“It is two worlds” cross-sectoral nurse collaboration related to care transitions: A qualitative study

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Abstract
Aims and objectives: To explore how the hospital and home care nurses talk about and experience cross-sectoral collaboration related to the transitional care of frail older patients.

Background: Effective communication and collaboration between nurses involved in care transition are crucial for a safe patient handover. Organisational systems to support cross-sectoral collaboration have been developed but do not always promote the intended dialogue and precise and useful exchange of information. Other factors may also be of importance to an effective and constructive cross-sectoral nurse collaboration.

Design: A qualitative design using thematic analysis.

Methods: Data were extracted from 24 focus group interviews conducted with registered nurses from eight hospital wards and six municipalities and a total of 165 hr of observations conducted in three hospital wards and three municipalities. The study was reported according to the COREQ guidelines.

Results: The perception of nursing and care differed across sectors. The nurses expressed having shared goals for the patients—however, these goals derived from different values, the perception of nursing and approach to the patients. The lack of knowledge of each other’s working conditions created assumptions and preconceptions, which affected communication and collaboration related to planning and executing care transition negatively.

Conclusions: The nurses perceived the hospital and home care as "two worlds". The collaboration between the nurses was characterised by insufficient communication and preconceptions rather than concrete knowledge and different cultures and professional identities. It can be questioned whether cross-sectoral collaboration between nurses should be characterised as interprofessional rather than intraprofessional collaboration as the features of the nurses’ collaboration.

Relevance to clinical practice: Organisational and political systems should recognise that nurses in different sectors are taking care of various aspects of nursing when planning on policies to support cross-sectoral collaboration. More possibilities for nurses across sectors to meet should be made available.

Keywords
collaboration, communication, cultural issues, primary/secondary care interface, qualitative study, transitional care
Changes towards shorter hospital stay and hospital nurses undertaking increasingly complex and technological tasks are challenging frail older patients’ fundamental care needs (Kitson & Soerensen, 2017) and make requirements for nurses across sectors to secure safe and timely transfer of patients with complex needs (Hesselink, Schoonhoven et al., 2012; Lemetti, Stolt, Rickard, & Suhonen, 2015). Transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care, as patients transfer between different locations or different levels of care within the same location (Coleman, Boul, & American Geriatrics Society Health Care Systems Committee, 2003). Processes related to discharge planning and transitional care and interventions to improve patient discharge and decrease readmission of chronically ill patients have been widely examined (Hesselink, Schoonhoven et al., 2012; Mora, Dorrejo, Carreon, & Butt, 2017).

Structural and organisational barriers to intersectoral collaboration concerning care transitions have been identified in many studies over the past years (Axelsson & Axelsson, 2009). Barriers may present on admission, during a hospital stay or related to discharge. Studies have examined intervention for optimising and securing safe handover of patients from hospital to home (Bauer et al., 2009; Shepperd et al., 2010). Structured and individually tailored discharge planning that includes both patients, their next of kin and relevant healthcare professionals may contribute to a reduction in hospital stay and readmission and increase patient satisfaction (Gonçalves-Bradley, Lannin, Clemson, Cameron, & Shepperd, 2016). It has been shown that effective interventions should include structured communication tools in the form of electronic communication systems, coordination and improvement of continuity of care, discharge planning and clear communication (Hesselink, Schoonhoven et al., 2012; LaMantia, Schenemann, Viera, Busby-Whitehead, & Hanson, 2010; Laugaland, Aase, & Barach, 2012).

2 | BACKGROUND

Nurse collaboration has a positive impact on patient outcome (Gardner, 2005; McNeil, Strasser, Lightfoot, & Pong, 2016) and plays a central role in processing information and coordination of care needed for successful care transition (Apker, Propp, Zabava, & Ford, and Nancee Hofmeister, 2006). However, there is a lack of detailed knowledge regarding how nurses collaborate across different healthcare settings (Lemetti et al., 2015). Collaboration can be defined as a process related to sharing and working together with others towards a common goal. It is a complex and dynamic process that requires skills and shared goals and commitment (Allen, Ottmann, & Roberts, 2013; D’Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005).

Interventions that include involvement of the patient and the family caregivers, provision of support, information and education to the patient and family have shown effective to address the complexity of transition of patients from hospital to home (Hesselink, Flink et al., 2012; Hirschman, Shaid, McCauley, Pauly, & Naylor, 2015). Also, effective communication and collaboration between healthcare professionals involved in the process are crucial for a safe patient handover (Bauer et al., 2009).

Organisational initiatives have been implemented in Denmark to ensure safe and effective care across different sectors. In 2012, an electronic message system to provide structured and useful information exchange between hospital and home care services was introduced (Petersen, Foged, Madsen, Andersen, & Nørholm, 2018). Further, discharge coordinators and liaison nurses as well as “follow-home teams” are widely used in hospitals and home care to optimise and ensure a coherent patient pathway.

In a large study examining registered nurses’ perspectives on cross-sectoral communication, we have previously shown that standards and organisational systems like an e-message system do not support the intended dialogue and precise and useful exchange of information (Foged, Nørholm, Andersen, & Petersen, 2018; Petersen et al., 2018). However, other factors may be of importance to ensure effective and constructive collaboration between the nurses, in both sectors. In this study, the cross-sectoral collaboration is understood as the registered nurses working together across hospitals and home care services to provide consistent, coordinated and appropriate care in a timely fashion related to discharge (Winters, Magalhaes, Kinsella, & Kothari, 2016). We will address the factors that influence the cross-sectional collaboration from the perspective of these nurses.

3 | AIM

The study aimed to explore how the registered nurses at the hospital and in the home care talk about and experience cross-sectoral collaboration related to transitional care of frail older patients.

4 | METHODS

4.1 | Study design

The present study is a part of a larger study where we have used a descriptive qualitative design to obtain information about the beliefs,
emotions and behaviours of the nurses (Morse, 2012) with the purpose to investigate their experiences and perspectives. We used the Consolidated Criteria for Reporting Qualitative Research (COREQ) to ensure explicit and comprehensive reporting of the study (Tong, Sainsbury, & Craig, 2007). See Supporting Information Appendix S1.

4.2 | Data collection

Data were collected using focus group interviews and participant observations. The authors in collaboration conducted a total of 24 semi-structured interviews including 79 nurses from three medical and surgical hospital wards and eight different units in six municipalities. The participants were informed about the background and goals for the study before the interviews. No leaders or other staff were present during the interview. Field notes were made during the interviews and used for evaluating and refining the interview guide. The focus group interviews were audio-recorded and transcribed verbatim. Transcripts were not returned to the participants, but results were discussed in a later workshop.

Further, participant observations were performed in 11 settings and included three hospital wards and eight municipality units. Field notes were recorded and transcribed on a daily basis. Interviews and observations were performed until no new perspectives or insight appeared.

The interviews were conducted in collaboration between the authors, and the observational study was performed by a research assistant with a nursing background and qualifications within social sciences. Interviews were only conducted once with each focus group. Details on the participants are shown in Table 1. More details on the data collection, relations with the participants and the authors have previously been reported (Foged et al., 2018; Petersen et al., 2018).

4.3 | Study setting

Denmark is a small country with 5.5 million people. The Danish healthcare system is tax paid and based on the principles of free and equal access to health care for all citizens. The present study was carried out at a large university hospital in the Capital Region of Denmark in collaboration with six adjacent municipalities. The university hospital has 730 beds, 5,500 employees and more than 90,000 admissions/y. Stay at the hospital is < 4 days in 50% of the patients and 85% is admitted acutely.

Nurses working in the hospital and the home care setting are all registered nurses with a bachelor’s degree in nursing. There are no further educational requirements for staff nurses working in both sectors, though some of the nurses have postgraduate courses or higher education.

Nurses at the hospital are responsible for planning and providing all aspects of nursing and medical care during the patient’s hospital stay. In the home care setting, the nurses are responsible for planning and providing specialised nursing care.

The home care service includes the registered home care nurses as well as a large group of healthcare staff with one or two years of education and practical training. The two groups work in separate systems within the municipalities. The patients’ need for nursing care after discharge is assessed by a discharge coordinator who is responsible for coordinating and planning the more complex transitions from hospital to home. Nurses are not involved in less complex transitions where the need for care relates to personal and practical assistance.

An e-message system was used for nurse communication between hospitals and municipalities in relation to admission and discharge of patients. The e-message system held five key elements, including reports and notifications related to admission and discharge as well as care plans and a message platform. More details on the system have been reported previously (Foged et al., 2018; Petersen et al., 2018).

4.4 | Data analysis

The following research questions were used in the analysis process: How do nurses experience cross-sectoral collaboration in connection to admission and discharge of frail older patients? What were the themes brought up by the nurses when they were talking about cross-sectoral collaboration?

All data from the main study (data corpus), including focus group interviews and field notes, were handled in Excel spreadsheets and re-analysed. We searched the data corpus for themes and patterns related to collaborations using thematic analysis as described by Braun and Clarke (2006). The thematic analysis involved searching across all data to identify repeated patterns of meaning. We identified instances where our topic of interest was referred to and extracted these for use in a new data set. Then, data were coded and organised into meaningful units which were sorted into potential

<table>
<thead>
<tr>
<th>TABLE 1 Description of participants</th>
<th>Hospital nurses</th>
<th>Home care nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>27</td>
<td>52</td>
</tr>
<tr>
<td>Female</td>
<td>27</td>
<td>50</td>
</tr>
<tr>
<td>Mean years employed at current position (range)</td>
<td>4.6 (0.25–26)</td>
<td>5.4 (0.5–25)</td>
</tr>
<tr>
<td>Mean nursing experience in years (range)</td>
<td>8.6(0.5–32)</td>
<td>17.6 (0.9–46)</td>
</tr>
<tr>
<td>Nurses with postgraduate courses (range)</td>
<td>7 (26%)</td>
<td>20 (38%)</td>
</tr>
<tr>
<td>Nurses with masters of science</td>
<td>0</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>
themes. We analysed codes and themes by moving back and forward between the data set, codes and potential themes. We developed a thematic map of our data and worked with defining and refining the themes during the writing process. We identified one main theme containing three subthemes. As the data resulted in one large and complex theme, we took care to consider each subtheme to ensure as little overlap as possible.

4.5 Ethical consideration

This study was performed according to the Helsinki Declaration. The participants gave consent to participation and were informed about anonymity and confidentiality. Data were stored in a logged-in file drive. According to Danish law, formal ethical approval is not required for studies not involving biomedical issues.

5 RESULTS

The thematic analysis identified one main theme “It is two worlds” and three subthemes: “Different objectives and approaches to nursing in the two worlds,” “Assumptions and preconceptions in the two worlds” and “Interaction and collaboration between nurses in the two worlds.”

The nurses perceived the hospital and home care as “two worlds” with different cultures. These cultures were explained by different focuses and approaches to the patient, as well as different perceptions of nursing and languages used in the two sectors. Further, a lack of knowledge and respect for each other’s professionalism and working conditions were identified, all of which influenced the collaboration related to planning and executing the care transition of older people and care after discharge.

5.1 Different objective and approach to nursing in the two worlds

The nurses’ perception of nursing and care differed across sectors. The home care nurses’ main tasks included coordination of care and specialised nursing tasks, for example medication, palliative care and wound care. Fundamentals of care, like the patients’ need for food, elimination and personal hygiene, were not a part of their job. These tasks were taking care of by home care providers with one or two years of training. In the home care, nursing was described as comprehensive and including the patients’ entire situation.

At the hospital, nursing included all aspects of care related to the patient’s acute needs. Their focus was on care and treatment related to the patients’ acute problems and on planning and executing discharge from the hospital. They considered themselves as specialists within their medical field. The fundamentals of care were an integrated part of the hospital nurses’ job, but not all of them knew that the same did not apply for the home care nurses, which at times led to an unnecessary or insufficient transfer of information from hospital to home care.

Nurses in both sectors perceived themselves as the ones taking care of the “whole patient” and referred to the other part as “specialised” and only taking care of certain aspects of the patient’s care needs.

The hospital nurses are totally focused on their specialties and do not care about the other diseases the patient may have. (Observation Municipality)

The perception of nursing influenced the nurses’ approach to the patients. The home care nurses defined themselves as being holistic and consequently referred to the patient as “the citizen.” They stated that in contrast to the hospital nurse, they were taking care of the “whole person” while focusing on health promotion and prevention of disease. While the patients were described as guests at the hospital, the home care nurses considered themselves as guests in the patients’ homes.

Well, that’s because our citizens, when they are hospitalized, they are guests at the hospital and the hospital decides. They have their facilities and their service level. When they come home, we are guests in their homes, even if they live in a nursing home. Then we offer a service. So, it’s completely different worlds. (Home care nurse)

Unclear responsibility for a safe care transition challenged the collaboration. The nurses all felt a substantial responsibility for the patients while they were in their care. However, they were unsure who had the overall responsibility for the transition process. The hospital nurses mainly saw the patients in the acute phase and had limited access to information on the patients’ habitual condition. They described that they worried about how the patient would manage after discharge, while the home care nurses assumed that the opposite applied. At times, distrust and lack of knowledge about the other party’s qualifications and experiences contributed to worry for the patient while in the care of the other.

And sometimes things happen very quickly. And you think: Is this the right solution for the patient? What was the functional level before admission? It can drop very much at that age, so what’s a realistic goal for the patient? (Hospital nurse)

According to the home care nurses, the patients’ functional level after discharge was in general underestimated by the hospital nurses.

It’s because we have to know the citizen’s need for care. And when the hospital has a hospital bed, a lift, and two porters to help transfer the patient, and the hospital nurses do not take the patient’s needs for help at home into consideration, then things go wrong. (Home care nurse)
5.2 | Assumptions and preconceptions in the two worlds

Nurses in both sectors talked about the hospital and the municipality as being two worlds with different working environments, cultures and experiences.

It’s different worlds. There are two worlds; we can see that... It’s a whole different environment that we are in. Another way of working (...) it also has an impact on communication and relations and how to act together and think about the other, right?  
(Hospital nurse)

The nurses referred to different cultures when they talked about and described their working environments. The different cultures were from the perspectives of the nurses shaped by the organisational systems and perceptions of what was best for the patient. There was a clear perception among them that although they shared a common goal of a safe care transition, nursing in the two sectors was strongly influenced by different mindsets, cultures were from the perspectives of the nurses shaped by the patient. There was a clear perception among them that although organisational systems and perceptions of what was best for the different ways of working with the patients and different working conditions. Nursing at a hospital ward was referred to as “giving instructions to the patient” and “knowing what is best for the patient,” whereas nursing in the home care was referred to as being “based on the citizen's need and wishes” and “negotiation with the citizen towards a common goal.” The nurses agreed that lack of understanding for each other’s working conditions was a barrier for good collaboration.

We don’t understand how each other do things. And the way we are working differs a lot. So, we don’t know how to meet yet.  
(Hospital nurse)

Knowledge about and understanding of the terms under which the other party was working varied between the home care nurses and the hospital nurses. The hospital nurses did not know about resources and actual possibilities in each municipality. Although they expressed a large concern for how the older vulnerable patients would manage after discharge, most of them did not consider knowledge of the home care nurses’ work and working condition as necessary for taking care of the patients at the hospital. The hospital nurses did not distinguish between the different municipalities but referred to them as “the municipality,” regardless of with whom they were collaborating. Limited knowledge of how care was organised in the various municipalities challenged the cross-sectoral collaboration. The hospital nurses expressed a wish for the home care nurses to specialise in the more complex care needs of the older patients.

While both hospital and home care nurses stated that the nurses from the other sector did not understand how they were working, they simultaneously expressed that they understood the other party’s working conditions.

It’s because they work differently there [in home care]. Their mindset is different. It’s because they are working with something completely different.  
(Hospital nurse)

The hospital nurses were under pressure from physicians and hospital administrators to contribute to an effective and fast patient trajectory. Consequently, the patients’ stay at the hospital were often short, leaving the hospital nurses little time to gain a more comprehensive insight into the patient’s needs and problems after discharge. These working conditions were known to the home care nurses.

They [hospital nurses] are under pressure from higher up in the system. There will be a doctor at 13.15 Friday afternoon saying: ‘Home, home, home, stay, home, home, out of the hospital ...’. And then it has been cleaned up.  
(Home care nurse)

All nurses in the study were registered nurses. However, their work experience differed significantly. The hospital nurses were generally younger with few years of nursing experiences. None of them had worked as home care nurses. Thus, their knowledge of the home care nurses’ work and the problems and challenges they were facing was derived from patients, colleague’s experiences and previous cross-sectoral collaboration. They did not reflect much on this and did not consider it to be a problem in their daily work. The home care nurses were in general older and more experienced nurses, all with a background as hospital nurses. They often described the working conditions at the hospital as the reason for leaving the hospital to work as home care nurses, and they expressed an understanding of the heavy workload at the hospital. They reflected on the hospital nurses’ limited knowledge of the conditions under which the home care nurses were working and how it affected their collaboration negatively.

Most of us have previously worked in hospitals. We know how they are thinking, how they work and the problems. Most hospital nurses are younger and less experienced. They are fighting to find their own feet, so being able to get an overview of what is happening on the other side of the fence is difficult.  
(Home care nurse)

5.3 | Interaction and collaboration between nurses in the two worlds

The hospital and home care nurses expressed a shared goal of a smooth and safe transition for the patient and emphasised the importance of understanding each other’s worlds for the benefit of the patients. However, collaboration and the way to achieve the goal were challenged by different organisational systems.

The demand for a shorter hospital stay and heavy workloads hindered the hospital nurses in focusing on collaboration with the
home care nurses. The hospital nurses described collaboration to be important. However, they did not worry about the lack of collaboration as they did not find it essential for taking care of the patients at the hospital. The home care nurses were highly dependent on information from the hospital nurses to provide proper care to the patients after discharge and described good collaboration and communication as a prerequisite for much of their work. Inadequate or imprecise information left the home care nurses with significant challenges in performing their daily work, and they all expressed a need for more direct collaboration with the hospital nurses.

When you meet face to face, you talk differently. Maybe someone could visit us [the hospital nurses] to see what it’s like.... To get an understanding of each other’s worlds. (Home care nurse)

The home care nurses claimed that the hospital nurses worried too much when they assessed the patient's need for help after discharge and would promise the patient more help than the home care nurses considered necessary, or that it was possible, to provide. As the right to decide the level of care after discharge was exclusive with the home care services, the hospital nurses sometimes felt they had to advocate for the patient. Although the hospital nurses supported the patients' wish for care after discharge, the home care nurses could decide otherwise. It was not that the home care nurses did not understand the perspective of the patient and her family, but they had to take political decisions and limited resources as well as their professional experience and knowledge into consideration when making these decisions.

Different approaches to the patient were often referred to by nurses in both sectors, and they described how collaboration related to discharge at times became a struggle when the nurses in the two sectors could not agree on what was the best for the patient. They used expressions like "fighting for the patient," "battle" and "winning" when they described difficult collaboration.

I think it’s a battle when you cannot agree on what is going to happen to the patient. But it’s a battle worth fighting. (Hospital nurse)

The hospital and home care nurses rarely met in person, and phone calls were made at times when the home care nurses needed more information after discharge. The tone and language used could either promote or hamper collaboration. It made the nurses feel like colleagues when a positive and friendly tone was used in a direct dialogue, either when meeting in person or talking on the phone.

If I call and there are consensus and a friendly tone, and we agree on something or laugh, then I think we are colleagues. But if someone rejects me on the phone or makes some excuses, then I think: 'I don't care, because you have to look into this problem'. Then I consider her [the other nurse] as from someplace different. (Home care nurse)

In both sectors, the nurses tried to keep a kind tone during the telephone conversation, even when their facial expression suggested that they were annoyed and irritated. The home care nurses described that they could use a harsh tone at times when they could not get the information they wanted and had experienced being sent from one person to another without anyone taking responsibility for helping.

And you must call [to get information]. And if you are a little stressed and on overtime and you are met by 'I can't take care of that', then you take a deep breath not to shout: 'You bloody well have to!' Then you can get at little harsh. (Home care nurse)

The hospital nurses explained that they were often unprepared for the phone call and occupied with other tasks and the harsh tone made them feel being attacked.

Often, you feel being attacked, if you don't have the answers ready beforehand or if you're going to need to search for them. (...) There is nothing worse than an evening shift where you get a phone call before even having had a chance to meet the patients. (Hospital nurse)

The cross-sectoral collaboration was influenced by the language that was used. The hospital nurses mostly used specialised medical terminology both in their written and spoken communication. To them, medical terms were a part of their daily language, and they used it expecting the home care nurses to understand it. However, the home care nurses felt challenged and sometimes had to Google the most difficult terms to get meaning of them. The home care nurses used a mix of everyday language and medical terms. When they were talking to the hospital nurses, they strove to use medical terms to emphasise their professionalism.

I am using the Latin diagnosis, and so. Then you are being taken more seriously because we speak the same language. (Home care nurse)

To improve collaboration between hospital and home care, most of the municipalities had specialised nurses to coordinate and plan the more complex transitions from hospital to home. How these coordinators worked differed between the municipalities, and their expectations to the hospital nurses differed in several areas. Some coordinators expected the hospital nurses to be engaged in the discharge planning, while others managed on their own. Some discharge coordinators visited the hospital on a daily or weekly basis and made the discharge arrangements without involving the hospital nurses.

“We do expect that some nursing staff at the ward has prepared the meeting. It is far from reality. They don't have time for that. So, most discharge conferences are held without the hospital nurses.” (Home care nurse)
The hospital nurses did not reflect largely upon these differences, and due to heavy workload, they often left the discharge coordinators with the responsibility for discharge planning. At times, this could challenge the cross-sectoral communication and contribute to misunderstandings and poor collaboration. Discharge coordinators could feel frustrated when they visited the ward to coordinate discharge planning, and the hospital nurses were too busy to participate. The hospital nurses did not consider this a problem.

We hardly ever participate. The coordinators join us at the office, and then they sit down, and we talk about the patient. Sometimes 20 min, sometimes half an hour. And then you say: Do I have to be present at the discharge planning meeting with the patient and the relatives? Usually, it is OK without us.

(Hospital nurse)

6 | DISCUSSION

Nurse-to-nurse collaboration is an essential part of nurses work, but there is a need for improvement of collaboration between nurses across sectors (Kirsebom, Wadensten, & Hedström, 2013). The collaboration between the hospital nurses and home care nurses was characterised by insufficient communication, lack of knowledge of working conditions, different cultures and different perceptions of nursing, and the nurses described the hospital and home care as "two worlds" with separate cultures and professional identities.

Practices in health care are characterised by separate systems (Glouberman & Mintzberg, 2001) with different values and aims (Hellesi & Fagermøn, 2010). Although nurses in the present study claimed to work towards the same goals related to care transition, it was evident that these goals were derived from different perceptions of nursing, values and approaches to patients. The home care nurses had all previously worked at the hospitals, and their trust in the hospital nurses to plan for the patient was limited. The underlying perception of working in two worlds challenged the nurses in doing and planning what they perceived as "the right thing" for the individual patient. Thus, it can be questioned whether the goals for the patients expressed by the nurses in the two sectors were in concordance. The nurses described that discharge planning at times was a “battle” as they did not always agree on the level of support and care after discharge. Significant differences in objectives and tasks may obstruct coordination of discharge across sectors (Romøren, Pedersen, & Førde, 2017), and it has previously been shown that hospital and home care nurses do not share a common understanding of when a patient is ready for discharge (Hellesi & Fagermøn, 2010).

Fundamentals of care include integration of a patient’s fundamental physical and psychosocial and relational needs. What constitutes the fundamentals of care has been discussed widely but not agreed on (Feo, Kitson, & Conroy, 2018). The context under which care was anchored in different cultures and settings and the perception of what constitutes nursing differed. The nurses in our study expressed a shared goal of a safe care transition of the patients, and it can be questioned whether the goal was, in fact, the same. The different objectives and focuses on patients across sectors challenged collaboration between the nurses. They expressed different professional beliefs and values with a focus on disease and treatment and health and prevention, respectively. Nurses’ mutual desire to collaborate in a respectful and supportive way (Terhi Lemetti, Voutilainen, Stolt, Eloranta, & Suhonen, 2017) was also found in this study. Professional beliefs and values are likely determining factors for collaboration (Supper et al., 2015), and the ability to respect and listen to the collaborating partner’s rationale and knowledge about organisational systems is essential to successful collaboration (Gardner, 2005).

Collaboration is a process that, among others, contains knowledge and shared objectives as well as awareness and understanding of work roles and interaction (Lemetti et al., 2015). A lack of understanding and learning about each other was identified, which promoted insufficiently and at times conflictual collaboration. In particular among the hospital nurses, we found limited insight into the organisational levels and working conditions in the home care. This in line with other studies where nurses’ cross-sectoral communication and collaboration have been found to be characterised by lack of knowledge about each other (Bjuresäter, Larsson, Nordström, & Athlin, 2008; Kirsebom et al., 2013), unclear roles (Payne, Kerr, Hawker, Harday, & Powell, 2002) and unclear responsibilities (Bjuresäter et al., 2008).

During care transitions, bidirectional communication between nurses is required (Coleman et al., 2003). The nurses in the present study were concerned about lack of cross-sectoral communication and collaboration. When there were opportunities for direct meetings and personal dialogue, it led to a shared understanding of what was the goal for the patient. Meeting in person created a possibility for negotiating a common goal in the form of a safe plan for the patient’s transition to home care, which was expressed by the nurses as good collaboration. Knowing and meeting each other as well as a mutual desire to collaborate in a respectful and supportive way is known as essential prerequisites to effective collaboration (Lemetti et al., 2017).

Care planning and transitional care for patients with comprehensive care needs is a complex process involving multiple contributors and coordination across sectors (Hesselink, Schoonhoven et al., 2012). Hellesi and Fagermøn (2010) argues that cultural diversity must be considered when planning for care across healthcare boundaries. The nurses described obstacles for good cross-sectoral collaboration related to unintended effects of both organisational systems and cultural factors. Intraprofessional collaboration involves multiple members of the same profession working together to deliver quality care (Registered Nurses’ Association of Ontario, 2016). As such, the cross-sectoral collaboration between the nurses in this study could be defined as an intraprofessional collaborative practice. However, different approaches to the patients and different perceptions of nursing
as well as lack of insight into each other’s worlds contradict this. The nurses described themselves as working in different contexts, having different cultures and different professional features and characteristics, which suggest that nurse collaboration across sectors is different. Interprofessional collaboration is defined as health workers from different professional backgrounds working together to deliver the highest quality of care (WHO | Framework for Action on Interprofessional Education and Collaborative Practice’ n.d.). One can argue that the cross-sectoral collaboration between nurses should be an interprofessional practice, rather than an intraprofessional. Perceptions of different professional features and different professional identities were enhanced by a feeling of lack of respect and understanding from nurses from the other sector, which negatively influenced how the nurses collaborated in planning and executing a safe and smooth transition. The roles and responsibilities related to care transitions were not always clear to the nurses, which could lead to distrust and discussions about what was best for the patient after discharge.

6.1 | Strengths and limitations

The present study was performed as a part of a larger study and as such data were not collected specifically for this, which is both a strength and a limitation of the study. The strength of the study is the large and rich data material collected in different settings using both interviews and observations. A limitation is that the original aim of the study was to explore cross-sectoral communication and not specifically nurse-to-nurse collaboration. It can be discussed whether we have missed out on relevant data and that the results had been different had we explicitly focused on nurses’ collaboration in the data collection. Another strength is that we for this study extracted data on collaboration into a new data set and performed a thematic analysis of this new data set, specifically for this study. The thematic analysis included an ongoing process to identify and refine the specifics of each theme, and by doing so, we have uncovered the nurses’ underlying assumptions and perceptions.

7 | CONCLUSION

In this study, we have explored how the hospital and home care nurses perceive and describe cross-sectoral collaboration. Nurses from hospitals and home care services belong to the same profession and are expected to collaborate in planning and executing safe and timely transfer of patients with complex care needs. We found that nurses across sectors are highly motivated for collaboration and doing the best for the patients, but this goal is hindered by a perception of working in two different worlds with different objectives, different perceptions of nursing, different organisational systems and different cultures, all perceived as obstacles for good cross-sectoral collaboration. Organisation and communication systems appear to take for granted that nurses across sectors are automatically working together as one. The results from this study shed light on substantial differences in how nursing is perceived across sectors, and we argue that underlying cultural and organisational systems should be explored and taken into consideration when planning and implementing collaborative systems.

8 | RELEVANCE TO CLINICAL PRACTICE

Nurses are required to navigate the patients through the healthcare system. However, patient trajectory and patient safety are challenged when cross-sectoral collaboration is obstructed. We found that nursing is described and interpreted differently across sectors, which indicates that it should be expressed more clearly what nursing entails related to transitional care of frail older patients. Further, nurses need to be more explicit in defining and talking about how nursing is performed and understood in different settings. More possibilities for personal meetings related to cross-sectoral collaboration should be made available and prioritised by the nurses to increase the knowledge and understanding of each other's field of work. Organisational and political systems should recognise that nurses in different sectors are taking care of various aspects of nursing, and as such, politicians and administrators should regard the nurses as two professions working together on a common goal when planning on systems to support cross-sectoral collaboration.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTION

The research team consisted of two female senior researchers (HVP, VN) with more than ten years of research experience, and a female research assistant (SF) with no prior research experience all of whom have a nursing background. Study design and plan: HVP and VN; data collection: HVP, VN and SF; thematic analysis and manuscript drafting: HVP and VN; manuscript comment: SF; agreement of the final version of the manuscript: all authors.

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**SUPPORTING INFORMATION**

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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