Benefits and drawbacks related to the integration of social and health services:

Findings from an ethnographic study in Reykjavik

Kristín Björnsdóttir, Professor

Faculty of Nursing, Health Sciences

University of Iceland

UNIVERSITY OF ICELAND
FACULTY OF NURSING

Background

Policy trends:

- The home has become a preferred place of health care.
- Older people with complex health issues (many diseases and fluctuating symptoms) will live at home and need advanced health services there.
- Health issues must be addressed in relationships and teams – different knowledge and competencies working together – integration as a keyword.

Background

Policy trends

- Emphasis placed on person centred care and patient participation.
- Self-care and re-ablement have become keywords – successful aging, healthy aging, active aging.
- The benefits of technology must be explored.
- Practice as evidence based – use clinical pathways.

Integration of health and social services in Iceland

- Agreement made between the welfare services in Reykjavik and the Icelandic government to transfer home care nursing services to the city in 2009.
- Emphasis placed on developing the care of older people by a full integration of health and social services locally and by enhancing integration with the services at the University hospital.

Ethnographic studies

Two studies have been conducted:

- The purpose of both studies was to contribute to our understanding of good practice in home care of older persons. The focus was:
  - Home care nursing provided to people over 80.
  - Integration of services provided to people diagnosed with III and IV level heart failure and their families.

Theoretical background

- Leutz (2005) on levels of integration.
- ANT- Materially sensitive semiotic tradition – people and objects shape each other in mutual relation.
- Practice is always ethical - The practice of good care involves the enactment of *ideals* and *values* (Mol, 2002; 2008; Moser, 2010; Pols, 2008, 2012, 2013).
- Good practice - trying out different ways (Mol, Moser and Pols, 2010).
- *Directives* for what should be done and who should do it (Pols, 2012).

Method

- Ethnographic studies
- Field work and interviews

Study I – Older persons over 80 years (2010)

- 5 teams participated (team leaders and 2-4 members)
- 3-4 older persons – 15 in total

Study II – Patients diagnosed with heart failure and family (2010-2014).

- 12 cases – fieldwork, interviews - team leaders, patients and family.

Findings related to integration of nursing and social services in the community

- Health and social services were united in one organization (2009), although in different locations.
- Regular (weekly or monthly) meetings were held to co-ordinate services which aimed at preventing gaps and repetition.
- Issues around user/patient wellbeing were brought up for discussion and consultation – ´Would it be possible for someone from your team to stop by and assess her?´ - responsibility for clients was shared and flexible – health states constantly changing.

Findings related to integration of nursing and social services in the community

- Information around service needs travelled between systems, although the computer systems are still incompatible – this was important for relatives.
- Tasks and responsibilities were shared, but that ´had to be done with some caution´ - quote from a nurse.
- Differences in traditions and culture were noted – social services emphasised the user, while the nurses were concerned about prompt responses when difficulties emerged.

Home care nursing teams

- Team leader in the nursing teams - worked as a case manager with 2-5 RN‘s and LPN‘s.
- These teams attended health issues – long term health problems, frail elderly and severely disabled individuals, complex needs and advanced interventions (often technologically).
- These teams worked closely with the social services, although these services were not fully integrated in one team.
- The team leaders had much responsibility in providing guidance and in monitoring the care provided.

Home care nursing teams

- The team leaders did the initial assessment and developed a plan that was then constantly revised and re-evaluated by all the team members.
- The team leaders described (and I observed during the field work) how they tried to develop a tightly woven net around each patient to assure good and dependable services – chronic care infrastrucre.
- The net might involve different care workers from the team, relatives, OT and PT and services such as medication preparation, meals, transportation, recreation and social visits.
- The nurses had developed a comportment of being *respectful, honest* and *dependable.*

Findings from study II:

Integration of home care nursing and hospital services

- People diagnosed with III and IV level heart failure are cared for by nurses in the ambulatory unit at the national hospital and by home care nurses.
- The aim is to develop services that prevent visits to the emergency unit and admittance to the hospital.
- Guidelines regarding assessment and treatments were developed (self care emphasised) and access to the hospital information system was provided.
- Home care nurses can call the nurses at the ambulatory unit for consultation. These nurses provide person centred suggestions in addition to contacting specialist if needed.
- Work methods and knowledge shared between systems.

Benefits

- Mutual respect and trust has developed between workers in different settings and organisations – there is an understanding of shared responsibility.
- Collective values and norms have developed among the workers in the home care community services.
- Channels for sharing knowledge and understandings have developed.
- Patients and their relatives feel that the system is working, that people are talking to each other and that everyone is going in the same direction.

Drawbacks

- Home care nursing is not integrated with the community health system (heilsugæsla) – exchange of information, knowledge and understandings does not happen spontaneously – there are no formal ways of exchange, although informal conversations were frequent.
- Channels for collaboration and consultation with different types of physicians are unclear which leads to frustration and inefficiencies.
- Nursing and social services are in many ways integrated, but there are still financial barriers to integration and the electronic documentation systems are incompatible.

Discussion

- Integration enhances communication, understanding and mutual respect among different work groups (We-we understanding instead of We-they). Interplay of people, relationships and processes leads to positive outcomes.
- Management must develop clear aims for the services, together with workers, but then they must give them (the teams) the authority and flexibility to develop approaches to care.

Discussion

- Working together takes time and effort, but solutions do emerge in discussions.
- There is a strong call internationally, for placing patients and their carers at the centre of care planning. This calls for new approaches to care, away from regimented tasks and counting minutes.

Discussion

- The demand for EBP has to be taken seriously. If health services are to be provided outside hospitals health care workers in the community must have access to new knowledge and methods.
- Knowledge travels via the integration of community and hospital services – the project around heart failure patients is an important example of knowledge exchange and development.

Discussion

- Similar projects exist to some extend – although not formal around the cafe of patients with diabetes, stroke, COPD, wound care and care of older persons in general.
- Methods to enhance EBP must be explored – such as possibilities to participate in formal education and on site developments of evidence based work methods.

Suggestions

- Well integrated electronic documentation and information systems may compensate for divisions in services – development of shared electronic clinical records, electronic knowledge sources and a culture of evidence based practice needs to be supported.
- Attention must be paid to the development and maintenance of work relationships between home care and community services (heilsugæsla) – this remains to be done.
- Channels between different physicians and home care nurses need to be developed.
- Further studies are needed regarding the integration of services in the home and as experienced by patients.

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