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ORIGINAL RESEARCH

# Implementation of a New Integrated Healthcare Model; Quality Aspects to Support the Complex Home Care of Older Adults with Multiple Needs

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**Aim:** This study aims to describe experiences of the implementation of a new integrated healthcare model for older adults with complex care needs due to multimorbidity, living at home, from a health and welfare personnel perspective. The goal was to diminish hospitalization and still carry out high quality care at home for older adults living with multimorbidity. The model was implemented by two organizations working in cooperation, the municipality, and the region that handles interprofessional social care and healthcare in people's homes.

**Materials and Method:** Open-ended group interviews with personnel were carried out, three of the group interviews pre-implementations of the model, and three of the group interviews post-implementation. The interviews were audiotaped and analysed according to the procedure of thematic analysis.

**Results:** The quality of the integrated care model was based on care-chain cooperation, shared professionalism, and creating relations with the patient including closeness to next of kin, which was underlined by the participants. Unencumbered time gave the professionals the possibility to develop quality in integrated healthcare as part of integrated and person-centred care. The coproduction of education, research interviews and the follow-up meeting identified successes in diminishing hospitalization rates according to the participants' experiences of the post-implementation interviews. An identified failure was, however, that shared professionalism was not developed over time, rather the different responsibilities were accentuated according to the information retrieved at the follow-up meeting.

**Conclusion:** Quality aspects of the model were identified in the present study. However, when implementation of a new model is completed, the organizations always have their own interpretation of how to further understand the model in question.

**Plain language summary:** The intention of the present study was to follow the process of working with a new model of providing care at home, thus preventing increased numbers of hospital readmissions, based on the professionals´ point of view of what quality care is for older adults with complex care needs due to multimorbidity, living in their own home. The professionals were interviewed in group settings on several occasions during the implementation.

The result showed hopeful expectations expressed by the professionals before the new model was implemented, such as a hope for getting more time for high-quality care for the older adults with multimorbidity. During the teamwork, the conversation within the team members was praised as a key factor that included shared professionalism from professionals with different levels of education and focus on their work. According to the staff, unnecessary hospital stays were reduced, while the interprofessional care-chain cooperation was improved through the work of the integrated care team. For many team members, the positive difference in both work and care satisfaction was highlighted in comparison to regular home care as they were able to use their multi-disciplinary skills and support.

**Keywords:** integrated-care model, multi-morbidity, interprofessional care, home-based care, person-centred integrated care

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## Introduction

Receiving healthcare at home is intended to make older adults with complex care needs, due to multimorbidity, feel safe and secure. Feeling safe should reduce the stress of having to move back and forth between their homes and healthcare institutions.[1] In Sweden, it is possible to receive qualified healthcare at home, but there are shortcomings to overcome in the previous system to make the efforts suitable for the older adults, their next of kin and the healthcare personnel. Much pressure is put upon the individual older adult to coordinate his/her own healthcare needs through primary care visits and hospital stays. The situation is stressful for informal caregivers who often shoulder a heavy burden of social- and instrumental care as well as emotional concern.[2,3] Research suggests that to diminish hospitalization, and especially the going back and forth between home and the healthcare providers, extended collaboration of healthcare professionals is needed [cf 1]. Moreover, a matter of great concern is the need for interorganizational and interprofessional collaboration, which is critical in the transition from hospital to home-based care. The absence of shared responsibility of care between organizations hinders an integrated person-centred care in Sweden.[2] Quality in healthcare in an older adult's own home basically requires an overall interprofessional cooperation strategy.[4] Janssen et al,[5] point out the importance of interdisciplinary collaboration between professionals in all advanced care situations at home as well as in healthcare institutions. Swedish research shows that social- and healthcare services are often experienced as being fragmented and provided by many different service providers.[6] This fragmentation of social- and healthcare services makes communication difficult for all involved, the older adult/patient, next of kin and different care professionals. Moreover, older adults/patients and next of kin report being uninformed about medical ordinations and decided healthcare treatments.[1] Finally, the stable relations that exist in the older adult's livelihood, often of major importance in daily living and health situations, are seldom recognised as health resources.[2]

Earlier research points out the need for multi-professional cooperation, in social and healthcare services, such as hospital clinics, homecare and social services, day centres and short-term respite in care homes.[6] In fact, professionals with different competencies thus have opportunities to complement each other, although an interdisciplinary team approach is more effective than multidisciplinary teamwork, where the professionals work beside each other rather than share competencies.[7] However, Hansson et al,[8] point out several obstacles for effective communication and care planning for older adults with multiple care needs. There was a lack of communication with the older adult and their next of kin, lack of collaboration between professional caregivers and lack of mutual care planning including health resources not being distributed according to the actual needs of the person.

In some parts of Sweden, a more advanced home healthcare service serving patients with multiple care needs, due to multimorbidity is provided and organized by hospital-centred care and not municipality-organized healthcare. In other parts of Sweden, multi-professional teams have been co-financed and organized between these two separate care providers, as in the context of this study. The National Board of Health and Welfare in Sweden reported [11: p 52] that every fourth hospitalization among older adults with multiple care needs is closely followed by a new hospitalization. The need to develop collaboration between hospital-centred care and municipalities to achieve interprofessional collaboration in home care was explored by Larsen, Broberger and Petersson[9] from the experiences of home care professionals. They found that simple solutions are not the answer to solve complex situations and that not only structures but interpersonal relations and interactions need to be considered. Positive results from Morris[10] showed continuity of care and led to less time being spent in hospital. A critical point, however, was that it was the professionals rather than patients who thought that healthcare had improved.

Patients and families stressed the need for an orderly care start at home after being discharged from hospital, putting the person in centre.[11] The need to deal with a broad range of care coordination issues, such as medical needs and daily activities, was also in focus.

Fragmentation of care for an older adult with multiple care needs is often due to care given by several professionals from different disciplines and organizations. This calls for collaboration between all involved in the care.[12] The same study[12] discusses the results of an educational programme intervention, where attitudes to other professionals as well as self-reported team skills improved after the intervention.

The Good Quality Local Healthcare Model (GQLHM) is not a new level of organization in Sweden or a name for ordinary primary care, even though primary care is a core within GQLH. GQLHM is defined by The Swedish Association of Local Authorities and Regions (SALAR) as a new way of integrating health, care, and social welfare. At the core of the GQLHM is a person-centred approach based upon the person's needs and conditions, involving, and adapting efforts to meet an individual's needs.[13] Fundamental for person-centred care are respect for the person, the person's right to self-determination and equal understandings, advocated where accurate interventions according to physical condition or health status are acknowledged.[14]

## Empirical Research Context

In 2016, the Swedish government decided to investigate effective care and in 2019 published[15] the results in a partial report named "Good Local Care in co-operation". Several municipalities accordingly started change processes, and this article is based on one such example. The challenges of meeting the needs from the professionals' point of view in the care of the older adults in a Swedish municipality, cooperating with the region in the newly developed GQLHM's, are numerous. Though, earlier research[16] points out that integrated person-centered care interventions show the strongest evidence for optimization of the results of service utilization.

GQLHM is a concept used in the present project, originating in a report from regions and municipalities.[15] It turned out to be a significant symbol for the new way of care, which was intended to unite multiprofessionals personnel into interprofessional care work. The competency of care professionals was therefore personally tailored, and the care was carried out at the home of the older adult's complex care needs due to multimorbidity.

The implementation of the GQLHM may be viewed in many ways by the older adults, based on their individual situation [cf 1]. However, the intention of the present study is to follow the process of the new model of providing care at home, thus preventing increased numbers of hospital readmissions, based on the professionals´ point of view of what quality care is. The aim is therefore to describe the pros and cons of the implementation of a GQLHM for older adults with complex care needs, due to multimorbidity, living at home from caring personnel perspectives.

However, the knowledge of earlier studies is not specifically focused on older adults with complex care needs due to multimorbidity where GQLHM is implemented in home care. Hence, further research is warranted of home care studied of this specific frail group of patients.

## Materials and Methods

### Design and Participants

Six open-ended group interviews were conducted with mixed professionals/staff; 22 participants in total, of which 17 were enrolled nurses, three registered nurses (RNs), one occupational therapist (OT), and one physiotherapist (PT). Twenty-two personnel were the total population of the new GQLHM team that provided the interprofessional care work in the patient's home. The age of the participants ranged from 24 to 63 years and experience in the profession ranged from 3 to 39 years. Both males and females were included. Group interviews 1–3 (~7 participants in each group) took place during an educational introduction week of the implementation and consisted of participants who were about to form the new home care team. For the post-implementation, group interviews (4–6) were conducted again 1 year after implementation of the GQLHM with the same 22 participants.

Each group interview started with the same introduction from the interviewer:

> To receive care at home can mean different things to different people. With different views of what constitutes good care, older people may not be given care interventions at home that make the experience safe and secure. What is good care at home in your opinion?

In the pre-implementation group interviews (1–3), the discussion was based on a homecare case. In the post-implementation group interviews (4–6), the quality of the GQLHM was a shared experience among the participants.

> What pros and cons of the implementation?

The open-ended group interviews were recorded digitally and later transcribed and lasted for 30–71 min.

## Ethics

The study was approved by the Regional Ethics Committee in Uppsala, Sweden. The participants were informed that participation was voluntary, and that any data collected would be handled without anyone unauthorized taking part. The participants informed consent included publication of anonymized responses. Further ethical considerations were carried out in line with the World Medical Association Declaration of Helsinki[17] and The Swedish Data Protection Authority (DPA) GDPR (2016/679).[18]

## Analysis

The analysis was conducted in six analytical steps of thematic analysis, according to Braun and Clark.[19] The first step was to get acquainted with the data through reading of transcribed interviews, which led to creating codes related to the aim, and from patterned responses. Then the material was organised and sorted out to visualize codes that served as a basis for creating and identifying potential themes and subthemes. In addition, themes were continuously analysed in a circular process.[20] where contrasts and differences in the findings received specific attention. To control quality during the analysis and emerging of themes, the research group worked together discussing and revising the extracted themes and subthemes until consensus was reached. One main theme and five interrelated sub-themes evolved, which is presented in the findings section. Since these themes were identified through the group interview discussions pre-implementation of the GQLHM and post-implementation after having worked with the model for 1 year, they could be interpreted as following the process of implementation of the model when providing and interpreting the GQLHM to older adults with multiple care needs in their own home. Prior to finalizing the article, interview group participants were given the opportunity to comment on and clarify their experiences before and after the implementation at a follow-up meeting with the research group. The main contributions from the follow-up discussion are also commented on in the results section.

# Results

## The Main Theme: Quality in Integrated Healthcare

In pre-implementation (G1-3) interviews the care personnel explained the potential quality in the unbelievably luxurious to have such a small multi-professional group to work in. The participants described their hopes and expectations regarding having unencumbered time in relation to care and the importance of meeting next of kins living together with their spouse in the presence of homecare. As well as the possibility of shared professionality within the GQLHM team as well as being links in the care-chain. The experienced quality in homecare was especially about feeling safe as caring personnel and safe as the person with complex caring needs. Safe and secure care was also discussed after a year of working with the new model post-implementation (G4-6), although fewer superlatives were used. The personnel related the quality of homecare to having different professionals in place, including a physician who was easy to get in touch with and in place once a week.

## Five Sub-Themes Were Identified as Parts of Quality in GQLHM

Creating relations, closeness to the next of kin, unencumbered time, care-chain cooperation, shared professionalism.

## Creating Relations

Securing quality in homecare is related to holding on to person-centred care, which was discussed in the interview groups pre-implementation. The enrolled nurses discuss the person's influence in care and how much that is possible in every situation. Being there for the person, caring with heart and feelings, forming relations and alliance and mediating trust. Making the person participate in his/her own care such as giving the person the possibility to decide about his/her own life.

> To work with heart and feelings and mind and really let the person herself […] decide about her life. That we have an alliance. (G1)

> The nurses discuss person-centred care in terms of trust and feeling good about their work contribution in relation to the person. (G2)

Participants in group 1 talk about their own feelings of person-centred care:

> It should feel good in your heart when you go home at the end of the day.

According to the caring personnel, quality homecare needs to be adjusted to the person and be delivered with continuity, knowing that the caregivers add to the experience of feeling safe and secure.

> The patient also knows the staff […] the same people come home to them […] I think it leads to an increased feeling of being safe and secure. (G4)

The GQLHM personnel were able to create relations and continuity to promote wellbeing for the person with multiple care needs as part of securing care-satisfaction and quality in homecare.

> that we create relations […] also support their mental health. (G5)

And G6 uses almost the same words and adds:

> […] "through the assurance of those who come they feel better

Creating relations is related to forming a secure and reliable situation for the person with those who come to work in their home. Continuity in care and establishing safe and secure homecare were discussed in all interview groups.

Another situation that underlines the need for commitment and continuity in care is related to palliative care.

> Myself I come from a care home, then of course we are with the person at the end of life, palliative care. (G6)

She tells how she and another carer wash and dress the dead person, and that next of kin then say farewell.

> We need that time because they will soon die. But if we have too many users, we don't have the time. It is in this way that we should act, I think. We should follow them until they say "goodbye. (G6)

Having worked at care homes means that the chance of being experienced in end-of-life care is greater than for an enrolled nurse /nurse aid working in home help/home care. The possibility to continue homecare as palliative care was expressed in the researcher follow-up meeting after one year of working with the GQLHM. The GQLHM team then proudly announced that palliative care was now possible to deliver as part of the GQLHM due to close cooperation with the palliative team in the region.

> Being able to decide from the beginning that I want to die at home…and if we would not be there with nurses and physicians and occupational therapists and everything behind us…then it would not have gone so well at home. (G4)

> The good thing with our group is that we have some from home help/ home healthcare, some from care homes where it is a matter of course to be with them at the end of life, palliative care…this is how we should work. (G5)

## Closeness to the Next of Kin

One gets to know the family well working in a small group of professionals, but it is also the case in ordinary home help (G3). Several of the group interviews mention the importance of meeting couples living together in their own homes in the presence of homecare. It is noteworthy that next of kin are part of the care context and an important resource, providing that the person receiving care allows it, which was spelled out in the pre-implementation interviews (G1, G2). However, the risk of next of kin taking control from the older adult in focus of care needs to be considered. For example, one interviewee says that it should not be the opinion of the next of kin that decides on pain relief (G3). Moreover, safety is created by having the next of kin participating in the care (G1). The importance of listening to next of kin with sensitivity is emphasized by many.

Next of kin, it can be a great grief for them, that their husband or wife … they also need care (G1).

But awareness that the relationship is not always good is also expressed.

> Some next of kin must really be pushed… that they can take help from us, we must remind them that it is their right to get relief from caring. (G4)

> We help each other, so we are as dependent on next of kin as they are our partners. (G5)

This acknowledges that it is due to the input of next of kin that many older adults can continue to live at home, and that care personnel must sometimes remind them to ask for help and use the available relief services (there are municipal relief services for next of kin) we somehow work in a team also with the next of kin.

In the post-implementation interview (G6), quite detailed reports on how the care personnel communicate with next of kin are given, regarding house cleaning, laundry, walks, medicine and inviting the next of kin to meetings (which is another service offered to support them). The cooperation with next of kin works so well;

> I am so meticulous to call next of kin if something happens and they can call us even if it is only to ask -Does anything need to be bought this week? Well then, we check what needs to be bought. (G6)

There is a dilemma when the person with complex care needs, due to multimorbidity, dies, and the other spouse becomes alone and must change professionals (if not eligible to participate in the GQLHM (G4). The feeling of being in safe hands can also be a strong relief from anxiety for the spouse at home (G3). The added competence from all personnel in the GQLHM team can form a care-chain with links in the close network of the person with complex care needs, due to multimorbidity that lasts until death arrives.

## Unencumbered Time

The interview group discussed how the GQLHM in terms of caring had to have enough time for each person. There is agreement that person tailored time is important when developing homecare (G1). With more time to form individually there is time to see and care for the whole person. An example is told by an experienced homecare worker, an enrolled nurse who argues that to be able to support a person to walk, you simply support the person walking around a few times in the person's home, with a walker on each visit. When cleaning, you can include the person to do some dusting or in personal care to comb their own hair (G3). According to the group discussions, unscheduled time is needed to enable caring for the whole person. Being flexible in one's care, means steering actions according to the needs and feelings of the persons. This is highly valued and includes having unencumbered time. But there were also voices of doubt about whether everyone was going to be equal in this GQLHM.

> That there will be time, this is most important for good care […] I don´t think there will be time […] no, but I hope there will be. (G3)

The participants' comments show the ambivalence, the need for person tailored time, time not allocated to a particular task and doubts that it would really happen.

> I think it is that (time) which is what we all worry about, because we have our backgrounds from a stressful environment, both from care homes home help/care, hospital. (G3)

A different voice among them comes from an enrolled nurse who has experience of having plenty of time, thanks to structured tasks, the worry was if there would now be enough time when doing her duties. In interview group 3 (pre-implementation) the discussions centre around time and how the GQLHM was supposed to work. Since the patients have varied needs and their conditions can vary, flexibility in work time is needed.

> How the hell can we put a time frame on ill persons?. (G3)

In the post-implementation interviews (G 4–6) time was also mentioned a bit more concretely as a necessary requirement for quality of homecare. Then, having unencumbered time was related to the person's feelings of trust in experiencing a safe and secure situation that now had come in effect by being able to transfer planned duties to a colleague, just to be able to give enough time to the person in need.


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I think it is important that one makes them feel safe and secure with oneself (the care personnel) when one comes. That one not only comes in and is super stressed; that one comes in and has tranquillity after all. […] yes, that we have the time […] I am in a patient´s home and something happens that makes me need to stay longer. I will then simply call some of my colleagues and they will take my next visit, because we have the possibility to do so. (G6)

Time to listen and to help, not being in a hurry, is emphasized in post-implementation interview 5. This unencumbered time is related to new task challenges, such as feeding a person with a tube. Still, the post-implementation discussion also questions whether there is enough time to learn new skills, and whether enrolled nurses will be allowed to work side by side with nurses to learn more medical skills. The GQLHM also makes it possible to save time:

To not have to go to the primary care centre […] here once again time is very, very important. It often depends on it. (G5)

The caring personnel underline that caring and safe medical conditions really depended on having enough time.

There is talk about the improvements enrolled nurses experienced in comparison to ordinary home help:

It takes several days less for the patient to receive help. Discussion continues Don´t take in too many patients because it then becomes like normal home help and we would have to run the heck out of us, that is not how it should be, it won´t be good. (G5)

So, with experience of the new way of working this quote shows that there is a risk of going back to the old way, with too many people to care for and limited visiting time.

The GQLHM had come closer to deliver unencumbered time for the enrolled nurses, but in relation to distance and travel time between the persons' homes there were still major difficulties. Since the enrolled nurses employed in municipality homecare did not have any time allowed for travel between visits in different users' homes in their digital planning schedule, scheduled visits had to be called off and changed. This reality was expressed by the enrolled nurses at the follow-up meeting with the research group.

## Care-Chain cooperation

The intentions of implementing the GQLHM team as a chain that would be a bridge between the medical organization of the region and the social care part administered by the municipality seemed perforce to practice. The pre-implementation interview being a link in the care-chain was formulated as follows:

To escape going to the hospital it is necessary to have a doctor nearby who can come home and make an assessment, and that we can do a bit more a bit more health and medical care… the whole chain as we say, where home care staff can do delegated tasks. (G3)

A barrier identified in the pre-implementation interviews was the system-wise communication channels between the region and the municipality. The GQLHM team meetings were mentioned in pre-implementation interview (G2) as a safe way of finding solutions to system communication difficulties. There is some doubt that there is enough time or interest to attend team meetings, from two categories of rehabilitation professionals: occupational therapist (OT) and physiotherapist (PT). However, in the interview group containing an OT and PT they were said to be invited to the team meetings, and it felt positive to have support from a multi-professional team.

That we as enrolled nurses go out, that we then have OTs and PTs and physicians and registered nurses backing us up. So that we can feel safe and ask and. It becomes good work with a team". (G4)

Dietitian, counsellor and "elder-nurse" were also mentioned as important actors in homecare.

Night personnel were specifically mentioned in relation to communication barriers since they had no communication channel to the GQLHM team. This is because the GQLHM does not work around-the-clock even though it takes place in the last part of life for the older adults with multiple needs.

There were repeated discussions about the different documentation systems between the region and the municipality and the barrier this situation had on effective communication,

It would have been clear as a bell if we used the same journal (documentation) system. (G3)

There is some optimism that the region and the municipality will be able to enter each other's digital patient documentation systems. However, having a shared documentation system is a wish outside the care personnel's control, where some seemed less optimistic than others.

> The only thing we can see is our regional nurse who can go into […] the regional journals and then she can see when anyone else is there. (G6)

Communication and team meetings are emphasized as being vital for handling these communication gaps. When the roles of the occupational therapist (OT) and physiotherapist (PT) in the team are brought up in pre-implementation interviews

> We hope they (the OT and PT) want to come into the team and have time and engagement. (G1)

Rehabilitation expertise is important for managing daily life at home, for example, the OT has the important role of checking the home environment to prevent falls (G3). The double system of having PTs in both municipal and regional employment is seen as an obstacle to shared communication.

One post-implementation interview (G4) specifically talks about the two different laws regulating their care work: social services law and healthcare law, which create a division in planning and carrying out care and of course had influence on communication and cooperation among staff. According to the post-implementation interview, the care-chain cooperation was attaining the goal of fewer hospitalizations:

> There are those who have not been to the hospital at all since we came into the picture. (G 5)

So, it seems like the GQLHM makes a difference when it comes to less hospitalization for older adults with multiple needs living in their own home.

## Shared professionalism

In pre-implementation interviews enrolled nurses' professionalism included having more ambition than before they wanted to be part of holistic care, where the `dirty bodywork´ is included.

> I experience that care is all this […] that is around, thus shower and hygiene and eating breakfast, this that makes the flow of everyday life. (G3)

According to enrolled nurses, caring should be related to shared professionalism in the team. Home care enrolled nurses looked forward to working closer with nurses and rehabilitation professionals. Working closer with more educated healthcare professionals created opportunities to learn more and to use everyone's competences. The mix of professionals in the GQLHM may add further quality to the quality of homecare.

> That one knows one's job- in a team, some have experience from homecare, others from hospital care. (G3)

Communication among homecare staff, for example, the physiotherapist and nurses had the same line of thought in the pre-implementation interviews.

> To share work experiences and together develop professional knowledge. (G3)

The other professionals depend on and trust the enrolled nurses´ knowledge and contribution in caring for the person and know that the persons in need value them and know them by name:

> they know who is coming. (G3)

Shared professionalism with respect and trust in different competencies is seen as a prerequisite to quality of homecare.

> That visiting staff are competent, not only to carry out things practically but in the encounters that one is professional and competent. (G1)

Shared professionalism is an issue, which evokes strong feelings among some of the enrolled nurses. Those who identify caring competence as their main strength feel underestimated.

> I am terrified that the prerequisites we are told to have won´t be there" […] then we would become an ordinary home help/home healthcare". (G3, several voices)

Later in the same interview someone adds that:

> We are after all more multi-professional. […]

One of the enrolled nurses in the pre-implementation interview is afraid that working in the GQLHM is the same depreciation and ends by saying:

> […] no one will send home patients with us. So, we won´t be able to show our competence.

In the post-implementation interviews, this worry still exists according to some of the enrolled nurses just doing general things such as wiping, taking care of toileting and so on. Some of them want to have more challenges and responsibilities since that is why they applied for this possible new work situation.

> […] Not only wipe "number two" […] that we will have more challenging cases […] more responsibilities". (G5)

The enrolled nurses' discussion relates to identified obstacles connected to shared professionalism and wanting to further develop their medical competencies. The enrolled nurses express in the pre-implementation interviews that fine goals may not be met or may be removed. Still, the post-implementation interviews mention both specific and interrelated aspects of shared professionality. This is exemplified by registered nurses (RNs) and enrolled nurses sharing the same office (G5). This is also shown when the physician is referred to by their first name (G6) giving a sense of closeness within the team. Moreover, a wish for the GQLHM to hold on to its value of sharing professionalism and

> that it will continue in this spirit (G6)

was accentuated.

However, after a year of practicing the GQLHM, the division of labour is stagnated with clear and more separate responsibilities between different professions. Separate responsibilities are now more restricted than were discussed beforehand. At the beginning, the assessment decision on care interventions made prior to GQLHM was not so strictly followed, caring personnel helped with everything. But now it is more structured you must follow the assessment plan,

> we follow the decision and do it. And we talk about it in the group so that all are aware of what do we have a decision on? So, that is something that has changed as well. (G5).

## Discussion

This study aims to describe the experiences of the implementation of a GQLHM for older adults with complex care needs, due to multimorbidity, living at home, based on the caring personnel's perspectives. Quality in local healthcare is related to identified quality aspects in the caring practice, identified by the interviewees and interpreted by the researchers. Elmersjö and Sundin[21] show that most of the municipality has addressed common problems in home care services in Sweden. But they have solved them with specific solutions that are unique to the municipality and its own conditions. An important prerequisite in the municipality is that organisational change is followed up with adequate resources in the form of working hours, working conditions, education and training. The quality aspects also include creating relations with the person with complex needs, closeness to the next of kin, the presence of unencumbered time for healthcare workers and how shared professionalism can be organized and developed for the involved healthcare team actors. In the person's close healthcare at home, there is a need to have a functional care-chain cooperation between healthcare actors inside and outside the integrated healthcare team from night staff to more distant parts of the healthcare system in the municipality and the region. But, as Lethinc[22] claims, also structural, political, cultural, and economic

factors play a significant role in an experience of organizational support, not only factors within the care organization or in the immediate context.

The present study has identified steps forward in the development of the GQLHM. There were more nuances after 1 year of the project, such as how to work flexibly when the older person is described as "time bound" or in evenings where the night personnel were not part of the GQLHM teamwork. Having dedicated night personnel has been identified as a municipal organization problem in previous research of care interventions related to older people and reablement.[2] Thus, the central finding of enrolled nurses needing unencumbered time to fulfil person-centred care for older adults with complex care needs, due to multimorbidity, at home was partly realized. The shared professionalism within the care team was related to this as well as the fact that all professionals involved were there or at least were easier to reach. However, the division of responsibilities was even more strictly divided according to post-implementation interview (G5).

Nurturing GQLHM is about extending communication channels and establishing possible terms for unencumbered time and shared professionalism. The professionals working with the GQLHM also underlined the importance of nurturing trustful relationships with next of kin [c.f.14]. This is also underlined in research focusing on palliative care of older people in community care.[23] The GQLHM team post-implementation in the present study experienced within the first year of working together that dying at home became part of the caring process. Thus, nurturing relationships with next of kin when preparing for death were important.

The need to co-work and communicate across health and welfare organizations to secure safe caring and quality of care of older persons living at home is in line with other pieces of research.[6,9] Likewise, co-work is needed between different care professionals, especially when delivering home-based care, in which the enrolled nurses are of great importance in ensuring person-centred care of the older person. The effectiveness of care could be related to how much shared professionalism was used in the GQLHM and how well the organization of work facilitated interprofessional teamwork [c.f. 7,12]. Enrolled nurses wanted to use and develop their medical competences and to do more varied tasks than just home-care and self-care activities. There is a development potential in shared professionalism within the team members. The GQLHM team seemed to nurture interprofessional communication, enabling shared efforts to give older people, primarily those with complex care needs due to multimorbidity, the possibility of receiving integrated care at home. However, organizational changes are requested to make integrated care with quality.[5]

However, enrolled nurses also expressed that professional care is holistic and therefore needs to cater to a manifold of needs, which the older person with multiple needs at home may have. Nonetheless, some enrolled nurses wanted to distance themselves from the dirty bodywork [cf 28] and wanted recognition of their abilities to do qualified care work. A suggested strategy that needs to be developed further concerns the ambitions of the different members in the interprofessional team. To find a strategy of how shared interprofessional teamwork could be further developed seems to be needed, at least from the enrolled nurses' perspectives. Such a strategy has been previously identified as a prerequisite for good quality healthcare.[4] The way post-implementation interviewees used first names when talking about physicians, possibly indicates less hierarchy and that the shared professional teamwork was established. The enrolled nurses knew they were a foundation for personal care, but still they had to retreat to work based on ordinary care assessment plans, where their work tasks were specified by the social care manager in the municipal organization rather than through team decisions. In addition, this also points to a need for organizational change within each sector. In municipality organized care, the assessment system hinders quality in GQLHM teams being able to find their own solutions by using their team resources more flexibly to deliver person-centred care. Morris[10] argues that the integration between health and social care needs to be the starting point when developing professional care. Furthermore, Larsen, Broberger and Pettersson[9] pinpoint the need for trustful relations to be able to work flexibly for a high-quality home healthcare.

Integration is poor, primarily in different, organizational documentation systems. According to the participants in the present study, this constitutes an enormous challenge created by the Swedish model, which divides care responsibility between regions (healthcare) and municipalities (social services and homecare). The digitalization within health and welfare has not made communication any easier. It does, however, provide new opportunities even though these are not critically reflected on.[24] The present study identified communication barriers within different organizational care systems where the participants strongly wished for a joint documentation system to secure person-centred care. Hence, communication and documentation challenges connect to all the other themes identified in the present study and would, if the

problems of separate documentation systems were solved, enable a better flow in the care, which the older person in homecare could benefit from. However, shared professionalism and extended interorganizational cooperation did limit hospitalization numbers according to the participants in the present study.

The identified quality aspects and sub-themes: creating relations, closeness to next of kin, unencumbered time, care-chain cooperation, and shared professionalism were repeated in several ways in the interview groups. Before arriving at these concepts, different lenses, which otherwise might have been overlooked were used when thematizing the results. Some of these were rejected for being too similar. Our findings are of course partly formed by the educational programme that our participants took part in before the interview groups were conducted. The quality and richness of data showed that the participants' shared lived experiences as well as their discussions about different views about care work, and presumably, the openness in the discussions, was improved by the university course. The GQLHM was discussed and reformulated through the healthcare professionals' working experiences before and after their mutual work experiences. Given that the results can only partly be recognized from the educational course contents, then this is in line with another study[12] that found that interprofessional skills and knowledge improved through the educational programme.

## Conclusion

Sweden, as well as other European countries, are undergoing demographic changes with an increasing older population and professional shortage in welfare services. The conversion to a GQLHM is supposed to be one solution to these challenges. Quality aspects of a GQLHM was identified in the present study as care-chain cooperation, shared professionalism, and creating relations with the patient including closeness to next of kin. Unencumbered time and shared professionalism give the professionals the possibility to develop quality in integrated healthcare as part of person-centred care. However, when implementation is done of a new model, the organizational contexts always make their own interpretation of how to further understand the model in question. By characterizing these experiences, we can better prepare GQLHM interventions, so they adjust to the specific work in interprofessional teams.

## Disclosure

The authors report no conflicts of interest in this work.

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