m talking to’ and to ‘lose sense of isolation’. This type of

collegial, respectful climate promoted practitioner competencies and was seen as a facilitator of interprofessional collaboration.

Practitioner competencies

Practitioner competencies were defined as each health care provider’s ability to enact her role with the purpose of meeting the client’s needs and achieving patient care goals. These were not professional competencies as outlined by their respective governing bodies. Two key actions described within this theme were communication and collaboration.

Communication

Communication was seen both as a facilitator and barrier to collaboration. Communication included face-to-face contact, e-mails, telephone calls, voice-mails, assessments, and a common chart that was left in the client’s home. As a facilitator, communication within the team was seen as a critical element to enhancing team functioning.

“Because we all communicated with each other and the clients knew that so they could talk about the other people on the team because normally in community care they’ll say oh my OT is so and so and I don’t always know who that person is and I don’t have communication with them. So for them to say oh so and so was here and it’s like oh yes and you know and at the meetings they’ll say oh one of the clients is having an issue with blah, blah, blah, so then we can all sort of go from there where as you know previously that wouldn’t happen.”

How groups communicated was an important aspect of interprofessional collaboration. For the health care professionals there was a renewed interest in teamwork because they were able to meet face-to-face. In the past, the majority of communication occurred indirectly and asynchronously through e-mail, voice mail or through documentation in the client’s chart. Face-to-face communication was valued by the health care professionals and during the focus groups it was clear that camaraderie had developed amongst the team members.

“I think having face-to-face meeting is important. I haven’t met a lot of the case managers face-to-face and I think that there’s a different relationship when you do. Maybe not all the time, but when you meet somebody face-to-face it’s almost as if it becomes more human.”

“Yes, it’s case manager and OT or PT it’s just a face-to-face contact really I think that’s very important. You know it can’t happen all the time, but I think it made a big difference in this case, it’s different from a phone call.”

“I think the face-to-face team approach was beneficial. Because working in the community you tend to be very isolated. So actually meeting face-to-face with people and coordinating a plan was a neat thing.”

“I think you lose the sense of isolation because we all work so independently, so we come in now and we can talk about people and we can brainstorm.”

Participants suggested that communication was enhanced through the opportunity to work together on a team. They noted that the weekly meetings provided them with, “dedicated and protected time” to relay important information, to pose questions, and to brainstorm issues. Communication between members also provided them with an opportunity to receive validation as they made clinical decisions related to the client. However, even though the respective organizations had provided the team members with protected time to engage in team meetings, finding the time to communicate was seen as a barrier to interprofessional collaboration. The time required to communicate often left the team members feeling overwhelmed by the workload. Participants also noted that a great deal of time was needed in order to meet with other team members, to complete their assessments, to utilize the assessment tools and to remain focused on other tasks required of them by their respective organizations.

“These meetings take a huge amount of time out of our caseload.”

“It was really difficult for us to keep up with talking about each and every one of them [clients] every month.”

Collaboration

Collaboration was defined as team members working together towards a common patient goal. Activities included in collaboration were described as; information gathering and sharing, reviewing of the client’s goals, making of clinical decisions, discussing care options, evaluating interventions, and adjusting the plan of care.

Collaboration involved both the gathering and sharing of information. To do this in a collaborative fashion it required that each practitioner had a firm understanding of their role on the team. In order to develop and implement a plan of care, each member utilized standardized clinical assessment tools relevant to their individual roles. Once data were gathered, this information was then shared with the team to identify client needs, goals, and to develop a plan of care. The benefit of a team approach to addressing the issue of falls was evident when different team members gathered different information that ultimately led to a broader understanding of the client and his/her needs. Participants did, however, describe instances when the collected data

was conflicting and this led to a team discussion about why this might have occurred and how to reconcile the discrepancies.

“They may have had a fall but they don’t mention it to one of us but they’ll mention it to another so in the end sooner or later the truth comes out, so the team really is much better at finding things.”

“Each time everybody came to the table someone’s client either told them or they had said something that somebody else didn’t even think about or see. You know just happened to be there at the time or to see the stress with the caregiver. If you caught them (the client) on a different day they wanted to talk about something different they gave a new perspective and again probably different personalities too. People share different things and so it gave more for each of us to think about and a better rounded view of the client as well.”

“What I’m finding at the group meetings is how I don’t seem to get the same kind of information as some other people. That there are components that if we hadn’t had all these people going in to get information we may not have gotten as complete a picture, as we get when we’re a group.”

Information gathering by the team was also seen as a barrier by one participant who describes her experience as follows:

“We would all go in at different points, ask the same questions we could end up with four different answers and we’re supposed to collaborate and put them all on one sheet.”

The team identified strategies to ensure that the client was not overwhelmed and to reduce the level of frustration experienced by the health care providers. An example is described below.

“With this particular gentleman, he does not want all these questions. I mean for all four of us to be asking him questions, so we talked last week maybe just having one or two of us to ask or maybe just one of us having to ask those questions.”

Information sharing was important to the team members and served to promote problem solving.

“I think that there are clients that I would have been willing to throw in the towel with during the process but again, being able to problem solve some of that and have other people suggest different approaches or try different things gave me hope to go back in and try a different tact or...maybe not give up.”

When team members took the time that was necessary to engage in effective communication and collaboration they felt that the client and family benefited.

Team members' perception of outcomes

The data suggest that the client and family were aware that the team members were working together and that this created an enhanced level of trust between health care professionals and their clients and families. Participants described perceived benefits of a team approach to care provision for both the client and family.

"There's a different level of trust now [between me and the client]."

"I think that it is nice for the clients too that they know, that we are actually communicating behind the scenes on a regular basis. Because I had another client where the one family concern is that they thought nobody was talking with each other, and nobody knew what each other was doing. And I know that, you know especially in this one case that it was mentioned the fact that they knew we all were sort of getting together. And I would often refer to what someone had said or mentioned. So that makes them [the family] feel we're all together in this. It is not just individual people coming in from whatever direction, dropping in on them."

"I think working as a team and collaborating as a team was to the benefit of the client. I'm usually on my own and I go out and do the assessment and sometimes I make that referral to the Community Care Access Center for OT/PT, but I never get to follow-up and actually find out what has actually been done for the client because then we actually ended up discharging the client so that's what interested me the most."

"...with that length of time you build that trust, and you get to know the family that much better and you make that connection, you know what the family support is like and they just feel more comfortable as time goes on to divulge that intimate, confidential information to you."

"I think the value of being involved for six months was even though some of them did have continuing falls I think when we were there and we got them to analyze why they had that fall because they weren't using their walker or for whatever reason I think that might have made a difference because a number of them that were having falls ended up not having any falls by the end of the study. So...I think that maybe had some impact."

However, other data suggested that the team approach was associated with some negative outcomes.

"...It was challenging for some clients though because they...you know there's some confusion at the beginning because there was a lot of services and I think because a lot of the age component and they agree to things and they forget and then families come in and so that was the challenging part but once they got on board then...you know to what we were doing then they actually were really appreciative of the six-month follow-up."

"We feel bad for the clients cause we all kind of descend upon them. Sometimes we've all been there on the same day and it's not been intentional and in the ideal world it would be nice for all of us to sit down here with our agendas and say okay I'm gonna go Monday you go Wednesday, but we're all juggling our other case loads and cases that often have a priority and we often have to bump people, so we really can't forecast what our whole week is gonna be like... I've felt bad for some of our clients who've been overwhelmed with all of us coming and we're all asking a lot of the same questions and it's almost too much for them at times to handle."

Other team members described how focusing on falls may have had a negative impact on the client.

"It's made them [the clients] more focused on falls, almost a negative thing cause we come in and say have you had a fall rather than how safe have you been."

"Reminding them [the clients] it's what keeps it top of their mind and it can make them more anxious."

Overall, the participants felt that the experience of engaging in an interprofessional approach to care was positive for both the provider and the client and family.

Organizational support

Organizational support is defined as release time, reduced workload, and coverage financial provided by the participant's respective agency. Overwhelmingly, the participants described their appreciation for organizational support.

"I've had support because I've had someone, there's supposed to be someone at my desk today, I'm not sure, but there's supposed to be. They've really tried very hard to give me someone at my desk once a week, it's been great."

"Our professional leaders are at least always sort of checking in with us to make sure everything is going okay and we have any issues that need to be taken to the working committee. Very supportive. The pressure of seeing our regular caseload but recognize too that we've got to see our new clients and it takes a period of time so they know when to back off with some of the pressure."

These findings help to provide a picture of how professionals engage in interprofessional care in the community.

Discussion

This study sought to explore the experiences of an interprofessional team as it engaged in a collaborative approach to fall prevention in the frail older adult population. The purpose was also to describe the barriers

and facilitators to interprofessional care within the community setting. This is one of the first studies to explore these questions from the perspective of front-line home care providers. The data provide a glimpse into their experiences and help to illustrate how the team is an important consideration when implementing and evaluating integrated care at the service delivery level.

Some of the factors described by Kodner and Kyriacou [5] as being integral to the development and operationalisation of elements of an integrated care plan are evident in the study findings. Interprofessional collaboration is described as one strategy for enhancing the continuity of patient care and the integration of services. Kodner and Kyriacou [5] explored two American organizational models of fully integrated care and Leutz [51] suggested three levels of integration within these models: 1) linkage, 2) co-ordination, and 3) full integration. In order to develop and operationalize any of these forms of integrated care these authors suggest that 15 factors must be considered. Three of the fifteen factors are described by participants in the current study and include; 1) primary care which requires a co-ordinated plan of care across professionals, 2) care management which involves the planning, arranging and monitoring of patient care, and 3) teamwork which includes both communication and collaboration across members of the team. In this study, these factors are best situated at the coordination level of integration. This level emphasizes the coordination of patient care, the sharing of information, comprehensive assessments, and joint care planning and team care.

In the current study participants did not describe power struggles within their teams. Rather, they described a co-ordinated plan of care across team members. This was not the case in the study conducted by Rees et al. In their study, they found that some members of the team were “less seen as a core member” [52, p. 531]. They also found that team members felt the need to defend their professional boundaries. The participants in the current study had worked together for 6 months prior to the current investigation. This prior knowledge of one another’s roles may have prevented role confusion, role strain and contributed to their positive perspective. It is also important to note that the members of these two teams that met regularly did not represent a group with varying levels of formal power as all were front-line providers and this may have played an important role in ensuring effective team work. A final factor may have been that those involved in the teams volunteered to participate in the intervention, so they already had positive attitudes about the upcoming experience and felt some ownership toward the new approach to care [53].

The health care professionals involved in this study described the importance of role clarity when providing

coordinated patient care. This understanding ensured that the correct client information was gathered from the correct health care professional. The need for role clarity and a common purpose/goal is supported by Cohen and Bailey [54], Evans and Dion [55] and Liedtka and Whitten [56] who all suggested that inter-professional collaboration involved sharing common goals and vision. The fact that all members of the team were working towards the common goal of preventing falls in the frail older adult promoted interprofessional collaboration.

Participants noted the importance of a supportive climate within which to engage in team activities. They suggested that there was a comfort within the teams and members enjoyed each other’s company. Rees et al. found that when implementing an integrated care pathway in the community with a mental health focus the team members valued the opportunity to work together in a “flexible informal manner and engaging in discussion and negotiation and liaison” [52, p. 53]. This environment also provided team members with the opportunity to ‘share ideas’ and to ‘share each other’s stress’.

In order to coordinate and monitor client care a variety of communication strategies were employed by the participants, but they were most satisfied by face-to-face and phone interaction as they felt that it promoted team work, developed personal relationships, and reduced isolation. What is important to note is that all of the participants were female and that this satisfaction with face-to-face and phone interaction may be related to gender. Future research is required to look at the role that gender may play in interprofessional collaboration.

The current study suggests that these participants perceived a benefit for both themselves and the clients (and families) when engaging in a coordinated approach to care. The benefits for collaboration are also noted in the literature. Several authors [16, 27, 35, 51] found that collaboration led to increased satisfaction and a greater understanding between health care professionals about client care. Although the current study cannot provide quantitative data to support what outcomes were achieved for the client and health care professional, it did provide qualitative data that suggest that further research is required in this area.

Throughout the various themes the importance of time was described. Time was required for the health care professionals to engage in various collaborative activities such as the weekly team meetings. The importance of having the necessary time allotted for interprofessional collaboration and ultimately integrated care to occur is noted in the current research. The concept of time is often described in terms of a lack

of resources for ongoing support, team development and change management. Mullins et al. [57] in a study of 106 subjects (occupational therapists, speech and language pathologists, and physical therapists) who were engaging in a team approach to rehabilitation in both outpatient and inpatient rehabilitation systems found that 22% of the team members felt that there was a lack of time to participate in team efforts. There is a gap in the literature related to the allotment of time for various interprofessional activities.

Interprofessional collaboration can be a positive experience for health care providers caring for those with chronic conditions when a positive attitude, a common goal, mutual respect, clarity of roles, clear communication and effective collaboration are combined. In the community setting, where each health care provider often works in isolation of other providers, it is possible to achieve effective service delivery [6].

Limitations

As with any research the present study had some limitations. First, this study commenced 3 months into the development of the interprofessional team and 3 months after they had started the intervention. This delay in accessing the participants may have resulted in recall bias and it may also have failed to capture a critical step in team development; formation. During the formation of the group the answers provided in focus groups may have been less positive than those that were received three months into the project. Second, data were gathered over a 3-month period which may not be long enough to determine whether or not the team dynamics changed over time. Finally, most of the members of the interprofessional team that were involved in the study had prior knowledge of one

another, had a general rapport established and this may have resulted in a more positive perception of the dynamics within the team.

Conclusion

Interprofessional collaboration is perceived by health care providers working in the community setting to be a positive experience for them as well as their clients. It is clear that in order for this type of an initiative to be successful it needs to receive support at the individual, team and organizational level. Without this support health care providers will be destined to continue to work in isolation and in a fragmented manner. As the population ages, and more clients with chronic, complex health care needs remain at home there is a need to continue to identify and implement models of service delivery that are proactive and collaborative with the ultimate goal of providing quality patient care. This study provides a glimpse into the experiences of home care providers in making the transition to an interprofessional model of care in the community setting.

Reviewers

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