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Full Length Article

Inpatient geriatric care in Sweden—Important factors from an inter-disciplinary team perspective

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ABSTRACT

The purpose of this study was to describe factors of importance for the quality of inpatient geriatric care from an inter-disciplinary team perspective, an area that has not been previously studied to our knowledge. The study design was qualitative descriptive with data being collected from focus-group interviews with members of geriatric care teams. The data collection was conducted at a Swedish university hospital with 69 beds for geriatric care. It comprised five group interviews with a total of 32 staff members, including representatives of all the seven professions working with geriatric care. Data was analysed using qualitative content analysis and a thematic framework approach. Three main themes were identified as being perceived as characterising important factors essential for quality geriatric care: Interactive assessment processes, A holistic care approach, and Proactive non-hierarchical interaction. Aspects of Time and Goal-Orientation were additionally running like common threads through these themes and informed them. Accessibility, open communication, and staff continuity were experienced as prerequisites for well-functioning teamwork. Including patients and relatives in care planning and implementation was seen as essential for good care, but was at risk due to budget cuts that imposed shortened hospital stays. To meet the care demands of the growing population of older frail people, more specialised team-based care according to the concept of Comprehensive Geriatric Assessment – which is possibly best provided by older-friendly hospitals – appears as a constructive solution for reaching high degrees of both staff and patient satisfaction in geriatric care. More research is needed in this area.

Introduction

Due to many of the world's populations aging, the demand for adequate health care for older people is rapidly increasing. Flaws in the care management of older people in hospital settings have been reported in a number of studies from various countries (Gill, Allore, Gahbauer, & Murphy, 2010; Haines et al., 2015). Common shortcomings include fragmented care due to a high level of specialization, and poor continuity of care (Clarfield, Bergman, & Kane, 2001). Despite the increasing number of older patients, care organizations and the competence of health care professionals have not changed to the degree required to be able to accommodate their needs. It has also been found that geriatric specialized care is not a priority in many countries, despite the demographic changes seen in their populations. In Sweden, the number of hospital beds for geriatric patients has decreased considerably in the last two decades.

Many older patients have complex health care needs based on co-morbidity or frail health. There is no global consensus on how to define frailty, however, common features of frail health in older people include decreased capacity in bodily functions leading to increased vulnerability in the event of acute illness or psychosocial trauma (Clegg, Young, Iliffe, Rikkert, & Rockwood, 2013). One perspective on frail health includes the presence of general weakness, fatigue, decreased endurance, weight loss, low physical activity, poor balance, decreased mental function, and low stress tolerance (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004), whereas another perspective is based on the presence of co-morbidity, loss of functional capacity, and specific health problems (Gobbens, Luijkx, Wijnen-Sponselee, & Schols, 2010). Even if definitions of frail health vary, it is agreed that frailty is a stronger predictor for health care needs and mortality than age alone (Clegg et al., 2013). Older patients with frail health are also at risk of loosing functional capacity during hospital stays, which may result in a higher level of dependency after discharge (Ellis, Whitehead, Robinson, O'Neill, & Langhorne, 2011; SBU, 2013) (Ellis, Whitehead, Robinson, O'Neill, & Langhorne, 2011; SBU, 2013). It has been shown that 3–5% of deaths in older adults could be delayed if frailty had been prevented

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based on comprehensive assessment (Shamliyan, Talley, Ramakrishnan, & Kane 2013).

Acknowledging the problems described above calls for hospital care of older people that does not only focus on the patients' specific diseases or conditions, but rather on a more holistic perspective that takes into account the specific needs of each individual.

Internationally, the most commonly used method for holistic acute care of older people is Comprehensive Geriatric Assessment (CGA) (Matthews, 1984). CGA has no standardized method of execution so specific assessment instruments vary between institutions and countries. In general, however, CGA includes the assessment of a patient's health history, current diseases and medication, functional status, psychosocial function, and cognitive, mental, and nutritional status (Ellis, Whitehead, O'Neill et al., 2011; Rubenstein, Wieland, & Bernabei, 1995). In addition, the experiences and perspectives of the patient and his/her family should be taken into account.

A central aspect of CGA is the role played by the care team, both in assessing and planning for the care of the patient (Headrick, Wilcock, & Batalden, 1998; Young et al., 2011). A review of the literature shows that CGA-based interventions performed by inter-professional teams who take on the primary responsibility for patient care is the most effective method to maintain the health and independence of older people (SBU, 2013).

Teamwork can be defined as a group of people with different professional backgrounds and competence who work together. The ability to work with others has been described as one of the core competences in health professionals to ensure high quality care (IOM, 2001). The team is considered to outperform the sum of the individual contributions made by members or that of a group of professionals who each carry out their tasks independently of one another. The value of the team is therefore considered to be greater than that of a group of individuals with their own agendas. As a structure, the team is a small group consisting of staff members with various competences, who communicate with each other and integrate their efforts to ensure continuous and reliable care (IOM, 2001). At a minimum, the team should consist of competences in medicine, nursing, social work and rehabilitation therapy (Baztan, Suarez-Garcia, Lopez-Arrieta, Rodriguez-Manas, & Rodriguez-Artalejo, 2009; SBU, 2013). The team should apply an inter-disciplinary approach and work towards common goals (Headrick et al., 1998; Young et al., 2011). Such teams can create synergies that may result in better outcomes and development of the team and its members (Epstein, 2014). A recent systematic review of acute hospital care of older people with frail health shows that an integrated teamwork approach had positive effects on both the functional ability of patients and the possibility for them to remain in their own homes post-discharge (SBU, 2013).

To sum up, systematic reviews show that CGA carried out by an inter-professional team that takes responsibility for the care of older patients with frail health results in them having a higher level of functional ability and independent living than regular care. These effects have not been observed when CGA is performed by individual professionals. As the role of the team seems crucial for the success of the intervention, it is of interest to study the perceptions of health care professionals on factors that may facilitate or hinder teamwork. Therefore, this study aims to describe factors of importance for the quality of hospital-based geriatric care from an inter-disciplinary team perspective. To our knowledge, this is not an area that has been previously studied.

2. Design and method

The design of the current study is qualitative descriptive with data collected from focus-group interviews of team members working with geriatric care. The Research Ethics Committee of the University of Dalarna has approved the study. The principle of informed consent was applied and the data was treated with integrity in all the stages of research.

2.1. Setting

The data collection was conducted at a Swedish university hospital with in total of 1100 beds, of which 69 were located in the Geriatric Clinic for specialized care, hereafter referred to as the clinic. Patients treated at the clinic were generally aged 65 years and over and had aging-associated diseases. The clinic's three geriatric wards located in the main hospital were directed towards medical disorders, orthopedic post-surgery care, and stroke. A fourth ward, located in a small rurally located community 60 km away from the main hospital, treated patients with all these health conditions as well as patients in need of palliative care.

Care episodes were usually initiated by referrals from other units of the hospital, such as the departments for orthopaedic or medical care. On occasion, patients arrived directly from the emergency department or via the geriatric home-visit team. A geriatrician at the clinic assessed all the referrals and decided who would be admitted to the clinic. The common criterion for admission was that they should be biologically aged individuals with diseases that require interventions from more than just a medical point of view, where a geriatric team was needed for the treatment.

Most patients in the clinic had complex medical disorders and functional limitations. Care was directed towards the early stages of the conditions; it was goal-oriented and limited in time. For all patients, routines according to the "Senior Alert" were applied – a Swedish quality registry for the support of standardized care and systematic preventive care processes for older adults (Qual Manag Health Care. 2015 Apr-Jun;24(2):96-101). The care was team-based with specific team-members responsible for the care of each patient, which clearly influenced the care procedures. The teams included the following professions: physician, registered nurse, assistant nurse, physiotherapist, occupational therapist, social worker plus access to a dietitian and speech therapist.

2.2. Participants

A mix of convenience and strategic sampling was used when including geriatric care team members working on the four wards of the clinic. Recruitment of participants was initiated with an information letter sent to the head of each of the clinic's wards, who gave their approval to ask the staff for participation. Staff members interested in participating were then listed and put into groups with the purpose of forming four focus groups with 5–10 members from the different wards and range of professions mentioned above (Group I–IV, Table 1). Later in the research process (see below) recruitment of only geriatricians for a fifth interview (Group V, Table 1) was carried out via the chief physicians at the clinic. The latter resulted in a sample of four senior geriatric specialists and one newly graduated geriatrician. In the other

Table 1
Overview of professionals participating in the interviews.

	Interview number					
	I	II	III	IV	V	All
Occupational therapist	1	1		1		*3*
Dietitian			1			1
Social worker	1	1	1			3
Physician	1		1	1	5	8
Physiotherapist	1	1	1	1		4
Registered Nurse	2	2	2	1		7
Assistant nurse		1	3	2		6
Participants/group	6	6	9	6	5	32

four groups (I–IV) a mix of professions participated.

2.3. Data collection and analysis

The interviews (lasting from 60 to 110 min) were all carried out by the first author who followed an interview guide focusing on the processes and descriptions of *how* the team worked together, rather than on the interventions they delivered. In line with the distinctive features of acute geriatric care described by Baztan et al. (2009), the interview questions concerned the participants' views on how they assessed patients' health status and how the assessments were performed, what kind of meeting routines they had and how they were followed, and how the planning and timing of interventions and discharge were carried out. Aspects of prioritizations, cooperation, responsibilities, and information collection and sharing were linked to all these areas. An essential part of the interviews was also the participants' reflections, which were encouraged by the interviewer asking probing questions. This was done by asking participants at the end of each interview to summarize any strengths and/or possibilities for improvements related to the areas discussed. In addition, each interview was concluded by the interviewer giving the interviewees a short summary of the interview to check whether the content had been correctly understood. All interviews were recorded and transcribed verbatim.

Data collection and the preliminary analysis were carried out in parallel processes to refine and validate the data. A preliminary analysis of the content was carried out by the interviewer and different stages of preliminary results were summarised, presented, checked, and discussed with groups of participants during the data collection process. This made it possible for participants to reflect upon content and complement or clarify data. It also resulted in the planning of the fifth interview with physicians (see above, Table 1). The purpose of this interview was to clarify how physicians, who were medically responsible at the clinic, viewed their role in the team.

The analysis for the current study was carried out by the first author according to the Thematic Framework approach (Ritchie & Lewis, 2003). This process involves the identification and coding of underlying categories and themes relating to the focus of the research. This yielded preliminary interpretations of the participants' views, which were reanalysed and again checked against the transcribed material. The results of each interview were then cumulatively compared to each other in order to find differences and similarities. The analysis involved dynamic processes in which effort was put into a subsequent deepening of understanding, so that underlying themes and patterns were discovered in relation to the purpose. The later stages of the analytical process aimed at testing theoretical ideas, and was thus carried out in a circular process of modifications and redefinitions in line with the process of analytical induction (Hammersley & Atkinson, 1995). This progressive process implied a gradual shift from descriptive purposes towards the development and testing of explanations from a more theoretical perspective (Hammersley & Atkinson, 1995). This analysis was validated by a parallel analysis of selected parts of the data (Hammersley & Atkinson, 1995; Mays & Pope, 2000) conducted by the second author, which was followed up by validating discussions through the whole process of writing up this article.

3. Results

Three main themes stood out as characterising and important factors that were perceived as essential for quality care: *Interactive assessment processes, A holistic care approach,* and *Proactive non-hierarchical interaction.* These were generated based on sub-themes identified in the transcribed interviews (see Appendix). Additionally, aspects of *Time and Goal Orientation* were running like common threads through these themes and informed them to different degrees. For example, the time aspect was, according to the interviewees, important for the care procedures for achieving early initiated assessments, goal-setting, and interventions. Early (aspect relating to time of hospital stay) goal setting was highlighted as important, along with discussions of how to balance the goals, early and over time, according to different perspectives of e.g. the patient and her/his medical and functional status and social circumstances. The goal-setting, therefore, resulted from a 'perspective-integration' in which the team members' assessments and patients and their relatives' needs, desires, and views were considered. However, these different perspectives were experienced by some as pointing in different directions resulting in different borders for the goals and interventions, and was therefore sometimes experienced as challenging, but still essential.

The three main themes identified are presented below with the aspects integrated in the text, which is accompanied with quotations from discussions during the interviews. The quotations are labelled with the interview occasion (I–V, see Table 1), a dash (−) shows when a new person starts talking, and three dots (…) indicates a minor transition and the possible omittance of parts of the transcription lacking in meaning. Exploratory comments from the interviewer are put in parentheses.

3.1. Interactive assessment processes

The team-based assessment was described as a process implying that the different professionals in the team assessed patients as early as possible after admission, and then discussed their conclusions with each other. One physiotherapist stated:

> '- I think that one of the major misunderstandings made by outsiders is that an assessment for all this rehabilitation and what we are doing can't be made in a second. We need to have a process.' (II)

The fora for the team coordination were the team conferences, i.e. meetings with representatives for the whole team participating, held once or twice each week and complemented with shorter and more frequent update meetings that could be both planned or spontaneous. The common scenario for the initiation of the assessment process described was that the assistant nurse and the registered nurse saw the patient first to collect data on his or her health history, and performed quick initial assessments for an overview of the patient's health status, including structured risk assessments regarding pressure ulcers, malnutrition, and falls. In addition, the physician always made an initial medical assessment of the patient's status on the day of admission and documented the results of this in the patient's journal. One ambition that was described by the team-members was that initial assessments should be carried out on the day of admission or, when this was not possible, the day after admission at the latest.

Physiotherapists and occupational therapists reported that they frequently coordinated and carried out their first assessments together. Their main common objective during the first assessment was to quickly collect data on the patients' overall health and make assessments concerning abilities and needs relating to mobility, including needs of support and/or aids. A physiotherapist and occupational therapist explained together:

> '- We pre-arrange who will cover what in the health history, so we don't ask the same things or record the same things, and so we have a common health history.
>
> 1- And common status as well.
>
> - And then we each have our own parts that we fill in, so that everyone involved in the care plan sees it…' (IV)

The reasons behind this coordination were multiple; to rapidly be able to arrange a first meeting with the patient without "forming a queue", to avoid tiring the patient out with the same questions from different people on different occasions, to rationalise the writing in the patient's journal, and to give the rest of the team a rapid report on how to assist any locomotion issues.

The interaction of the team with social workers and a dietitian was described as slightly diverse compared to the other team professionals, due to limited staffing. Social workers were described as a team resource and they decided which patients they would see and assess based on either reading the patient journals or on request from a team member. One dietitian served all the patients in the whole clinic and made assessments only if on a consultant referral from a physician at the geriatric clinic. The limited dietitian resources and contacts were reported by other team members to sometimes having a negative influence on the care process and discharge planning.

The importance of interviewing and talking to both patients and relatives about the patient's condition, life arrangements, and habits before hospitalisation was also stressed. The benefits of early contacts with relatives were discussed as follows:

‘- The more and the earlier we can inform the patient and inform the relatives, the calmer things get, the easier it is to work undisturbed and the more effective we can be …

- You notice a tremendous difference in how things progress when you take it at the start, straight away, and you can see what the expectations are and what problems might exist…

- You can kind of map it out and say; you are here.’ (I)

Early involvement of the patient and her/his relatives in goal setting for care was also reported to be significantly important. Although this was not viewed as an absolute rule, it was a common goal and expressed as part of a shared ‘culture’. On the other hand, the medical status of patients was considered to be the determining factor defining borders for the goals. Reflective discussions during the interviews suggested that it might be more effective for team members to have more meetings with patients for assessment and information, particularly early on in the care process, instead of queuing up for the first meeting.

It was suggested that the physician and registered nurse, who have the main responsibility for care, should carry out the initial patient contact together, and that perhaps the assistant nurse should also be involved at this stage, when/if their schedules allowed it. An assistant nurse and a geriatrician discussed this as follows:

’- (Assistant nurse): And maybe we can be of help if the patient needs further examination, and needs to be moved. So if there's any problem with that, we can help. And then things might go more smoothly.

- (Geriatrician): Yes, and that is one thing; for these patients their assessment could be done better, as it is difficult to move them by yourself. To assess, inspect certain wounds and so on, it is a bit difficult to just tear off the dressing when you don’t have someone who…

- (Assistant nurse): Yes, I know, we can probably complement each other I think, very well. ’ (II)

3.2. Holistic care approach

The holistic approach concerned both a view of the care process as a whole, with different perspectives and parts that needed to be linked together, and a holistic view of the patient. Ambitions to view the patient as a whole and unique person with specific needs, wishes, and recourses, in a specific life situation, and taking this into consideration in the care-planning and interventions were clearly expressed. This approach was highlighted as a characteristic of the geriatric care at the clinic:

‘I think that this is one of our characteristics too, that we take in the whole person: How it was before (hospitalization), as this is really important for how we should think ahead.’ (II)

Still, the results of the medical examination together with that of the functional investigations constituted a basis for treatment. Knowledge of current illnesses and how they affected the patient was stressed as being vitally important for obtaining a clear picture of functional limitations and capacity as well as needs for support and help that were related to personal and environmental factors. This was necessary for correct planning and direction of care interventions. Since the majority of the patients had complex disorders and several functional limitations, the focus of assessments and treatments was described as less organ focused in favour of an emphasis on complex health problems. The team-conference worked as the main hub where the different professionals in the team synchronized their views and plans for the patient, and summarised them as a complex but whole picture, which led to the formulation of shared care goals:

‘Then it starts with the night shift maybe writing a bit about how the night was for these patients; if they slept well, were anxious, if they had used the toilet and if there was a risk of falling then. After that, the assistant nurse does the same thing in the morning and makes a summary of patients who need to be discussed (at the meeting). They can report things like ADL. The physiotherapist or occupational therapist has their knowledge and input and the registered nurses too, and then the physician. Then, at the team conference, you can sit down and set goals for each specific patient and go through their previous goals too, and then revise the goals …’ (IV)

The team-based primary care goals were described as steering the interventions delivered by all the team members, who also formulated their own sub-goals according to their profession. At follow-up conferences and update meetings the goals were assessed, revised, and reformulated when needed. The ambition to involve patients in setting goals was reported along with some difficulties in achieving this:

‘- Sometimes it can be unclear if the patients are involved in these goals.

- Yes, sometimes you sit in the rehabilitation team conferences and create goals with the team, but you forget the most important team member – the patient.’ (IV)

Despite these discrepancies between ambitions, lack of directive, and the experienced “culture”, it was evident that efforts were being made to involve patients and their relatives in the care processes. Emphasised reasons for this were to: i) Inform and support the patient's self-control in the caring situation and to provide comfort, ii) involve and engage the patient in actively participating in the care planning and execution, and iii) prepare a positive discharge and continued care, when needed. Well-functioning cooperation with patients and relatives was seen as important both for the ability to set and reach adequate goals and for the time efficiency of care episodes.

Formal meetings with relatives were planned for at the team conferences, including which team members should participate. A registered nurse and an assistant nurse experienced that they sometimes were more focused on supporting relatives than on the patients:

‘- Sometimes you don’t have much contact with a patient, it isn’t always a given, you can have more contact with their relatives, depending on what we are dealing with. And sometimes the relatives themselves make an appointment and visit (here) and they can need a lot of support, and sometimes there are a lot of relatives, sometimes even younger children are involved, it isn’t always adults…’ (IV)

Cooperation with staff who are responsible for the next step in the care path, which is predominantly municipality care, was viewed as important for preparing for discharge and making sure discharge was positive and there is continuity in care and support. Minimising delays in the care process and achieving optimal timing in care episodes was also important.

'- The goal is for the team to meet the patient on the day they are admitted so they can do at least an initial assessment, and also so they can initiate contact with the municipality, as well as the other relevant care operators – that this is part of it from the start. And the relatives, that you sort of include them in an overview of the patient; what is the situation? How was the situation before this care episode? That feels very important. ' (II)

All team members talked about how they reported to the next caregiver as soon as it was decided where the patient was going to stay after discharge. Contacts were handled by telephone or via a computer system for care communication. A good transition with optimal care continuity for the patient was strived for through cooperation that enabled a holistic view of the patient. This was expressed in the following comments:

'…We can help each other, you (the physiotherapist) and the occupational therapist can actually have direct contact with the municipality or report the need for supportive devices for the patient's specific issues, and medications. And the registered nurse can also be in contact, the social worker as well. That is probably why discharge can work so well, due to us all pulling together to share information and also receive information from others before the patient is discharged.' (IV)

3.3. Proactive non-hierarchical interaction

The interviews revealed two main features of team interaction – proactivity and communication – overrunning traditional hierarchical profession-based structures. This proactivity was obviously guided by the time-aspect and ambitions of promoting an effective care-path flow. Alongside the emphasised early assessments and rapid goal setting as discussed above, discharge planning was reported to be initiated soon after admission, with a focus on optimising the hospital stay without any delays:

'-The discharge process actually starts when a patient is admitted…

- At the first rehabilitation team conference you make a prognosis for the expected length of the patient's hospital stay and together we make an estimation as a team…' (IV)

Interaction, both in the form of planned and more spontaneous meetings between team members, was regarded as decisive for a well-functioning care process. As a complement to meetings in the form of team conferences and follow-up conferences, short (10–15 min) flow-reconciliation meetings specifically held to discuss a selection of patients took place regularly. The aim and focus of these meetings was to consider if the patient was ready for discharge or if further interventions were needed and also to co-ordinate these interventions without an unnecessary time delay. These meetings were also perceived as having a good impact on team cooperation:

'- It is quick and I think it's very good for collaboration too. It takes about 2–3 min to discuss each patient. You evaluate issues that have had question marks and go on from there. ' (IV)

Additionally, frequent informal contacts were judged as equally important for the promotion of the care process as the formal meetings. They were characterised as spontaneous discussions between the team members caused by new findings and/or changes in a patient's status or needs. Such contacts were perceived as being both necessary and an effective way of working, since problem solving and progress could be supported by direct and proactive actions provided by the appropriate team member. It was stated that the formal meetings gave structure to the whole care process, whereas the informal meetings solved individual questions and problems:

'- Structured meetings are really important. Before them, everyone prepares themselves and has thought the situation through. With quick meetings in the corridor, you often have only one question in mind, so you only discuss that.'(V)

Three prerequisites were highlighted as essential for effective formal and informal team interaction:

i) *Accessibility* – team-members making themselves accessible for each other on the ward for immediate addressing of questions, follow-up, and supervision,
ii) *Open Communication* without hierarchical barriers so that all team-members can give each other spontaneous feed-back and ideas for (modified) interventions, and
iii) *Staff Continuity*– to enable personal knowledge of each other within the team, which facilitates communication.

It was perceived that team communication generally worked very well. One exception was that interaction with physiotherapists and occupational therapists sometimes could be delayed because of occasional limited accessibility, which the staff implied was caused by some of the therapists working on several care wards. This was also seen as something that risked slowing down the care process. The importance of representatives from all team professions being available for interaction on the wards was discussed as follows:

'- It also becomes very important that we use the paramedics, not just as consultants but to get support with moving patients or with technical things, when caring for a patient, so that we are able to care for the patient.' (IV)

The assistant nurses were described as key members of the team, and their communication with other members was perceived as essential for a high quality of care produced by the team as a whole. This statement was grounded on the reported awareness of the assistant nurses being the professionals that met the patients most frequently in their daily work, and could therefore check and convey the patients' current status and needs to all other team members. They took the initiative and were given permission to take on this role that crosses traditional hierarchical profession-based structures. Other team-members reflected:

'- It is almost like somehow the assistant nurses act as the eyes and ears of the registered nurses, and it's true, they are the ones who are closest to the patients.

- I think that this is also very obvious at the rehabilitation team conferences, especially if they can't be there. Then a part of our picture is missing …because everyone knows how important their knowledge about the patients is.' (I)

Open communication was also experienced as important by the physicians. One of them compared their way of working at the geriatric clinic with other clinics in the hospital:

'- The difference for me is that I receive information about how the patient actually manages things in everyday life, and how important it is to receive this. ' (II)

4. Discussion

The results suggest that, from the perspective of the team working with older patients, factors that are most important to the quality of geriatric care are based on interactive assessment processes, a holistic care approach, and proactive non-hierarchical interaction. Common care goals, generated from profession specific sub-targets and adapted to the holistic picture of the patients' status, needs, wishes, and circumstances, were highlighted as directing care interventions. These goals were additionally directed against having as short a hospital stay as possible and early discharge for the patient in question. It was

stressed that the discharge planning optimally should be initiated immediately after admission and involves collaboration with patients, relatives and the next care provider.

Overall, the findings showed that well-working collaborations included frequent and continuous communication within the team, between team members, patients and their relatives, and between team members and other caregivers, all of which were viewed as fundamentally important facilitators for a high quality of care. In line with this, this kind of communication has previously been pointed out as a key aspect of caring well for older people (Conroy & Turpin, 2016). Good interdisciplinary relationships and communication has also been shown to be one of the most important predictors of job satisfaction for health care staff (Chang et al., 2009). Non-hierarchical interaction was reported as an important quality of inter-professional communication in the present study. This is an important feature of teamwork, as flaws in communication have been reported to be the causes of adverse events in hospital care (Joint Commission 2014). Additionally, teams that are working with flattened hierarchies have been shown to facilitate mutual trust and constructive challenge (Conroy & Turpin, 2016). On the other hand, the current results also showed that hospital organisation and staff allocation could hamper effective teamwork processes, as interaction with physiotherapists and occupational therapists was reported to sometimes be hampered by their limited accessibility on the ward. This was even more evident in relation to the dietitian on the team, who was the only one available to the patients in the entire clinic. That these resources were not readily available was reported to sometimes lengthen hospital stays, due to resulting delays in care processes including discharge planning.

However, the results also included an awareness of not always succeeding in communication with patients and relatives so they became key people in the goal setting and care planning, which pointed towards a holistic approach to the patient and to the care processes. Consideration of patients' individual status, needs, wishes, and resources was, according to the findings, a central feature of the care quality and also something that characterised the geriatric care given. The most important expressed purposes for involvement of patients and relatives in the care processes concerned support of patients' self-control, active participation in the care planning and performance, and preparation for a good discharge and continued care, when needed. Well-functioning cooperation with patients and relatives was also seen as important for both the formulation of adequate care goals and for the time efficiency of care episodes. This may also be related to the evident time orientation expressed in the interviews, which in turn can be viewed in the light of the drastic decrease in hospital bed numbers that has taken place in recent decades in Sweden (Schon, Lagergren, & Kareholt, 2016). In fact, Swedish health care has the lowest number of hospital beds per head of population of countries within the OECD (Organization for Economic Co-operation and Development), with 2.6 beds per 1000 in 2013, compared to an average of 4.8 beds per 1000 in the European Union (OECD, 2015). Moreover, despite the number of Swedish people aged 80 years or older more than doubling from 236,000 in 1980 to 500,000 in 2012, the proportion of people aged 80 years and over receiving public health care decreased from 62% to 37% (Szebehely & Ulmannen, 2012). Of course this has implications including increased pressure on hospital-based care, which often results in shorter hospital stays. The average length of hospital stays has decreased dramatically due to these cutbacks, which in combination with an increasing number of very old people has led to an increase in seriously ill, frail, and disabled individuals being discharged from hospital when they still have a need for care, support, and rehabilitation in their homes (Socialstyrelsen, 2005). Therefore, the valued contacts and cooperation between hospital-based care and community-based care found in this study are significantly important factors of care quality and a smooth care path, that promotes a well-functioning situation for patients after discharge.

The dilemma of focusing on both involving patients with frail health in their care and discharge planning, and on the time aspect of short hospital stays, is a previously recognized difficulty in the Swedish health care system (Ekdahl, Andersson, Wirehn, & Friedrichsen, 2011; Ekdahl, Hellstrom, Andersson, & Friedrichsen, 2012; Ekdahl, Linderholm, Hellstrom, Andersson, & Friedrichsen, 2012). Previously identified explanations for this are shortages of: time, the correct competence, a holistic view, adapted routines, and adequate economic funding for treatment of the growing group of older patients with frail health (Ekdahl, Hellstrom et al., 2012). Still, the determination seen to apply a holistic view in the care work reported here is in line with recent research arguing that, the 'holistic model of CGA' is evidently the most effective hospital service for older people with frail health, since it shifts the focus from predominantly medical perspectives to a more holistic patient-centred view (Conroy & Turpin, 2016). In agreement with other research and in line with the current results, it can be concluded that, although the evidence base for CGA is to some degree dated (Baztan et al., 2009; Ellis, Whitehead, Robinson et al., 2011; Epstein, 2014; Rubenstein et al., 1995; SBU, 2013), it still provides a structure that can be used to organise high quality care for older people. Additionally, according to the British Geriatrics Society's guidelines, CGA should be the "gold standard" for management of person-centred care for old people living with frail health, which is valid for the majority of in-patients in geriatric care (Turner, Clegg, British Geriatrics Society, Age UK, & Royal College of General Practioners, 2014).

Accessibility, open communication, and staff continuity were, according to the current results, seen as prerequisites for the achievement of well-working team collaboration in line with CGA. These factors may also work as contributing explanations to why mobile inpatient geriatric consultant teams cannot be proven to produce the same beneficial results as CGA implemented at geriatric ward facilities (Cameron & Kurrle, 2013; Deschodt, Flamaing, Haentjens, Boonen, & Milisen, 2013; Ellis, Whitehead, Robinson et al., 2011). Related explanations for the benefits of CGA, presented in other research, include that working closely together improves multidisciplinary collaborations and team-building, and more time focused on the care of older people facilitates more learning, skills, and expertise in this area, and control over the care process particularly over the execution of proposed interventions (Deschodt et al., 2013; Ellis, Whitehead, Robinson et al., 2011). Arguments are also raised in favour of increased levels of CGA-based care for older patients with frail health, which is a growing patient group that is already the dominant group in somatic hospital care in the Western world (Cameron & Kurrle, 2013; Ellis, 2012; Gustafson, 2011). Correspondingly, a paradigm shift has been proposed, towards an age-friendly or senior-friendly hospital concept, that delivers high quality care, without unnecessary risks for care complications, functional limitations, and decreased quality of life for older people with frail health and that also promotes their health, dignity, and active involvement in their own care (Chiou & Chen, 2009; Huang, Larente, & Morais, 2011; Wong, Ryan, & Liu, 2014). It has been concluded that the entire health-care system, as opposed to only specialized geriatric clinics, needs to learn and work together toward a holistic, multidimensional approach to the management of frailty and clinical challenges, to accomplish better health outcomes for the growing population of older adults (Wong et al., 2014).

When interpreting the current results, some methodological considerations should be taken into account. Firstly, the study data is entirely built on focus-group interviews, which may bias the results in a positive direction and hide problems if the interviewees, for any reason, present themselves and their work in an idealistic or over-optimistic way. On the other hand, the focus here was to describe factors of importance for quality in hospital-based geriatric care from an inside inter-disciplinary team perspective. In addition, all data were collected by one researcher, which may be both a drawback and an advantage, since different interviewers might invite different kinds of reflections from the interviewees, possibly depending on age and gender for example, but the continuity may have improved the validation processes,

exemplified below. All data was collected from one hospital in central Sweden, which may diminish the possibility of transferring results and conclusions to other settings, but interviews were conducted both with staff working on wards in a rural-hospital environment and in an urban university-hospital environment. Additionally, participants in the group interviews were staff belonging to the seven different professions found on the geriatric teams, but in new constellations to increase diversity, breadth, and depth of the interview discussions. Several procedures were conducted to ensure the quality of the data collection and analysis, including that i) the data collection included conclusions drawn by the interviewer at the end of each interview with an invitation to complement and/or correct it, ii) the data collection and preliminary analysis were carried out in parallel processes to refine and validate the data, iii) a complementary interview was conducted based on the preliminary analysis, and iv) the final analysis was validated by parallel analysis of selected parts of the data by both the authors and followed up by validating discussions through the whole process of writing up this article.

To our knowledge this is the first study that describes important factors for quality of inpatient geriatric care from an inter-disciplinary team perspective. Based on the results we conclude that working together in care processes with well-working non-hierarchical close team interactions, in line with the concept of CGA, is desirable from a staff perspective, in addition to the previously shown advantages for patient outcomes. Accessibility, open communication, and staff continuity are experienced as prerequisites to make it work well. Including patients and relatives in care planning and implementation is essential for good quality care, but this has been challenged due to budget cuts that have reduced the length of hospital stays. To meet the care demands of the growing population of older frail people, more specialised team-based care according to CGA, which is possibly best provided by older-friendly hospitals, appears to be a constructive solution for reaching a high degree of both staff and patient satisfaction in geriatric care. We also conclude that more research is needed in this area.

Declaration of interests

The authors declare that they have no conflicts of interest.

Appendix A

Themes	Categories
Interactive assessment processes	Different professional team members met and assessed the patients
	Initial assessments on the day of admission
	Interviewing and talking to relatives
	Early decisions about goals
	Involvement of the patient
	Coordination of the first assessments
	Sparse dietitian resources – negative
Holistic care approach	View of the care process
	View of the patient
	The focus of assessments and treatments were less organ focused in favour of an emphasis on complex health problems
	Discrepancies between ambitions, lack of directives and the experienced “culture” efforts to involve patients and their relatives
	Cooperation with municipality care
Proactive Non-Hierarchical Interaction	Proactivity and communication overrunning traditional hierarchical profession-based structures
	Interaction, both in the form of planned and more spontaneous meetings between team members
	Needs for representatives from all team professionals being available for interaction
	Assistant nurses had a role crossing traditional hierarchical profession-based structures

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