APPLYING OREM’S SELF-CARE DEFICIT NURSING THEORY TO PROMOTING DIABETIC KIDNEY DISEASE OUTCOMES IN AN INTERPROFESSIONAL COLLABORATION

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Disclosure

• Authors:
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• Learner objectives:
  • Learn about our integration of the Self-Care Deficit Nursing Theory applied to Diabetic Kidney Disease into interprofessional collaboration
  • Discuss the current clinical and academic relevance of the Self-Care Deficit Nursing Theory in the care of Diabetic Kidney Disease
Outline

• Background
• Theoretical Frame of Reference
• Purpose
• Methods
• Findings
• Conclusion
• Academic Relevance
• Clinical Relevance
Multidisciplinary Care for Diabetic Kidney Disease: A Nursing Perspective
Helou, N., Zanchi, A., & Shaha, M. submitted to Revue francophone internationale de recherche infirmière
Background

• Increased prevalence of long-term chronic conditions
• Limited healthcare resources
• Augmented costs
  empowering individuals to manage their own care on daily basis. ¹

Individuals with Diabetic Kidney Disease are expected to ²:

- Monitor blood glucose and blood pressure
- Take medications
- Plan their meals
- Be physically active
- Manage risk reduction (annual eye exam, prevention of hypoglycemia, foot care) etc
Background

- Self-care is carried out in different settings (work, household etc).
- Self-Care affects interactions with family members and friends.
- Interprofessional collaboration can influence self-care as part of available resources.\(^3\) one way to improve outcomes of individuals with chronic conditions.\(^4,5,6\)
- Theory based nursing research is essential for advancing nursing science and practice and for ensuring the unique contribution of the nursing profession to society.
Background

Potentially relevant papers after duplicates removed within databases (n = 868)

Papers included in systematic review (n = 3)
Background

• Summary of the findings:
  ✓ Only one study (Steed et al., 2005) measured patient outcomes
  ✓ None of the studies was based on a nursing theoretical framework
  ✓ None of the studies tailored care to individual patient needs with personalized goal setting and follow-up.
• Summary of meta-analysis findings:
  Statistically significant improvement of glycated hemoglobin as compared to usual care

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Mean Difference (SD) 95% CI</th>
<th>No of participants (studies)</th>
<th>I²</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney function- estimated Glomerular Filtration Rate (eGFR) in ml/min/1.73m² follow-up mean: 18 months</td>
<td>-3.3 (-6.55, -0.05)</td>
<td>221 (2 RCTs)</td>
<td>16%</td>
<td>0.05</td>
</tr>
<tr>
<td>Glycemic control (HbA1c) in percentage plasma glucose mmol/L follow-up mean: 13 months</td>
<td>-0.49 (-0.83, -0.16)</td>
<td>327 (3 RCTs)</td>
<td>22%</td>
<td>0.004*</td>
</tr>
<tr>
<td>Systolic blood pressure (SBP) in mmHg follow-up mean: 18 months</td>
<td>-4.08 (-10.03, 1.86)</td>
<td>221 (2 RCTs)</td>
<td>10%</td>
<td>0.18</td>
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<tr>
<td>Diastolic blood Pressure (DBP) in mmHg follow-up mean: 18 months</td>
<td>-1.89 (-5.02, 1.24)</td>
<td>221 (2 RCTs)</td>
<td>21%</td>
<td>0.24</td>
</tr>
<tr>
<td>Total cholesterol (TC) in mmol/L follow-up mean: 18 months</td>
<td>-0.31 (-0.72, 0.11)</td>
<td>221 (2 RCTs)</td>
<td>0%</td>
<td>0.15</td>
</tr>
</tbody>
</table>

CI= Confidence Interval; SD= Standard Deviation
*Significantly different at P<0.05
Nurses’ role in multidisciplinary management:

- Helping patients in developing their self-care abilities
- Providing follow-up in out-patient hospital and home settings using reminders
- Monitoring patient progress towards achieving set goals
- Coordinating patient care
- Guiding patients in establishing priority care goals, symptom monitoring, and problem-solving techniques

Background

Nurses' role in multidisciplinary management.
Theoretical Frame of Reference

- The Self-Care Deficit Nursing Theory (SCDNT) proposes that when patients’ abilities cannot meet their self-care, a deficit is established.
- Nursing, a helping and health regulatory system between the nurse and the patient, is needed to overcome limitations in self-care.
Theoretical Frame of Reference

Guiding and directing

Providing physical and psychological support

The SCDNT³ Nursing Interventions for DKD

Patient Teaching

Providing a supportive environment helping patients in identifying resources and finding ways of using them
Theoretical Frame of Reference

Designing a SCDNT based nursing intervention within DKD Interprofessional Management
**Patient Health Deviations Self-Care Requisites**

1. attending to associated feelings
2. seeking health-care providers' assistance
3. carrying out recommended actions
4. attending to treatment's effects
5. learning to live with DKD
6. integrating changes within family system

**Patient Conditioning Factors**

1. Age
2. Aging
3. Gender
4. Health state
5. Socio-cultural orientation
6. Family system
7. Patterns of living
8. Socio-economic level
9. MSMP study intervention

**Patient Self-Care Demands**

Goal setting

1. Being aware of DKD and attending to its effect
2. Carrying out medically prescribed treatment (Adherence to medication therapy)
3. Learning to live with DKD (Adherence to self-care activities)

**Healthcare Professionals** (MD, Dieticians, others)

**Patient Self-Care Agency**

**Nursing Agency**

**Nursing Agency Power Components**
Patient Self-Care Agency

Nursing Agency

Nursing Agency Power Components

Patient Self-Care

Patient Self-Care Agency Power Components

Patient Regulatory Results
1. Self-Care Behavior
2. Quality of Life
3. Glycemic Control
4. Kidney Function
1. Comprehensive initial clinical, behavioral and psychosocial patient assessment
   ✓ Including an evaluation of the patients’ self-care demands and deficits, self-appraisal of level of knowledge on DKD, antecedent self-care activities, self-care agency exercise, developed skills, resource availability, perceived need of self-care, family members’ interference in self-care performance, and decision making.
   ✓ In DKD, special attention needs to be given to three universal self-care requisites: maintenance of sufficient intake of food in accordance to blood glucose and insulin, maintenance of balance between activity and rest in a way to promote physical activity, and prevention of hazards to human life preventing hypoglycemia.
Theoretical Frame of Reference

SCDNT Based Nursing Intervention Within the Multidisciplinary Self-Care Management Program (MSMP)

1. Comprehensive initial clinical, behavioral and psychosocial patient assessment
   ✓ Health-Deviations Self-Care Requisites

3.1. “attending to associated feelings”
   a. emotional management and attitudes adjustment in relation to DKD

3.2. “seeking assistance from appropriate health-care providers”
   a. by attending regular follow-up
   b. more importantly when detecting signs and symptoms of DKD immediate or long-term complications
   c. when experiencing emotional distress

3.3. “carrying out recommended actions”:
   a. daily self-administrating of medication
   b. daily blood glucose testing
   c. daily insulin administration and management in relation to diet and activity level
   d. following dietary restriction of sodium intake in case of hypertension
   e. following dietary prescription in relation to diabetes and making adjustment based on glycemic blood levels
   f. engaging in regular physical activity
   g. engaging in foot care
Theoretical Frame of Reference
SCDNT Based Nursing Intervention Within the Multidisciplinary Self-Care Management Program (*MSMP*)

1. Comprehensive initial clinical, behavioral and psychosocial patient assessment
   ✓ Health-Deviations
   Self-Care Requisites

25. What type of meal plan are you following? 4
   - Small frequent meals
   - 5 or more fruits and vegetables a day
   - Food guide pyramid
   - Counting carbohydrate
   - Other __________

26. In the last week, how many days of the week did you follow your diet plan? 3.3
   - One day per week
   - 2 days per week
   - 3 to 4 days per week
   - 5 to 6 days per week
   - Every day

27. Who cooks meals in your home? 2 __________

28. Do you drink alcohol? 3 □ No □ Yes

* Numbers in italics corresponds to the numbering of the health condition regulatory system outlined in chapter II on the theoretical framework. The questionnaire was adapted based on the Diabetes Care Profile developed by the Michigan Diabetes Research and Training Center (1998), based on the Lifestyle Survey developed by Wilder Research Center (2004), based on the Prescription for Health Diabetes Project at the Open Door Health Center in Homestead, FL.*
Theoretical Frame of Reference

SCDNT Based Nursing Intervention Within the Multidisciplinary Self-Care Management Program (MSMP)

2. Screening of medication safety use at home and multidisciplinary discussion of individual medication practices.

3. Identifying current or potential self-care deficits with an evaluation of decision making abilities and coping skills.

4. Setting a self-care plan collaboratively with each patient including a self-directive priority treatment goal.

✔ Patients rate their own confidence in respect to the set goal and sign a contract of action.
Theoretical Frame of Reference
SCDNT Based Nursing Intervention Within the MSMP

5. Developing nursing interventions that help patients to:
   5. meet their self-care demands,
   6. modify or adjust conditioning factors that can resolve the self-care deficits,
   7. regulate their self-care agency,
   8. meet their on-going self-care demands,
   9. adjust ongoing self-care demands while maintaining targeted goal,
   10. integrate new self-care behaviors.

6. Coordinating care within the multidisciplinary team and across health-care services.
7. Ensuring adequacy of follow-up:
   ✓ ongoing assessment,
   ✓ proactive monitoring of symptoms, adherence to medication, diet, and exercise regimen,
   ✓ initiating patients to symptom self-monitoring,
   ✓ telephone calls to support behavioral changes.

SCDNT necessitate ongoing interpersonal communication. 3
Purpose

• To investigate the effect of a nurse-led theory-based Multidisciplinary Self-Care Management Program (MSMP) on quality of life (QoL), self-care, glycemic control, and renal function of adults with diabetic kidney disease. ⁹
The study used a uniform strongly balanced crossover design. The design periods are as follows:

- **Period 1 = 0-3 Months**
- **Period 2 = Months 3-6**
- **Period 3 = Months 6-9**
- **Period 4 = Months 9-12**

### Design Options

<table>
<thead>
<tr>
<th>Design</th>
<th>Period 1 = 0-3 Months</th>
<th>Period 2 = Months 3-6</th>
<th>Period 3 = Months 6-9</th>
<th>Period 4 = Months 9-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sequence ABBA (n=10)</td>
<td>A=UC</td>
<td>B=MSMP</td>
<td>B=MSMP</td>
<td>A=UC</td>
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<td>Sequence BAAB (n=10)</td>
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<td>A=UC</td>
<td>A=UC</td>
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<td>A=UC</td>
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<td>Sequence BBAA (n=10)</td>
<td>B=MSMP</td>
<td>B=MSMP</td>
<td>A=UC</td>
<td>A=UC</td>
</tr>
</tbody>
</table>

**Baseline**

**T1**

**T2**

**T3**

**T4**

MSMP = Multidisciplinary Self-Care Management Program, UC = Usual Care
## Methods

### Schedule and description of MSMP sequence-BAAB

<table>
<thead>
<tr>
<th>A multidisciplinary self-management program sequence BAAB</th>
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</thead>
<tbody>
<tr>
<td><strong>Weeks</strong> 1 &amp; 41</td>
</tr>
<tr>
<td>Nurse Home Visit</td>
</tr>
</tbody>
</table>

### Treatment

| Alleviate stress and better develop social interaction with the nurse

| 1. Comprehensive initial assessment & evaluation of patients self-care deficits | X |  |
| Current Medications | X |  |
| Priority setting-one goal & contract signing | X |  |
| 2. Teaching & Training on self-care | X | X |
| Education on DKD |  | X |
| Education on the risk of hypoglycemia |  | X |
| 3. Counseling on self-care development |  | X | X |
| 4. Guiding & support | X | X | X |
| 5. Coordination of Care | X | X | X | X | X | X |
| 6. Follow-up & proactive monitoring | X | X | X |
| Dietary plan and counseling | X | X | X |
## Results

Percentage Distribution of the Participants’ Self-Care Goals for two MSMP periods

<table>
<thead>
<tr>
<th>Participants’ goals</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Glycemic control mainly through a dietary plan</td>
<td>31</td>
</tr>
<tr>
<td>Physical activity plan</td>
<td>15</td>
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<tr>
<td>Prevention and management of hyper and hypoglycemia</td>
<td>13</td>
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<tr>
<td>Education on DKD</td>
<td>13</td>
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<tr>
<td>Foot care</td>
<td>8</td>
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<tr>
<td>Insulin injection techniques</td>
<td>8</td>
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<tr>
<td>Blood glucose testing</td>
<td>5</td>
</tr>
<tr>
<td>Psychosocial support</td>
<td>5</td>
</tr>
<tr>
<td>Weight loss</td>
<td>2</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
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</table>
Results

**Hypothesis I**: Range and Comparative Results of the Study dependent Variables Between the Treatment Groups

<table>
<thead>
<tr>
<th>Pre-Post Difference</th>
<th>Dimension(s) Measured</th>
<th>UC</th>
<th>MSMP</th>
<th>N</th>
<th>Mean Rank</th>
<th>N</th>
<th>Mean Rank</th>
<th>Man-Whitney U</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Care</strong></td>
<td>General Diet Habits</td>
<td></td>
<td></td>
<td>48</td>
<td>38.313</td>
<td>44</td>
<td>55.432</td>
<td>2439.000</td>
<td>.002*</td>
</tr>
<tr>
<td></td>
<td>Specific Diet Habits</td>
<td></td>
<td></td>
<td>48</td>
<td>37.021</td>
<td>44</td>
<td>56.841</td>
<td>2501.000</td>
<td>.000*</td>
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<tr>
<td></td>
<td>Exercise Habits</td>
<td></td>
<td></td>
<td>48</td>
<td>45.208</td>
<td>44</td>
<td>47.909</td>
<td>2108.000</td>
<td>.626</td>
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<td></td>
<td>Blood Sugar Testing</td>
<td></td>
<td></td>
<td>48</td>
<td>39.771</td>
<td>44</td>
<td>53.841</td>
<td>2369.000</td>
<td>.008*</td>
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<td></td>
<td>Foot Care</td>
<td></td>
<td></td>
<td>48</td>
<td>43.344</td>
<td>44</td>
<td>49.943</td>
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<td>.214</td>
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<tr>
<td></td>
<td>Antihypertensive Therapy</td>
<td></td>
<td></td>
<td>26</td>
<td>21.788</td>
<td>22</td>
<td>27.705</td>
<td>215.500</td>
<td>.140</td>
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<tr>
<td><strong>QoL</strong></td>
<td>Present</td>
<td></td>
<td></td>
<td>48</td>
<td>41.010</td>
<td>44</td>
<td>52.489</td>
<td>792.500</td>
<td>.026*</td>
</tr>
<tr>
<td></td>
<td>Impact of Diabetes</td>
<td></td>
<td></td>
<td>48</td>
<td>47.240</td>
<td>44</td>
<td>45.693</td>
<td>1020.500</td>
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<tr>
<td></td>
<td>Impact of Diabetes</td>
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<td>43.031</td>
<td>44</td>
<td>50.284</td>
<td>889.500</td>
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<td><strong>Blood Glucose</strong></td>
<td>Glycated Hemoglobin</td>
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<td>56</td>
<td>56.509</td>
<td>50</td>
<td>50.130</td>
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<tr>
<td><strong>Kidney Function</strong></td>
<td>Serum Creatinine</td>
<td></td>
<td></td>
<td>55</td>
<td>52.618</td>
<td>51</td>
<td>54.451</td>
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<tr>
<td></td>
<td>eGFR</td>
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<td>50.873</td>
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<td>Albumin/Creatinine Ratio</td>
<td></td>
<td></td>
<td>46</td>
<td>49.348</td>
<td>43</td>
<td>43.652</td>
<td>927.000</td>
<td>.306</td>
</tr>
</tbody>
</table>

Intent to Treat Data Including Dropouts; * Significantly different at p<0.05
Conclusion

- The implementation of a nurse-led interprofessional program using theory-based nursing practice improved QoL and self-care activities.
  - Taylor et al., (2001, p. 29) noted «...knowledge of self-care also has the potential for improving the QoL of individuals, families, and communities”

- Additional evidence to systematic review only study, that showed improvement of QoL and self-care with multidisciplinary care.
Academic Relevance

• The SCDNT remains congruent with current nursing practice because it is based on an evaluation of patients’ needs and self-care capacities.

• Further expansion is necessary in order to consider nursing interactions within an interprofessional team.

• Interprofessional collaboration considers the patient and family as part of the team and establishes shared goals.

• The SCDNT needs to address the impact of patient empowerment on self-care, and to reevaluate the collaborative relationship between the nurse and the patient to foster self-identified health related goals.
Clinical Relevance:

• Using the SCDNT, and the home visits, ensured guidance and support in the integration of life style and dietary changes within the participants’ family systems.

• The SCDNT ensured a needs-based approach.

• Nurses are to consider the influences of self-care management recommendations provided by the whole healthcare team, ensure coordination of care, and build nursing interventions based on patients’ self-identified health related goals.
Acknowledgment

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Thank you


Additional references as resources for questions
## Methods

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Dimension(s) Measured</th>
<th>Measure Used</th>
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<tbody>
<tr>
<td><strong>Patient Variables</strong></td>
<td></td>
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<tr>
<td>Self-Care Behavior</td>
<td>Diet Habits</td>
<td>R-SDSCA (inter-item 0.45)</td>
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<td>Exercise Habits</td>
<td>R-SDSCA (inter-item 0.47)</td>
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<td>Blood Sugar Testing</td>
<td>R-SDSCA (inter-item 0.47)</td>
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<tr>
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<td>Foot Care</td>
<td>R-SDSCA (inter-item 0.47)</td>
</tr>
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<td></td>
<td>Smoking</td>
<td>R-SDSCA (inter-item 0.47)</td>
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<td>Antihypertensive Therapy</td>
<td>MEMS</td>
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<td>Quality of Life (QoL)</td>
<td>Present QoL</td>
<td>ADDQoL (Cronbach $\alpha=0.947$)</td>
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<td>Impact of Diabetes on QoL</td>
<td>ADDQoL (Cronbach $\alpha=0.947$)</td>
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<td>Impact of Diabetes on Life Domains</td>
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<td>Blood Glucose Control</td>
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<td>Kidney Function</td>
<td>Serum Creatinine</td>
<td>$\mu$mol/L</td>
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<td>eGFR</td>
<td>ml/min using CKD_EPI</td>
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<td></td>
<td>Albumin/Creatinine Ratio</td>
<td>mg/mmol</td>
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Results

• Study Flow Diagram CONSORT 2010:
## Results

### Sociodemographic and Clinical Characteristics of Participants (n=32)

#### Clinical Characteristics

<table>
<thead>
<tr>
<th>Clinical Characteristics</th>
<th>Range</th>
<th>Mean and SD</th>
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<tbody>
<tr>
<td>Age (years)</td>
<td>50-91</td>
<td>67.8 ± 10.8</td>
</tr>
<tr>
<td>HbA1c (%)</td>
<td>5.7-10.5</td>
<td>7.7 ± 1.3</td>
</tr>
<tr>
<td>eGFR (ml/min)</td>
<td>15-108</td>
<td>41.3 ± 21.5</td>
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#### Sociodemographic Characteristics

<table>
<thead>
<tr>
<th>Sociodemographic Characteristics</th>
<th>Frequency</th>
<th>Percentage</th>
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<tr>
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</table>
Multidisciplinary mangement: concept analysis

• “The most common surrogate term was interdisciplinary collaboration. Related terms were interprofessional team, multidisciplinary team and teamwork. Attributes included: an evolving interpersonal process; shared goals, decision-making and care planning; interdependence; effective and frequent communication; evaluation of team processes; involving older adults and family members in the team; and diverse and flexible team membership. Antecedents comprised: role awareness; interprofessional education; trust between team members; belief that interprofessional collaboration improves care; and organizational support. Consequences included impacts on team composition and function, care planning processes and providers' knowledge, confidence and job satisfaction”.

Understanding interprofessional collaboration in the context of chronic disease management for older adults living in communities: a concept analysis. Bookey-Bassett S¹, Markle-Reid M², Micke CA², Akhtar-Danesh N².