

A Shared Viewpoint but Diverse Focus: A Case Study About Teamwork Within Geriatric Home Rehabilitation

Mia Fernando, Therese Hellman, Staffan Josephsson

Fernando, M, Hellman, T, Josephsson, S. (2014). A Shared Viewpoint but Diverse Focus: A Case Study About Teamwork Within Geriatric Home Rehabilitation. *Health, Interprofessional Practice & Education* 2(2):eP1043.
Available at: <https://doi.org/10.7772/2159-1253.1043>

© 2014 Fernando et al. This open access article is distributed under a Creative Commons Attribution License, which allows unrestricted use, distribution, and reproduction in any medium, providing the original author and source are credited.

HIPE is a journal published by Pacific University | ISSN 2641-1148

A Shared Viewpoint but Diverse Focus: A Case Study about Teamwork within Geriatric Home Rehabilitation

Mia Fernando MSc, Reg. Physiotherapist *Rehab Södra, Stockholm County Council, Stockholm, Sweden*

Therese Hellman PhD, Reg. Occupational Therapist *Division of Occupational Therapy, Department of Neurobiology, Care Sciences and Society, Karolinska Institutet, Stockholm, Sweden. Unit of Intervention and Implementation Research, Institute of Environmental Medicine, Karolinska Institutet, Stockholm, Sweden*

Staffan Josephsson PhD, Reg. Occupational Therapist *Professor, Division of Occupational Therapy, Department of Neurobiology, Care Sciences and Society, Karolinska Institutet, Stockholm, Sweden. Department of Occupational Therapy, Faculty of Health Science, Sør-Trøndelag University College, Trondheim, Norway. The Stockholms Sjukhem Foundation, The Research, Development and Education Unit, Stockholm, Sweden*

Abstract

BACKGROUND To explore the experiences of an occupational therapist and a physical therapist working together in geriatric home rehabilitation team.

METHODS A qualitative study based on interviews and observations. The participants, one occupational therapist and one physical therapist, were individually interviewed on three occasions during a six month period. Data was also collected by observing the OT and PT when performing home visits on two occasions. All data was analyzed by using a constant comparative approach.

RESULTS The analysis showed that the teamwork was based on shared basic values in combination with the participants' diverse focuses and work tasks. Overlaps were apparent, but were not an issue in this team due to strong professional identities, direct communication and shared responsibilities. The teamwork was much about negotiating the professional prioritizations and being open-minded towards the other's professions. The observations also revealed that the client played an important role in the teamwork.

CONCLUSION Important facilitators for creating productive teamwork are: clarification of similarities and differences in the professions included, identification of what work tasks are shared responsibility and what tasks are included in a specific profession, directness of communication, and acknowledgement of the client as an active team member.

Received: 02/26/2013 Accepted: 10/15/2013 Published: 03/28/2014

© 2014 Fernando, Hellman, & Josephsson. This open access article is distributed under a Creative Commons Attribution License, which allows unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Implications for Interprofessional Practice

- To form a productive teamwork between physical therapists and occupational therapists it is important to create a viewpoint with shared basic values for the team members' practices.
- The team members in this study found it important to have their separate focus and work tasks.
- To not let overlaps and crossing the boundaries between each other's professional domain of practice become an issue within the team it is important to feel secure in one's professional identity, and to have direct communication and shared responsibilities within the team.

Introduction

In 2008, 84% of the Swedish population aged 80 years and older lived in their own homes (Karlsson, 2008). Even if many older persons experience good health, the process of aging has been found to be strongly associated with an increased risk of health problems and functional limitations (Femia, Zarit, & Johansson, 2001; Iwarsson, 2005) and rehabilitation for this group is needed. It is known that the majority of elderly people, i.e., people over 65 years, prefer home-based care and rehabilitation (World Health Organization, 2001). Home-based rehabilitation often involves various rehabilitation professionals linked together in a team working with the client. The National Board of Health and Welfare (2007) emphasizes that a prerequisite for good results in home-based rehabilitation is a well-functioning collaboration between various professions. The objective of this study was to research how such teamwork between an occupational therapist and a physical therapist is experienced.

Literature Review

A team might be defined as a number of people with complementing competencies that are working towards a shared goal and have a reciprocal responsibility for reaching that goal (Katzenbach & Schmidt, 1993; Kvarnström, 2008). There is a range of team constellations in which the collaboration between professionals varies. The three most common are multiprofessional, interprofessional, and transprofessional teamwork (Thylefors, Persson, & Hellström, 2005). Multiprofessional teams include various professionals that are working with the same

project in parallel with each other but independently (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005). Interprofessional teams assume a higher degree of collaboration. The team is working towards a shared goal and clear communication within the team is essential (D'Amour et al., 2005; Körner, 2010). Transprofessional teams are characterized by a floating boundary between the professionals (D'Amour et al., 2005) and interactive and flexible collaboration (Thylefors et al., 2005).

In previous research, both barriers and facilitators have been identified for successful teamwork. Ability to collaborate, communicate, take responsibility, and work independently has been shown to facilitate effective teamwork (Hall, 2005). Successful work is also characterized by respect and confidence between the team members and shared interest for the client's needs (D'Amour et al., 2005). Role overlap and experiences of crossing the boundaries between each other's professional domain of practice are seen as barriers for effective teamwork (Kvarnström, 2008). Occupational therapists (OTs) and physical therapists (PTs) often overlap (Higgs, Refshauge, & Ellis, 2001; Rogers, 2005) even though the professions have diverse focuses. Both focus on promoting health and reducing poor health: physical therapists by working with physical functions and mobility (Broberg & Tyni-Lenné, 2009; Higgs et al., 2001) and occupational therapists by facilitating participation in everyday life (Rogers, 2005; Swedish Association of Occupational Therapists, 2002). Previous research has found that similarities between the two professions might bring about protectionism, which might aggravate the collaboration (Brown & Greenwood, 1999). Worries about being considered

“unnecessary” has, for example, been identified in the collaboration between OTs and PTs working with stroke rehabilitation (Booth & Hewison, 2002).

OTs and PTs frequently collaborate, and teamwork is seen as being beneficial in home-based rehabilitation. However, it is known that the collaboration between these professions might be hampered by the similarities that exist, and there is limited knowledge on how the team members experience their professional roles and identities while working in a home-based rehabilitation team. The aim of this study was to explore the experiences of an occupational therapist and a physical therapist working together in a geriatric home rehabilitation team.

Methods

This is an exploratory case study with a constant comparative approach (Charmaz, 2006). In this case study both interviews and participatory observations have been used. Observations were seen as an appropriate choice as the previous knowledge within this area is rather limited (Carter, Lubinsky & Domholdt, 2010), and they were performed in order to increase the empirical data concerning teamwork. The empirical data from the observations influenced the interviews as specific questions could be related to concretely shared situations. This method with multiple data collection methods was used to make it possible to thoroughly study actions and experiences in a process over time. Ethical approval was granted by the Regional Ethics Committee in Stockholm, Sweden.

Participants

The participants (i.e., an occupational therapist and a physical therapist) were recruited by convenience sampling (Carter, Lubinsky, & Domholdt, 2010). They were involved in a larger project that aims to develop, implement, and evaluate a new intervention targeting frail elders living at home. The OT and the PT were involved in the project as the team performing the intervention, and they started to work together in the team as the project started in the fall of 2011.

The OT had 21 years of experience within the profession. She had been conducting home visits to a great extent during her work as an OT, even though she had not been working with home rehabilitation in

particular. The PT had 12 years of experience within the profession, and she had been working with home rehabilitation for two years. Both had been working in various rehabilitation teams consisting of a variety of professions before this study.

Study Context

The tailored intervention program is based on the “Advancing Better Living for Elders” program (ABLE) (Gitlin et al., 2009; Gitlin et al., 2006). It is a home-based intervention program including individually developed rehabilitation plans for each patient. The program has been culturally adapted to the Swedish conditions within health care. As an example, the “My home rehabilitation” program involves both an occupational therapist and a physical therapist to the same extent because the “team collaboration” model is the most common way to conduct home rehabilitation services in Sweden. Furthermore, the program contains some new and vital components such as client participation, client-centered assessment, and process-oriented evaluation. The overall goal with the “My home rehabilitation” program is to focus on the frail older person’s ability to participate in everyday life and includes the following phases:

1. Conducting evaluations of the frail older person’s perceived needs in everyday life and professional assessments of the frail older person’s needs of community based participatory rehabilitation and home environmental impact using standardized instruments, such as the Client-Clinician Assessment Protocol (C-CAP) (Lilja & Peterson, 2011). This instrument provides a structured protocol that leaves room for flexibility based on the frail older person’s situation, preferences, and needs.
2. The client’s own engagement is strongly emphasized within the program and the individual goal setting is provided based on discussions in which the frail older person and the professionals mutually participate (agreement). The discussion takes its point of departure from the C-CAP assessment.
3. Implementing interventions focusing on the frail older person’s ability to participate in everyday life such as: (a) training in performing everyday life tasks by the use of control-oriented strategies and

energy conservation techniques, (b) training in cognitive strategies such as problem solving in the performance of everyday life tasks, (c) provision and training of assistive devices such as walkers, bath and shower aids, and (d) provision and training of home modifications such as automatic door openers and ramps.

4. Evaluating the effects of interventions from the perspective of the frail older person and the professionals using the agreement.

The structure of the visit may vary because it is essential for the professional to listen actively to the frail older person, and let the person lead the direction of the conversation and activity to areas that are important for her or him.

Data Collection

The data collection procedure consisted of three interviews with each participant and two observations during a period of six months. Following informed consent, the interviews were conducted at the participants' places of work. The interviews were open and unstructured (Carter et al., 2010; Kvale, 1996). The initial interviews were based on an interview guide comprising various areas targeting issues related to teamwork, such as collaboration, distribution and overlap of work tasks, and leadership. The last interview was based on the previous interviews and observations, which were carefully listened to and briefly analyzed prior to the forthcoming data collection point. The data comprised six digitally recorded interviews that lasted between 35 and 60 minutes, and they were transcribed verbatim.

Two observations were included in the data collection procedure in order to increase the understanding of the studied phenomena (Carter et al., 2010). The first observation was carried out between the first and the second interview occasions, and the second observation was performed in connection with the last interviews. During the observations the first author wrote comprehensive field notes (Charmaz, 2006). Each observation lasted for three hours and included one home visit together with the OT and the PT, as well as the time just before and after the visit. The two clients that were included in the observation

were informed thoroughly about the research and had the opportunity to decline participation. However, both clients gave their informed consent to participate in the study.

Data Analysis

The material was analyzed by constant comparison of data and was ongoing at the same time as data was collected (Charmaz, 2006). The initial analysis of data generated codes and memos, which guided the forthcoming interviews and observations.

In the initial phase of the analysis, all transcribed interviews were coded line-by-line (Charmaz, 2006). The codes were labeled in order to illustrate summaries of the content of segments in the various interviews. All field notes from the observations were analyzed in the same way during this initial phase. Memos were continuously written, which allowed the author to reflect creatively on the interviews, codes, and field notes (Charmaz, 2006). In the second step, the codes from all the interviews were compared with each other to identify patterns and contextures that could elucidate the aim of this study. The similarities and differences that were identified in the comparison of codes guided the creation of categories. One category could, for example, contain several codes that expressed similar issues. The categories were compared and related to each other. In this comparison of categories, a pattern within the data became clear and is presented in the results section. In the final analysis, the core category, a shared viewpoint but diverse focus, was developed from five categories. Each step of the analysis was peer examined by the third author and thoroughly discussed. To further enhance credibility, the second author peer examined the last steps of the analysis and thoroughly discussed the findings with the first author.

Results

A shared viewpoint but diverse focus

The core category describes how the OT and the PT had a shared viewpoint of their clients but described diverse focuses in their practical work. They described shared basic values as they both found it important to increase the client's quality of life during the rehabilitation. Still, they described diverse focuses in their practical work, which lead to distinct, separate, and unique work tasks.

This core category is further explained through the five categories: various perspectives but shared basic values, clear responsibilities enabled team player collaboration, negotiating among the professionals' prioritizations, working together as professionals and as persons, and including the client as an active team member.

Various perspectives but shared basic values

Both participants related that they had a mutual sphere that concerned thoughts about rehabilitation that aimed at increasing the client's quality of life. This was a shared basic value; however, it also became evident that team members had clearly distinct perspectives and underlying values to reach the overarching goal of increasing the client's quality of life. The PT focused on assessing and practicing with the client in order to regain disabled bodily functions. The role of the OT was mostly about assessing, practicing, and providing aids in order to improve the client's ability to perform activities in everyday life. These diverse perspectives often resulted in various entry points towards the client's difficulties. The analysis showed that the participants often identified the same needs through their assessments, even though they had their base in the separate professions, and the various knowledge bases complemented each other in a productive way. The PT describes this as follows:

The occupational therapist talks about a lot of activities in daily life, but we (physical therapists) talk more about functional ability. We might be talking on diverse levels, I don't know. But it is often about the same, same things anyway. To be able to move around in the home, primarily. However, we can support (each other) in various ways.

Even though the team members worked tightly together, they clearly expressed the differences between their various perspectives, and it seemed to be important for them to point out their specific knowledge and theoretical perspectives. Both expressed, in various ways that the PT worked with the body as a whole while the OT focused on the wholeness of the activity. The OT said:

One thing that I have now realized is that we see the wholeness; we see...well... the activities and the whole life situation, perhaps. And, well, the role

of the physical therapists is perhaps more specific, perhaps, targeting bodily functions.

And the PT elaborated on the same issue like this:

I need to do other, perhaps more specific tasks as a physical therapist, to be able to help the clients reach their goal... Partly, it is about recuperation; the body is supposed to recover and you should help the body to be strong and supple again. So I still feel that I'm more working on a bodily level.

The analysis also identified an important similarity between the participants that made their teamwork function well and productively. They both expressed that, despite the differences, they shared a mutual sphere that included ideas about rehabilitation that aimed at increasing the client's quality of life. Both participants agreed that their professional work was a great deal about helping the clients get back to their previous everyday life, and that they were striving towards the same goals. This shared standpoint formed a basis for their work together.

Clear responsibilities enabled team player collaboration

This category describes how the team members experienced their concrete and practical work with the clients. Both participants described that they had distinct separate work tasks and responsibilities, but the interviews and observations also revealed that there were areas and work tasks in which both participants had equivalent knowledge and competence. This shared competence was mostly apparent in work tasks where the activity itself was closely related to the client's body functions, such as basic movements in the home. Such overlap between the participants made them feel confident, as they knew that their colleague would be able to take over the training if they got sick. They also described situations when they helped each other and deliberately stepped in to the other's working area in order to be of assistance. For example, the PT could be asked by the OT to put marks on the wall to show where handles should be mounted. In the same way the OT could suggest another walking aid, even though the PT is mostly responsible for that task.

This collaboration was experienced as smooth and uncomplicated and, in the observations, it was also seen that the participants helped each other with

the various work tasks. Similarly, it became clear that there was a definite distinction between which tasks that belonged to which participant. One of the participants was the “owner” of the task, but under certain conditions, the other could also perform the task. The participants always reported back to the other about what they had done with the client and how it had turned out. Neither the PT nor the OT entered the other’s domain without having permission. The participants described how this was achieved by a negotiation with team players. The OT said:

Then it is like this, well can you do this, can you take that? It is a lot like that. And then we are always asking how it turned out. Yes, that is really primarily how we are doing things. It is not that we, I don’t feel that we are stepping in to each other’s area—not at all. It is a very humble attitude, from both of us.

The participants felt secure in their professional roles and had been working in their respective professions for many years. The analysis identified how such factors enabled constructive teamwork and made the overlaps unproblematic because the participants did not feel that they had to “protect” their professional boundaries and they were well aware of how the other team member worked in their profession. The PT said:

Well, I think we have merged together now. We know how we work and feel safe with how we are thinking and working.

Their previous work experiences made them competent enough to enter the other’s domain and made them feel secure enough to let the other one in.

Negotiating among the professionals’ prioritizations

Even though the participants worked closely together and did not experience overlaps as problematic, the analysis identified how they experienced their specific work tasks and focus areas and how to make room for each other. For example, at the beginning of the collaboration, the OT was troubled about how the goal should be labeled and worried that her goals would not be in focus. She related how the clients often want to focus on goals targeting bodily

functions, as they are easier to understand than goals targeting participation in everyday activities, such as preparing a meal or visiting relatives or friends. However, this concern did not materialize, as the PT and the OT consciously worked on how to formulate all the goals from the beginning of their collaboration. It has been an ongoing process, and as a team they have learned to put their separate goals into a larger goal targeting activities in which several dimensions are included. The OT gave an example of this:

We had a patient who needed to get out and to be able to walk outdoors to get to the physical practice that she wanted to participate in, gymnastics at a sheltered housing facility. I see the goal of her being able to get there in order to participate in this leisure activity so we first had to focus on physically getting her there, as the goal, and later it became broader.

However, during this process of negotiating goal formulations, the PT did experience the concern that the occupational therapist was afraid of. The PT experienced that their collaboration mostly had an occupational therapy approach that resulted in a prioritization of the OT’s work. In this process it became clear which work tasks the team members were ready to compromise on and which they were not. This issue was solved during the period of data collection by a straightforward conversation about their diverse focuses and a compromise around this. Through this conversation it became clear to the team members that they could perform some visits separately without losing their collaboration. That made their work more effective and they had, consequently, the possibility to clearly focus on their specific tasks during some visits. The OT concluded:

Even though we work as a team and do things together, you need to feel that you also have your own time to do specific tasks. I think that is very important as well.

Working together as professionals and as persons

To create productive teamwork, both the participants agreed that there was a need for reflection time and openness between them as persons as well as professionals. They related that they could schedule

a whole afternoon just to sit down and discuss their patients in order to find out what the next step would be and which one of them was the most suitable person to deal with it. The PT described it like this:

It is a process in which to find each other, both in planning when to set out...but also in finding ways of working together when we are at the patient's place.

The analysis identified a need for straightforward communication in order to avoid conflicts and misunderstandings, and the participants had created an open climate in which they valued each other's opinions. The OT stated:

Well, it is the collaboration that allows us to talk about things. Frankly and explicitly, what we think and feel. And that we are willing to change things to make them better and to do things in various ways and develop the process.

The analysis showed that the participants had a shared responsibility for their teamwork and no one was identified as having the role of a leader. They found it hard to imagine that one of them should be in charge over the other. The PT put it this way in the last interview:

Well, neither of us are, I'm thinking about leadership. Neither of us is the leader; we are two persons with different professions that are close to each other, it would be odd if either were to be the leader. We respect each other's assessments, that's how to do it.

The participants concluded that they were fortunate to be working well together and liking each other as persons as well as colleagues. They concluded that such might not always be the case in teams working together, thereby hampering the collaboration.

Including the client as an active team member

During the observations it became evident that the client also played an important role in the team. The client held a central position, both in terms of physical allocation and in conversations during the home visits. The OT and the PT gave the clients the opportunity to voice their opinions and to express their concerns and wishes for the forthcoming rehabilitation. The analysis

found that including the client as an active team member was time consuming and required a great deal of patience and flexibility since the client not always had the same agenda as the OT and PT had. During the observations it was noticed that both the OT and the PT had to hold themselves back, both as professionals and as individuals, in order to give the clients the central role that they needed. Even though this could be a very demanding process for the team members, they were aware of the benefits of including the clients in the team. The OT described this as follows:

It is very comprehensive covering the whole everyday situation. The focus is not on the specific diagnosis or why they have been at the hospital; it is more about the whole life situation. But that is good, I think, for the patient because they feel that someone cares about the whole situation and they get the chance to talk about what problems they actually experience at the moment.

In the same way as the team members valued the client as an active team member, the clients also valued the team members as appreciated and welcome guests in their homes. It became clear during the interviews and the observations that the team members were also valued from a social point of view in the clients' everyday lives. The collaborative approach between the team members and the clients created a feeling of trust, and that feeling made the clients sometimes bring up questions that were not issues for the team members' professions. For example, the clients often asked the OT and PT to help them with contacting care managers or health centers to make an appointment. The PT described it like this:

I feel that I'm working a lot as a sounding board, some kind of central function, since we are there for quite a long period and finally someone stays, then all the questions come up. And some of these questions are not our area at all.

Discussion

This study identified how the participants were collaborating through continuous negotiation between their unique professional focuses and a shared client viewpoint. The findings demonstrate functioning teamwork even though some worries were experienced by both of the participants. Some

facilitators and barriers of productive teamwork will be elaborated on and discussed further based on the findings from this study.

The core category, a shared viewpoint but diverse focus, is identified as the hub for the teamwork in this study. The PT and the OT had a shared viewpoint and a mutual goal for their interventions directed towards their client, something that earlier has been identified as important in previous research concerning teamwork (D'Amour et al., 2005; Katzenbach & Schmidt, 1993; Kvarnström, 2008). However, it has also been argued that similarities between the professions in a team might bring about protectionism that may thus aggravate the collaboration (Brown & Greenwood, 1999). Interestingly, this was not the case in our study, and there might be several reasons for this. The participants shared a mutual viewpoint and basic values; however, they also carefully described their diverse focuses, and that might be a facilitator for successful teamwork. They expressed clear professional identities in which they felt safe and secure, which made both feel comfortable in letting the other team member enter their domains.

In contradiction to earlier studies, overlaps and crossing the boundaries between each other's professions were not a big issue for the participants in this study. For example, Kvarnström (2008) found that overlaps and crossing the boundaries between professionals might create feelings of insecurity, be problematic, and be a source of conflicts. Rather, the participants experienced possible overlaps as positive as they knew that the client would get what was needed from the other team member even if they themselves were absent. This collaboration between the participants worked well, and they were pleased about not having someone who took on the role of leader. Still, they were careful about taking responsibility for their specific professional work tasks, which has previously been identified as promoting good teamwork (Hall, 2005).

However, the results also showed that teamwork was an issue for the participants and this caused some initial concerns. At the beginning of the collaboration, the participants tried to find suitable ways to work together, and they described some concerns about being unnecessary in the team. Few studies have focused specifically on the collaboration between OTs and PTs, but this finding is in line with Booth & Hewison's (2002) study about teamwork between these professions. This

concern might hamper positive teamwork (Booth & Hewison, 2002); however, the results of the present study showed that the participants managed to handle this issue before it affected the collaboration. The participants described the importance of straightforward communication and willingness to compromise in the team. Good communication has also been identified as a facilitator for well-functioning teamwork in previous research (Hall, 2005). The teamwork that was studied in this research was conducted within a specific research project, which enabled the participants to sit down and discuss their work to a larger extent than might have been possible in an ordinary home-based rehabilitation. Thus, this might be an important clinical implication in the provision of well-functioning teamwork.

One noteworthy finding in this study was that the client was identified as the third team member, and that is in line with the individually targeted intervention that the team is working with. It is interesting to note that this finding mostly emerged from the observations rather than from the interviews, and one might ask why it was not more pronounced by the participants since they had a client-centered approach. Perhaps the way of working in which the client participates in the planning and decision-making about rehabilitation is taken for granted by the participants. This might thus be labeled as tacit knowledge that is developed from experience and is unwarily applied in practice (Kothari, et al., 2012). The participants allowed the clients to direct the visits to a large extent, and they paid conscious attention to the clients' wishes and goals. This is in line with the view that a client-centered approach builds on an interdependent collaboration between the professionals and the client rather than on an independent goal setting (Kjellberg, Kählin, Haglund, & Taylor, 2012).

The teamwork was based on an enacted negotiation between the OT, the PT, and the client. They all had a shared goal and shared values; however, they approached the goal in different ways. This description reflects a team that is labeled as an interprofessional team by Thylefors and colleagues (2005). They have identified this team type to be more efficient than, for example, multidisciplinary teams that have a lower degree of collaboration. Thus, such collaboration might be desirable in geriatric home rehabilitation. However, interprofessional teamwork is recognized as very time consuming and the meeting time that is needed might be difficult to prioritize in clinical practice. Still, the

collaboration that was studied in this article relied on straightforward, respectful, and valued communication between all actors involved. Such collaboration might be supported by allocating time to discuss all professionals' values and goals; this would minimize the potential for conflicts caused by inadvertently crossing the boundaries between professionals' domains of practice.

Methodological Considerations

The choice of a qualitative constant comparative approach (Charmaz, 2006) for this study was made since the area under study is quite unknown and therefore a hypothesis generating an explorative method is relevant. However, the study only includes two participants, and the findings are not generalizable. Still, the findings in this study are drawn from the tangible level of interview data to a more theoretical level, which could be valuable for the purpose of reinforcing practice and contribute new insights into the role of teamwork within geriatric home rehabilitation. It would be interesting to expand research focusing on the teamwork between occupational therapists and physical therapists. Future research with a larger number of participants is needed. Furthermore, it would be valuable to conduct focus group interviews with OTs and PTs in order to gain more knowledge regarding their experiences and attitudes of working together as a collaborative team.

One aspect of trustworthiness (Krefting, 1991) concerns the issue that the participants in this present study are also colleagues who will continue their collaboration after they have reviewed the findings from this study. Thus, one limitation might be that the participants adjusted their answers during the interviews in order to maintain a good collegial atmosphere in future collaboration. However, in respect of this concern, the observations can be seen as strengths in the study, since that type of data contributed another dimension that increases the trustworthiness of the results.

Conclusion

The findings identified that the teamwork was based on the OTs and the PTs shared basic values in combination with their diverse focuses and work tasks. The professions were closely linked to each other, and overlaps and crossing interprofessional boundaries were apparent. Overlaps were identified as work tasks that both the participants had equal knowledge of,

and both were "owners" of the task, for example, in the case of mobility. The crossing of interprofessional boundaries was apparent when one participant gave the other permission to enter their domain. Both overlaps and the crossing the interprofessional boundaries worked well in this team due to strong professional identities, straightforward communication, and shared responsibilities. The teamwork was very much about negotiating between the professions' prioritizations and being open-minded towards the other's profession. The observations also identified the client as having an important role in the teamwork.

Our findings indicate that important facilitators for creating a productive teamwork are the clarification of similarities and differences in the professions included, the identification of what work tasks imply a shared responsibility, and what tasks are included in a specific profession, straightforward communication, and acknowledgement of the client as an active team member.

Conflicts of interest

The authors report no conflicts of interest.

Acknowledgements and Funding

The authors wish to acknowledge the participants for their time and willingness to share their experiences with us. Financial support was provided through the regional agreement on medical training and clinical research (ALF) between Stockholm County Council and Karolinska Institutet.

References

- Booth, J., & Hewison, A. (2002). Role overlap between occupational therapy and physiotherapy during in-patient stroke rehabilitation: an exploratory study. *Journal of Interprofessional Care*, 16(1), 31-40. <http://dx.doi.org/10.1080/13561820220104140>
- Broberg, C., & Tyni-Lenné, R. (2009). *Sjukgymnastik som vetenskap och profession*. [In English: *Physiotherapy as science and profession*]. Stockholm: Legitimerade Sjukgymnasters Riksförbund.
- Brown, T. G., & Greenwood, J. (1999). Occupational therapy and physiotherapy: Similar, but separate. *The British Journal of Occupational Therapy*, 62(4), 163-170.

- Carter, R. E., Lubinsky, J., & Domholdt, E. (2010). *Rehabilitation research: principles and applications*. St. Louis: Elsevier Inc.
- Charmaz, K. (2006). *Constructing grounded theory: a practical guide through qualitative analysis*. London: Sage Publications.
- D'Ámour, D., Ferrada-Videla, M., San Martin Rodriguez, L., & Beaulieu, M. (2005). The conceptual basis for interprofessional collaboration: core concepts and theoretical frameworks. *Journal of Interprofessional Care*, 19(1), 116-131. <http://dx.doi.org/10.1080/13561820500082529>
- Femia, E. E., Zarit, S. E., & Johansson, B. (2001). The disablement process in very late life: a study of the oldest old in Sweden. *Journal Of Gerontology: Psychological Sciences*, 56(1), 12-23. <http://dx.doi.org/10.1093/geronb/56.1.P12>
- Gitlin, L., Hauck, W., Dennis, M., Winter, L., Hodgson, N., & Schinfeld, S. (2009). Long-term effect on mortality of a home intervention that reduces functional difficulties in older adults: results from a randomized trial. *Journal of American Geriatrics Society*, 57(3), 476-481. <http://dx.doi.org/10.1111/j.1532-5415.2008.02147.x>
- Gitlin, L., Winter, L., Dennis, M., Corcoran, M., Schinfeld, S., & Hauck, W. (2006). A randomized trial of a multicomponent home intervention to reduce functional difficulties in older adults. *Journal of American Geriatrics Society*, 54(4), 809-816. <http://dx.doi.org/10.1111/j.1532-5415.2006.00703.x>
- Hall, P. (2005). Interprofessional teamwork: professional cultures as barriers. *Journal of Interprofessional Care*, 19(1), 188-196. <http://dx.doi.org/10.1080/13561820500081745>
- Higgs, J., Refshauge, K., & Ellis, E. (2001). Portrait of the physiotherapy profession. *Journal of Interprofessional Care*, 15(1), 79-89. <http://dx.doi.org/10.1080/13561820020022891>
- Iwarsson, S. (2005). A long-term perspective on person-environment fit and ADL dependence among Swedish adults. *Gerontologist*, 45(3), 327-336. <http://dx.doi.org/10.1093/geront/45.3.327>
- Karlsson, S. (2008). Older People's public health and social services - functional ability, health complaints, agreement in needs assessment and care satisfaction. Doctoral Dissertation. Lund: Lund University.
- Katzenbach, J., & Schmidt, D. (1993). The discipline of teams. *Harvard Business Review*, 71, 111-120.
- Kjellberg, A., Kåhlin, I., Haglund, L., & Taylor, R. (2012). The myth of participation in occupational therapy: reconceptualizing a client-centred approach. *Scandinavian Journal of Occupational Therapy*, 19(5), 421-427. <http://dx.doi.org/10.3109/11038128.2011.627378>
- Kothari, A., Rudman, D., Dobbins, M., Rouse, M., Sibbald, S., & Edwards, N. (2012). The use of tacit and explicit knowledge in public health: a qualitative study. *Implementation Science*, 7, 20. <http://dx.doi.org/10.1186/1748-5908-7-20>
- Krefting, L. (1991). Rigor in qualitative research: the assessment of trustworthiness. *American Journal of Occupational Therapy*, 45(3), 214-222. <http://dx.doi.org/10.5014/ajot.45.3.214>
- Kvale, S. (1996). *Interviews: an introduction to qualitative research interviewing*. Thousand Oaks: Sage.
- Kvarnström, S. (2008). Difficulties in collaboration: a critical incident study of interprofessional healthcare teamwork. *Journal of Interprofessional Care*, 22(2), 191-203. <http://dx.doi.org/10.1080/13561820701760600>
- Körner, M. (2010). Interprofessional teamwork in medical rehabilitation: a comparison of multidisciplinary and interdisciplinary team approach. *Clinical Rehabilitation*, 24(8), 745-755. <http://dx.doi.org/10.1177/0269215510367538>
- Lilja, M. & Petersson, I. (2011). *Riktlinjer för användning av Client-Clinician Assessment Protocol (C-CAP)*. [In English: *Guidelines for use of the Client-Clinician Assessment Protocol (C-CAP)*]. Stockholm: Karolinska Institutet.
- National Board of Health and Welfare [Socialstyrelsen]. (2007). *Rehabilitering för hemmaboende äldre* [In English: *Rehabilitation for elderly living at home*]. Stockholm: Socialstyrelsen.
- Rogers, S. (2005). Portrait of occupational therapy. *Journal of Interprofessional Care*, 19(1), 70-79. <http://dx.doi.org/10.1080/13561820400021767>
- Swedish Association of Occupational Therapists (FSA). (2002). *FSA's definition av ämnet*. [FSA's definition of the discipline]. Stockholm: Föbundet Sveriges Arbetsterapeuter.
- Thylefors, I., Persson, O., & Hellström, D. (2005). Team types, perceived efficiency and team climate in Sweden cross-professional teamwork. *Journal of Interprofessional Care*, 19(2), 102-114. <http://dx.doi.org/10.1080/13561820400024159>
- World Health Organization. (2001). *Active Ageing - a policy framework*. Geneva: World Health Organization.

Corresponding Author

Therese Hellman, PhD, Reg. Occupational Therapist

Karolinska Institutet
Department of Neurobiology
Caring Sciences and Society
Division of Occupational Therapy
Alfred Nobels Allé 23, 4th floor
SE-141 83 Huddinge

therese.hellman@ki.se