

Perceptions and Engagement of Interprofessional Collaboration Between Registered Nurses and Physical Therapists in a Home Health Care Setting at Saudi Arabia

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Abstract :

Background :

The lack of communication between home care services and general practitioners is criticized by therapists who conduct home visits ; from the standpoint of an interprofessional cooperation, PRHC and family members should be viewed as team members in a collaborative practice in order to address PRHC's demands. **Aim of the research** : Perceptions and Engagement of Interprofessional Collaboration Between Registered Nurses and Physical Therapists in a Home Health Care Setting. **Research question**: What are the perceptions of interprofessional collaboration in the home care context among PRHC, family members, home care service nurses, general practitioners, and therapy professionals? **Methodology**: **Research design**: Descriptive cross sectional research design was utilized to conduct this research. **Setting and sampling** : It was conducted at capital home care at Jeddah , Participants were specifically chosen based on a variety of heterogeneous factors, including gender, age, residence, caregiving, and family relationships. Participants were chosen for the focus groups based on their gender, place of residence, and level of work experience. Purposive sampling were utilized to conduct this research , 395 participant was assigned to share in this research. **Research instrument**: One questionnaire as used to conduct this research : **It consists of two part** ; **The first part** is to assess the socio demographic characteristics of the study subjects ; **The second part** was develop by the researcher based on the current related literature to assess the perception of collaboration. **Perceptions and Engagement of Interprofessional Collaboration Between Registered Nurses and Physical Therapists in a Home Health Care Setting Results** Spearman's rho correlations that were performed to investigate the connection between cooperation and mutual respect are shown in Table 7. Positive correlations exist between the overall collaboration score and its associated dimensions as well as mutual trust (47****; .38****; 53****, 31****) respectively. **Conclusion**: Improved interprofessional cooperation could help close gaps in the home health care scenario and allow for the prediction of unfavorable outcomes. Van den Bussche et al. claim that when there is strong teamwork, the likelihood of avoiding hospital admissions is estimated more positively [10]. Regarding the effects of quality healthcare at home, interprofessional collaboration is also a touchy subject in other nations

Introduction:

According to Pham et al. (2012), medical errors are avoidable adverse events or unintentional injury that patients experience and that may lengthen hospital stays, increase morbidity, or increase mortality. Poor communication between healthcare professionals is partly to blame for these medical errors, which highlights the significance of enhancing teamwork (Neily et al., 2010, Pham et al., 2012).

The phrases "interprofessional collaboration," "teamwork," "interdisciplinary," and "multidisciplinary" are all used interchangeably in the literature to refer to collaboration amongst health care professionals (Xyrichis & Lowton, 2008). According to King et al. (2008), teams are known to make less mistakes than individuals, particularly when

everyone on the team is aware of their specific roles and depends on communication, cooperation, and coordination to reach the best results.

Teamwork, roles, responsibilities, communication, learning, critical reflection, relationships, and ethical practices are among the interprofessional education (IPE) learning domains for healthcare providers that were delineated by the WHO (2010). They advised listening to coworkers, being aware of one another's responsibilities, and cooperating for the benefit of the patient (WHO, 2010). The significance of interprofessional collaboration in healthcare is reinforced by the WHO's (2010) recommendations for IPE and teamwork. Life expectancy is steadily rising. Additionally, the population in need of care is continuously increasing [1]. Of the nearly 5 million people in need of care in 2021, the majority (4.1 million) received care in their homes, frequently with assistance from family members [1]. A home care service was used more frequently when the individuals in need of care were older. Over a million people were getting home care at the end of 2021, thanks to the efforts of over 15,400 home care services [1].

People receiving home care (PRHC) are also frequently cared for by family members, general practitioners (GPs), physiotherapists, occupational therapists, and speech therapists. The opinions of all the major participant groups about interprofessional collaboration are not well understood in Germany. Understanding the present forms of collaboration in the home care setting requires a deep understanding of their viewpoints. In healthcare, "collaborative practice occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care across settings," according to the World Health Organization (WHO, 2010) [2].

By involving experts from a variety of disciplines, interprofessional collaboration fosters a comprehensive approach that takes into account the different needs of patients, improving the quality of care [3, 4]. Interprofessional collaboration in home care needs to be improved, according to international scientific literature. The problematic nature of working relationships between professional groups is revealed by the ambiguous definition of roles and responsibilities combined with a lack of information sharing [5-7]. Additionally, professionals frequently don't understand how other professionals in home care typically function [8] and don't know enough about the information required to provide high-quality care [9].

Furthermore, there are clear structural obstacles pertaining to documentation systems, availability, and care fragmentation brought on by geographic circumstances [8].

Furthermore, global research presents a heterogeneous image of the viewpoints of the participating groups: In one study, GPs rated their collaboration with home services and physiotherapists as highly important and excellent [11], while in another, they complained about uncomfortable, irregular, and inadequate documentation and communication in the partnership [10]. Because they frequently handle medication and talk about diagnoses and test results [11], general practitioners view themselves as the care coordinators [7, 11, 12].

Significant of the study :

Nurses don't always participate in medical procedures unless there are issues, and they hardly ever interact with general practitioners or other specialists [7]. The lack of communication between home care services and general practitioners is criticized by therapists who conduct home visits [13]. Careau et al. demonstrated that, from the standpoint of an interprofessional cooperation, PRHC and family members should be viewed as team members in a collaborative practice in order to address PRHC's demands [14]. Despite the fact that PRHC are typically happy with their care [7,15], they only occasionally see shared agreements between their own family and general practitioners. Specifically, interprofessional collaboration in home care is not experienced by older individuals [16]. Comprehensive data on the viewpoint of interprofessional collaboration in the setting of home care is currently lacking in Saudi Arabia. These realizations are crucial for creating a future healthcare model that is both efficient and sustainable.

Aim of the research :

Perceptions and Engagement of Interprofessional Collaboration Between Registered Nurses and Physical Therapists in a Home Health Care Setting

To assess the Research question:

What are the perceptions of interprofessional collaboration in the home care context among PRHC, family members, home care service nurses, general practitioners, and therapy professionals?

Methodology:

Research design:

Descriptive cross sectional research design was utilized to conduct this research

Setting and sampling :

Setting:

Capital Home Healthcare is a specialized facility which provides health care at home and its roots go back to 2012 in Abu Dhabi, ever since it has grown throughout the United Arab Emirates and launched its expansion in the Kingdom of Saudi Arabia in 2022 in line with the Kingdom's Vision 2030. Capital Home Healthcare is dedicated in raising the standards of living for patients and clients in Saudi Arabia and the United Arab Emirates. Through our expertise in home health care, we are helping to change the way patients receive medical care, making it more convenient, cost-effective, and effortless.

Participants were specifically chosen based on a variety of heterogeneous factors, including gender, age, residence, caregiving, and family relationships. Participants were chosen for the focus groups based on their gender, place of residence, and level of work experience. Purposive sampling were utilized to conduct this research , 395 participant was assigned to share in this research

Research instrument:

One questionnaire as used to conduct this research :

It consists of two part

The first part is to assess the socio demographic characteristics of the study subjects

The second part was develop by the researcher based on the current related literature to assess the perception of collaboration Perceptions and Engagement of Interprofessional Collaboration Between Registered Nurses and Physical Therapists in a Home Health Care **Setting**

A five-point Likert scale was used in the first section to rate 25 statements about the advantages, obstacles, and motivation of the health information applications (1 being strongly disagree, 2 disagree, 3 neither agree nor disagree, 4 agree, and 5 strongly agree).

Reliability: The internal consistency of the instruments utilized in this investigation was assessed using Cronbach's alpha test. The results of the relevant test for the study instrument showed that the self-administrative nurses' questionnaire had an acceptable reliability of 0,804, while the nurses' observational checklist had an acceptable reliability of 0.883.

*** Pilot research:** To evaluate the tools' usefulness, comprehensibility, and effectiveness, a pilot study was conducted on 10% of the entire sample of nurses. The nurses who participated in the pilot study were included to the study sample based on the analysis's findings with only minor adjustments

Statistical analysis:

The demographic and organizational factors, as well as the respondents' opinions regarding the advantages, difficulties, and drive to use health information systems, were examined using descriptive statistics. The data were tested using a one-sample t-test to see if the mean score of each question was substantially greater than 3. This is the midpoint on the Likert scale for the "Neither agree nor disagree" response to the item. The study employed one-way analysis of variance (ANOVA) .

Results:

Table I displays the respondents' profiles by occupation, job experience, education, age, and gender. With a comparatively high standard deviation of 9.6 years, the average respondent's age was 36.2 years. This indicates that medical staff is youthful. In terms of gender, 86.2 percent of the respondents were women, and the remaining 13.8 percent were men. Since nurses are often female, the majority of the sample (55.2%) were nurses, which accounts for the sex disparity.

According to the table, nurses made up around two thirds of the sample, followed by phytotherapies (17.2%).According to the findings, the sample's nurse-physician ratio is 3.8, which is higher than the Ministry of Health's ratio of 2.5 [26].

Table 1 Frequency Distribution of The Respondent of The Research:

Socio demographic data	No	%
Age		
20 - 29	117	28.4
30 - 39	147	41.6
40 - 49	64	16.7
50 and above	48	13.2
(Mean =36.2± SD 9.6)		
Gender:		
Male	60	19.88
Female	335	80.12
Education:		

High school or less	20	3.4
Bachelors' degree	278	78.3
Postgraduate degree	67	17.3
Experience (years):		
Less than 5	140	42.7
5 - 9	110	27.3
10 - 14	74	20.2
15 - 19	23	5.6
20	18	4.2
(Mean =7.1± SD 5.5)		
Profession:		
Physiotherapist	66	34.5
Nurse	246	65.5

The psychometric properties of the five summated scale scores are shown in table 4. This table contains the modified esteem subscale, which was used to measure mutual regard, as well as the four sub scores and total score, which were used to measure collaboration. The average score for mutual respect (M = 3.38) indicated moderate to high levels of respect, whereas the average score for collaboration (M = 2.02) indicated low levels of collaboration.

Table 2The level of collaboration and its related dimension

	Mean± SD		
Partnership Scale	2.15 ± 0.47		
Cooperation Scale	2.17 ± 0.46		
Coordination Scale	2.71± 0.60		
Total Score Scale	2.02 ± 0.43		
Mutual Respect Scale	3.38± 0.64		

Table 3 pointed that Additional Spearman's rho correlations that were performed to investigate the connection between cooperation and mutual respect are shown in Table 7. Positive correlations exist between the overall collaboration score and its associated dimensions as well as mutual trust(47****, .38****; 53****, 31****) respectively

Table 3 spearman Correlations for Collaborative Scales with Mutual Respect Scores

	Mutual Respect Scale	
Collaboration Scale Total	47****	
Partnership Scale.	.38****	
Cooperation Scale .67**** .40***	53****	
Coordination Scale .34* .28*	31****	

* p < .05, ** p < .01, *** p < .005, and **** p < .001 (2-tailed)

Discussion :

Interprofessional collaboration is uncommon, according to this study. Participants frequently don't think this is required or important in less complex care situations. Our results are consistent with those of earlier international studies conducted in the homecare setting, which found that professionals typically operate independently of one another and frequently fail to see the advantages of collaboration or the necessity of altering the current care structures [6, 7, 10]. In particular, nurses, general practitioners, and even physiotherapists are unaware of occupational therapy's skills [6, 7, 10]. PRHC and family members also do not see the need for change, remain largely content with the treatment they receive, and might not even be aware that interprofessional collaboration exists [16].

According to our research, professionals frequently only interact through organizational coordination, which is seen as difficult. Negative effects of poor coordination include overlapping appointments, missed therapy time, and cancellations. The following investigations have also demonstrated this: In their research, Sakai et al. hypothesized that teams with better coordination are better able to satisfy customer needs [24]. Notably, there may be a high risk in the treatment process if information on new prescriptions or altered orders is not shared [25].It can be inferred that professional relationships facilitate dependable information sharing and prompt feedback, which supports organizational coordination and therapeutic modifications in home care.

Our findings indicate that although information sharing is not formally established, it is thought to be crucial for teamwork, particularly in complex care situations. This is consistent with past international studies that found that while collaboration is officially unresolved, it functions well in some areas [10, 11, 25–28].

The existing care structures view the absence of communication guidelines for contact initiative, timing, topic, and standardized means as crucial [25]. There are serious risks of adverse events and care errors when there is inadequate information sharing with the PRHC or family members, who frequently act as mediators [5, 9, 10, 16, 25, 27, 29]. Our data, however, shows that several PRHC and family members explicitly stated a wish to remain in charge of the care situation and be incorporated into it.

Nurses bear a great deal of responsibility for the PRHC and frequently step in as mediators from PRHC or relatives. According to a number of research [7, 16, 30, 31], nurses should lead the collaborative effort. This may suggest that a sudden health crisis or the inability of one professional or family member to get in touch with other professionals and/or family members can result in a vulnerable scenario in less complex care situations if the various health carers are not connected beforehand [16].

Our data shows that when a patient's health status seems to be about to deteriorate or when an individual care situation becomes more complex, experts are more likely to meet, support, and communicate with one another. Other writers have reported similar results [3, 7, 10, 16, 27, 31–33]. Furthermore, in accordance with the Careau et al. framework, collaborative practices—such as the goal of forming a partnership with clients or their families, practitioner-to-practice interaction, and the integration of disciplinary knowledge—should intensify in accordance with the growing complexity of the client's biological, psychological, and social needs [14]. In this situation, interprofessional collaboration could reduce workloads and offer more flexible care by integrating nursing and medical duties to enable ongoing modifications in the event that care demands increase [3, 26, 34]. The challenge of selecting the most efficient communication method is another important subject. Healthcare professionals become frustrated and experience irregularities as a result. This is supported by the research, which claims that insufficient communication, incomplete information, double documentation, and poor mutual availability may arise from a lack of dependable communication channels and shared formal documentation systems [3, 8, 10, 31, 34].

Our data indicates that professional-to-professional direct communication is often uncommon. On the one hand, this could be explained in part by the fragmentation of care, lack of formal communication systems, other experts' unavailability, and time and money restrictions. However, in less complicated health care scenarios, there may not be a perceived need for it. Our findings also lend credence to the notion that trust, person-related characteristics, and a shared understanding of the expertise of the different care participants all play a role in interprofessional collaboration. This is in line with a number of research where participants emphasized the value of familiarity and trust in promoting productive communication and teamwork in interprofessional healthcare settings [7, 10, 25–27, 29, 31, 35].

Professionals can benefit from interprofessional training by gaining competencies including knowledge, abilities, attitudes, and behaviors that enable them to collaborate with one another and share a common goal of providing more patient-centered responsive care [35, 36].

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Furthermore, a number of research that point to a lack of time and insufficient reimbursement confirm our findings regarding the obstacles to interprofessional collaboration [3, 26, 31]. The difficulties professionals have due to varying work schedules and procedures, geographical limitations, and personnel turnover are further supported by our data [5, 8, 29, 31, 33, 37]. Nieuwbower et al. [31] have documented GPs' efforts to reduce communication with home care providers by urging the PRHC or family members to choose their (the GP's) preferred service. In the study by Berg et al., secure audio conferences were used to improve care planning for shared patients. They reported a range of experiences, including late participants and misunderstandings, but also effective communication and more comprehensive picture

[8]

Conclusion:

Our study is novel because it examined how various professional groups, PRHC, and family members saw interprofessional collaboration to gain a comprehensive perspective and a wide-ranging, unique understanding of the home care environment in Germany. It adds to the growing body of research on interprofessional teamwork in home health care. Interprofessional care is now infrequent in PRHC healthcare settings. Information sharing and organizational coordination are frequently left to the PRHC or family members, and they don't always function well

enough. Because professional collaboration methods are not predetermined for a worsening of the PRHC's health, the home care situation may become precarious.

Improved interprofessional cooperation could help close gaps in the home health care scenario and allow for the prediction of unfavorable outcomes. Van den Bussche et al. claim that when there is strong teamwork, the likelihood of avoiding hospital admissions is estimated more positively [10]. Regarding the effects of quality healthcare at home, interprofessional collaboration is also a touchy subject in other nations [5–8, 16, 29–32, 34, 35, 40].

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