Context Sensitive Health Informatics: Sustainability in Dynamic Ecosystems
R. Marcilly et al. (Eds.)

doi:10.3233/SHTI190135

Lost in Translation? Care Coordination Across Contexts in Swedish Homecare Nursing

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Abstract. The responsibilities for delivery of care in Sweden is divided between the regions and the municipalities. The regions run the hospitals and the primary care centres (PCCs) whereas the municipalities are responsible for homecare nursing and nursing homes. The homecare nurses and the doctors they need to seek advice from, thus belong to different organizations/contexts. As more patients with multi- and long-term illnesses are taken care of in their homes the workload of the homecare nurses has increased. A new healthcare agreement has thus been signed between a region in South Sweden and its municipalities. The healthcare agreement states that doctors from the PCCs are to form mobile teams together with the homecare nurses. This paper reports from a pre-study investigating how the agreement, in terms of translation sociology, is interpreted in four of the municipalities. The aim of the research project as a whole is to develop digital support systems for the mobile teams.

Keywords. Care coordination, homecare, nursing, teams, sociology of translation

1. Introduction

In Sweden, there is an increasing trend of patients, especially the elderly, being cared for in their home, even during multi- and long-term illnesses [1, 2]. This means that the care moves from the hospitals to the patients' homes. This, in turn, increases the workload of the homecare nurses [3]. Another aggravating circumstance is that the organization and responsibility of healthcare in Sweden is divided between two organizational levels, the regions and the municipalities included in the regions. The regions run the hospitals and the primary care centres (PCCs) whereas the municipalities are responsible for homecare nursing and nursing homes. The homecare nurses and the doctors they need to seek advice from, thus belong to different organizations. In response to this, a new *healthcare agreement* was signed in 2016 between a Region in Southern Sweden and the region's municipalities. The healthcare agreement states that the homecare nurses should be able to call a doctor from the PPC when needed. When called upon, a doctor is to reside in the patient's home within two hours, around the clock, to team up with the homecare nurse. A PPC doctor and a homecare nurse are thus the core of the new team but can, when needed, request other care professionals as an assistant nurse, a physiotherapist or

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an occupational therapist to join the team. This will potentially imply increased support for the homecare nursing staff, as they will get a team to turn to.

Besides the apparent organizational challenges with a transition to a new work form including several organizations, the interpretation of the core concept, the *team*, can constitute another obstacle. Previous research indicates that different understandings of how the team is supposed to work together lead to poor team functionality and communication failures [4-6]. Furthermore, we know that the concepts of a *team* and *teamwork*, sometimes are interpreted differently [7, 8]. Thus, it is of interest to investigate how a team based organizational change initiative, implemented broadly in several different municipalities, is interpreted and translated into organizational practice.

In this paper, we present findings from a pre-study of how the new healthcare agreement has been interpreted in the local context in four different municipalities. The pre-study is the first step in a larger project intended to develop digital support systems for the mobile teams. In the paper we will consider; 1) how the interpretation of the agreement and multi-professional team varies between the different municipalities, 2) to what degree the multi-professional teams have materialized in the four municipalities so far, 3) how (and by whom) the cooperation between the region and the municipalities has been organized, and 4) what possible indications this may have for the future development of digital support systems.

2. Theory: Sociology of translation

To catch and analyse the variations in interpretation of the agreement and multi-professional teams between the different municipalities we use *sociology of translation* i.e. the notion that ideas are translated when they move in/through the field [9, 10]. Latour [9] and Callon [10] define *translation* in a wide sense, including all possible variations in a process of interpretation. Thus, here translation goes beyond mere translation word for word, and also refers to, for instance, that an abstract language can be translated into a concrete one, or that words can be translated into action. This implies that it is difficult to control the process of implementation. Latour [9] writes of tokens, which implies anything that can be spread. Latour's intention with the concept of translation is to give an alternative to the "usual" diffusion models [11]. Latour [9] rather sees each and every encounter between the token being spread and the people it meets as an "happening" to which the outcome cannot be predicted. This in turn has implications for the power of the ideas. There is an important difference between Latour's and Callon's translation models as they focus on or highlight different parts of the translation process. Latour's translation model highlights the translation itself, while Callon's model of translation highlights the translators and how they become translated through the process. Callon uses the concept of the *obligatory passage* to explain how different translators (actors) are linked to each other through the mutual "problem".

3. Methodology

The design of the pre-study was qualitative and the data was obtained through: 1) document studies related to the *healthcare agreement* and its implementation and 2) semi-structured interviews with representatives from the four municipalities' home care nursing units. The interview questions were concerned with; *the current organization of*

home care nursing in the municipality, *how the mobile teams are interpreted and organized*, *plans to develop their organization with regards to the mobile teams, power and influence over the organization of the mobile teams, how the patients were selected and enrolled in the program, and perceived effects on the patient care and the work environment of the nurses.* All interviews were recorded and transcribed. In total, 13 persons were interviewed, from the four municipalities (see table 1).

Table 1. Number of interviewed personnel in relation to municipality and profession/occupation.

Municipality	Section manager	Home health-care nurse	Medically responsible nurse	Social service manager
A	2	1	0	0
B	0	1	1	0
C	2	3	0	1
D	1	1	0	0

4. Results: The agreement and interpretation of the agreement in four municipalities

In the agreement, the region and the municipalities commit to a common development of the organization and work-routines of the mobile teams, their healthcare quality and a better resource allocation. Enrolment of patients into a mobile team is to be a common activity and decision between the region and the municipalities (i.e. a doctor from a PPC and a nurse from the homecare organization). In order to be enrolled, the patient has to fulfil four out of six predefined inclusion criteria. If the patient accepts enrolment, a joint coordinated individual plan for the patient's care is established. Before the agreement, the municipalities have been able to call a *mobile doctor service*, an emergency service procured by the Region when the PPCs are closed (ca 16.30-8.00). The mobile doctor service provides a doctor on call that comes directly to the patients' home. Patients are normally listed on a specific doctor at a PCC of their own choice.

4.1. The state of affairs in the municipalities

The four municipalities were chosen to represent different types of municipalities in the Region: two small towns, one by the sea including small satellite villages A (a total of 20 000 inhabitants); one in the country side including rural habitation B (a total of 15 000 inhabitants); and two larger towns, one with concentrated town habitation C (a total of 33 000 inhabitants) and one including rural habitation D (a total of 33 000 habitation).

4.1.1. Municipality A

In municipality A, the respondents from the homecare organisation did not know which patients were enrolled and listed on the mobile team. They had vague perception of the mobile team and seemed to have the opinion that the mobile teams are the PCCs responsibility. The homecare nurses were not informed of the list of patients that had been enrolled in the mobile teams and they have to phone the PCC to be informed on the matter. During the day the PCC sends a doctor to team up with the homecare nurse or decides what other actions to take (as calling the mobile doctor service or arranging for an ambulance transport to the hospital). In municipality A they claim that they mostly work in the same way as they did before, daytime they call for a doctor from the PCC and other hours they call the mobile doctor service. They have not made any changes in

their organization or the composition of their staff on behalf of the agreement. Still they feel that the PCC doctors make more visits to the patients than before but they also point out that the intention was even more enhanced cooperation with the PCC and that it is difficult to share information between the homecare and the PCCs as they belong to two different healthcare organizations. They communicate with the PCC through a weekly meeting about patients (planning), fax and telephone. They also told us that they are interested in becoming more mobile, amongst other with support of e-health technology, but they did not connect this to the agreement or the mobile team. The respondents also commented that the mobile doctor service was intended to become superfluous but that this has not happened yet.

4.1.2. Municipality B

The respondents in municipality B referred to another type of a mobile team – regional mobile teams that have been put together by and depart from the regional hospital and serve the municipalities in the area. These teams are better equipped than the local mobile team and the mobile doctor service and can provide more advanced care on site. The routine is that when needed the homecare nurses call the PCC for a doctor and the PCC decides whether to send one of their own doctors, the mobile doctor service or the regional mobile team to the patient. According to the respondents, the PCC doctors rarely come themselves though. The homecare nurses are involved, together with the PCC, in the enrolment of patients into the local mobile teams. Planning is done through a monthly meeting between the operational managers from the PCCs and the municipality together with the medically responsible nurse. They do not work differently from before but say that now the PCC takes larger responsibility to call for the mobile doctor service or the regional mobile team. The respondents also made a comment about not really understanding why there is an enrolment of patients for the mobile team because all patients seem to have the right to be visited by the regional mobile team. The bottom line is that the respondents from municipality B do not feel that they work with the PCC in mobile teams but they do meet up with the regional mobile team at the patient's home.

4.1.3. Municipality C

In municipality C, they have decided that the mobile team coincides with their "ordinary teams". They have thus not created any new organizational forms or teams for the mobile team but have extended their teams with competence in rehabilitation. The respondents also doubt that the PCCs are well enough equipped to work with the mobile teams i.e. to fulfil their part of the agreement. Still, they have good communication with the different PCCs amongst others through already existing collaboration groups. The local hospital is also involved in the communication. The municipality has chosen to work with one particular PCC to form the mobile teams. The other PCCs are included in the information loop but are not involved in setting the guidelines for the cooperation. The respondents note that on a higher level in the organizations everyone agrees on what the agreement means, but that when it comes to the shop-floor in a particular PCC the interpretation can be more problematic. The PCCs work as they have always done and individual doctors can be more or less informed about the agreement. The result is, according to the respondents, that the doctors are not always involved and engaged in the enrolment of patients and the writing of the joint coordinated individual plans. They perceive the lack of doctors as the main cause of this. As the PCC does not live up to their part of the agreement, the region has come up with the idea of a regional mobile team as a support

(the same sort of team as in municipality B). However, in the homecare organization they have done what they can but are dependent on the PCC to develop their part of the mobile teams further and come into action.

4.1.4. Municipality D

In municipality D the respondents claim that the homecare nurses have worked in mobile teams with doctors from the PCCs for quite a while before the agreement (daytime). Therefore, the agreement has not changed much for their organization. Normally, the particular doctor that the patient is assigned to will team up with the homecare nurse. Thus, more or less all doctors at a PCC can be involved in a team with the same homecare nurse. One of the PCCs is testing a system where one doctor takes all team calls and teams up with the same homecare nurse (forming a stable team). However, some nurses work with as many as three different PCCs and with several doctors at each PCC. If the patient changes PCC or doctor the homecare nurses will follow the patient and work with a new PCC and doctor. The respondents claim that sometimes the PCCs try to get the homecare nurses to contact the specialists in the hospital but the nurses refuse, as this is the responsibility of the PCCs. Still, they say that they have had a good cooperation and communication with the PCCs since before and sometimes the doctors manage to team up with the homecare nurse and sometimes the PCC calls the mobile doctor service or the regional mobile team instead. None of the PCCs provide doctors during the nightshift yet (the same is true for the other municipalities). The respondents also claim that the number of patients that are sent to the emergency at the hospital have not been reduced even if that was one of the aims of the implementation of the mobile teams. They also comment the fact that the regional mobile team is called the same as the local mobile team (both are called "the mobile team") which they think is confusing and a pity. The respondents also state that they need to reorganize some of the homecare nurses' work so that they cover up for the nurse that teams up with the doctor (implicitly meaning that the nurse that teams up with the doctor misses out on her/his round of patients). They will thus hire an assistant nurse that can support the homecare nurses. The enrolment of the patients is done in cooperation between the homecare nurses and the PCCs and the homecare nurses have weekly planning meetings with the PCCs. The respondents do not feel that there is a need for the PCCs to provide a doctor outside daytime as they have a good cooperation and communication with the mobile doctor service.

5. Discussion

The brief accounts from the interviews in the municipalities above, show that the agreement has been interpreted or translated, in Latour's [9] and Callon's [10] meaning, in different ways in the different contexts/municipalities. The interpretations also seem to be dependent on the local routines and the contact and communication channels between the homecare and PCCs'. Where there is an established communication and cooperation between the homecare and the PCCs, as in municipalities C and D, the translation of the agreement into practice seems to be simpler than in municipalities A and B where the communication and planning is not so elaborated or happens on a level above the homecare nurses and the PCC doctors. In addition, there is a difference between the different PCCs understanding of the agreement and the degree to which they translate it into practice. Several of the respondents describe a disbelief in the PCCs

capacity to fulfil their part of the agreement. The fact that the PCCs often prefer to call the mobile doctor service or the regional mobile team instead of sending their own doctors also indicates that they have problems realizing the agreement in practice.

The common enrolment of patients could have been an obligatory passage [10] for both the homecare nurses and the doctors, as they become linked to the patient and the mobile team. However, the doctors do not seem to be totally translated into team members (even though the degree of commitment varies between the different municipalities) as they pass on the task to the mobile doctor service or the regional mobile team. This shows that an obligatory passage only works as long as there are enough available resources, in this case doctors, to materialize the engagement in practice or as long as the problem is not recognized as mutual and the linkage of the obligatory passage is not made as in municipality A where the homecare nurses were not even invited to participate in the enrolment of the patients.

All the municipalities have, to different degrees, translated the agreement to become a part of "business as usual", adjusting their work only to a small extent, or not at all. In some cases (C and D) because the existing routines already resembled the agreement and the mobile teams or because there was a confusion about what the agreement and the mobile team really meant (as in municipality A and B). An idea, in this case the agreement, that allows for this type of adjustment to the existing contexts has to be vague or abstract enough for the different actors to translate it in different ways [12]. However, a digital system is per definition more concrete and does not allow the same type of local interpretation. The task to develop a uniform digital support system for the mobile teams will thus be challenging as long as the participating organisations do not align their interpretation of how to translate the agreement into practice.

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