Exploring Shared Care Plans for Older People Regarding their Fulfilment of Policy Requirements and Shared Decision Making

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Abstract

The aim was to explore the documentation in shared care plans regarding their fulfilment of policy requirements and shared decision-making. The sample consists of 15 shared care plans established for older people in Sweden. The requirements in the Swedish law and the 15 indicators of shared decision making (SDM) in the Multifocal Approach to the Sharing in SDM inventory was used to define the main categories. The older person and next of kin were present at 14 of the care planning meetings. The individual's agreement to the establishment was documented in ten of the plans. Six out of 15 indicators of SDM were reflected but the headings focused mainly at the policy requirements. The decision-making process needs to be acknowledged more in the templates that are used in shared care plans to support a care planning process and a documentation based on SDM.

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Exploración de Planes de Atención Compartida para Mayores en Relación al Cumplimiento de los Requisitos Políticos y la Toma de Decisiones Compartidas

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Abstract

El objetivo era explorar los planes de atención compartida según el cumplimiento de los requisitos de la política y la toma de decisiones compartidas. La muestra consta de 15 planes de atención compartida establecidos para mayores en Suecia. Se utilizaron los requisitos de la ley sueca y los 15 indicadores de toma de decisiones compartidas (TDC) del inventario del Enfoque Multifocal de la TDC para definir las categorías principales. La persona mayor y sus familiares estuvieron presentes en 14 de las reuniones de planificación de la asistencia. El acuerdo de la persona con el establecimiento estaba documentado en 10 de los planes. Se reflejaron 6 de los 15 indicadores de TDC, pero los títulos se centraron en los requisitos de la política. El proceso de toma de decisiones debe ser más reconocido en las plantillas que se utilizan en los planes de atención compartida para promover que el proceso de planificación de la atención y la documentación se basen en el TDC.

Palabras clave: participación de los pacientes, política sanitaria, planificación de la atención a los pacientes, fragilidad de los ancianos

L egislative health policies are governmental tools to affect the distribution of health services and access to care in the population (Kominski, 2014) and can be of great significance for care practice, research and evaluation (Russell & Fawcett, 2005, 2006). One health policy that can be expected to have an impact both on health care and its outcomes is the establishment of Shared Care Plans (SCP) i.e. care plans that are established through inter-professional collaboration and shared between organisations (Trivedi et al., 2013; van Dongen et al., 2016). Shared care plans have become more commonly recommended in health policies and guidelines even though there is still limited evidence for their value for those who are targeted (Bevilacqua et al., 2020; Bjerkan et al., 2011; Condelius et al., 2016; Deschodt et al., 2020; Newbould et al., 2012; Tsakitzidis et al., 2016; van Dongen et al., 2016). This calls for more research focusing at the outcomes of the establishment of SCPs.

Social services and home nursing care in Sweden is provided by the municipalities, while hospital care and outpatient care is provided by the county councils. Thus, people in need of both social services and healthcare receive this from various principals and organizations with no one taking overall responsibility. This affect the continuity in care for people with more complex care needs. In 2010, the Swedish Government inaugurated a new paragraph regarding the establishment of SCPs in the Health and Medical Services Act (The Swedish Ministry of Health and Social Affairs, 1982:763) and in the Social Services Act (The Swedish Ministry of Health and Social Affairs, 2001:453). The paragraph says:

> When the individual needs interventions both from social services and from health care, the municipality together with the county council must establish a care plan. The plan shall be established if the municipality or the county council deem it as necessary for meeting the needs of the individual, and if the individual agrees to its establishment. Work on the plan shall begin without delay. The plan shall, whenever possible, be drawn up together with the individual. Close relatives shall be given the opportunity to participate in the work on the plan, if appropriate, and that the individual does not object. The plan shall state:
> 1. the interventions required,
> 2. the interventions each principal is responsible for,

3. the actions taken by someone other than the municipality or county council,
4. which of the principals that has the overall responsibility for the plan (Ministry of Health and Social Affairs Sweden, 2001:453).

The governmental intentions with this legislation is to ensure that the municipalities and the county councils collaborate in the care of people in need of both social services and health care and that their responsibilities are made clear through the establishment of a SCP (The Swedish Parlament, 2008; The Swedish Parliamentary Committee on Health and Welfare, 2009). These intentions are made clear through the wording in the paragraph that state that the plan must be established by "the municipality together with the county council*"* (Ministry of Health and Social Affairs Sweden, 2001:453) and that the written care plans must contain information that clarifies their responsibilities. The evaluation of this governmental intention is, therefore, straight forward and in line with the requirements stated in the paragraph i.e. if the policy requirements are fulfilled so are these governmental intentions.

Another governmental intention with SCPs is to improve the involvement and influence of patients and family members in the care planning process and to ensure that care is provided in accordance with their needs and wishes (The Swedish Parlament, 2008; The Swedish Parliamentary Committee on Health and Welfare, 2009). According to the governmental bill, the starting point as well as the aim for the establishments of SCPs should be the needs of the individual which should be evaluated from the perspective of professionals as well as the individual (The Swedish Parlament, 2008; The Swedish Parliamentary Committee on Health and Welfare, 2009). This potential outcome of the establishment of SCPs is important in the care of older people who often face difficulties in making their needs and wishes heard in the care planning process (Backman et al., 2020; Bennett et al., 2019; Berglund et al., 2012; Kristensson et al., 2018; Ramgard et al., 2015). However, the way the individual is described in the paragraph is not in line with the active and influential role of the patient that the government is aiming for. The individual is described as a passive participant where a SCP shall be established "if the municipality or the county council deem it as necessary*"* and together with the person "whenever possible" (Ministry of Health and Social Affairs Sweden, 2001:453). Since the terminology used in policies are of significance for the involvement opportunities that are implemented for patients in care

(Jones & Pietila, 2018) this way of describing the individual may constitute a hindrance in the realisation of this important governmental intention. A logical question is thus to what extent the individual's involvement in the care planning process is reflected in the SCPs that are established in relation to the factors that are more clearly regulated.

Patients' level of involvement can range from indirect to direct where a direct involvement implies being an active part in decision-making (Tritter, 2009). The level of direct involvement can be measured and evaluated through the concept of Shared Decision Making (SDM) (Belanger et al., 2011; Bomhof-Roordink et al., 2019; Coulter et al., 2011). SDM requires that professionals regard the person as an equal partner and that decisions are based upon his/her true preferences, knowing the full range of alternatives and effects of choices (Elwyn et al., 2012; Pelzang, 2010). SDM have a positive impact on patient satisfaction and adherence to care (Niburski et al., 2020; Sanftenberg et al., 2021; Steven, 2020) and is a fundamental aspect of person-centered care (McCormack, 2003). Thus, SDM may serve as a tool when exploring to what extent the individual's level of involvement in the care planning process is reflected in the care plans that have been established.

The aim of this study was to explore the documentation in shared care plans for older people regarding their fulfilment of policy requirements and shared decision-making.

Materials and Methods

Sample and Data Collection

The sample consists of 15 shared care plans that were established for older people in two municipalities in southern Sweden, during the period November-2013 to December-2014. The plans were identified and collected through a contact person within elderly care in the two municipalities. Those older persons who had a care plan established during the study period (N=38) were contacted by the contact person and asked if their information could be handed over to the research group. Fifteen persons agreed to this and gave their informed, written consent to have their care plan included in the study.

Ethical Approval

The Regional Ethical Review Board in Lund approved the study (Dnr 2013/549).

Data Analyses

In the first step of the analysis, the authors read all the care plans to get an overall impression of their content. The authors then came together to discuss and summarise the overall similarities and differences in the plans.

To explore the care plans regarding the requirements in the paragraph the text was sorted into nine predefined categories by the first author, using directed content analysis (Hsieh & Shannon, 2005). The categories were constructed in accordance to the requirements stated in the paragraph and named after these as the following:

- SCP established in collaboration between the municipality and the county council
- the individual´s agreement to the establishment
- the individual´s participation at the meeting
- family members´ participation at the meeting
- the individual´s agreement or opposing to family members´ participation
- the interventions required
- the interventions each principal is responsible for
- actions taken by someone other than the municipality or the county council
- the authority with the overall responsibility for the plan.

Passages in the text that could provide information about these nine requirements were sorted into the categories by the first author. The second author then read the text in each category to check for and agree to its accuracy. The same procedure (Hsieh & Shannon, 2005) was then used to explore the documents with regard to SDM. Fifteen predefined categories were constructed in accordance with the observer sheet of the Multifocal Approach to the Sharing in SDM inventory (MAPPIN´SDM) (Kasper et al., 2012). The MAPPIN´SDM is a comprehensive inventory measuring 15

indicators of SDM. The 15 indicators of SDM that were rephrased into main categories are shown and defined in Table 1.

Table 1.
Indicators of shared decision making according to MAPPIN´SDM (Kasper et al. 2012)

1. Defining the problem". The first indicator of SDM is the skill of defining the problem that requires a decision-making process and of clarifying the urgency of the problem and what decisions that must be made.
2. "*The equipoise statement*",. An important precondition for shared decision-making is a mutual understanding regarding alternatives. The meaning and the consequences of the alternatives to the person needs to be acknowledged besides the statement of alternatives by the professionals.
3. "*Preferred communication approach*", refers to how the participants provide each other with information and how they communicate their preferences regarding information exchange.
4. "*Distribution of roles*". This indicator reflects the persons preferred level of involvement in the decision-making process and how this has been elucidated.
5. *"Listing the options"*, deals with the systematic listing of the alternatives of how to deal with the problems. This, more systematic, listing of options should be done after the alternatives have been identified from everyone's perspectives. The option to do nothing or deferring a decision should be included.
6. "*The pros and cons of alternatives and options*", deals with the presentation of risk and benefit of listed options which is the core of risk communication. It highlights that information about risk and benefit should be presented in an objective way and explained thoroughly.
7. "*Exspectations and worries*" reflect the importance of communicating the persons point of view. It deals with the persons expectations, worries, fears and preferences regarding the alternatives and management of the problem (not worries as a problem).
8. *"Indicating the source of recommendations/information*" refers to the importance of communicating the source upon which the recommendations or information are based i.e. personal opinions and experiences, research findings, guidelines or PMs.
9. "*Evaluation of the persons understanding*" deals with the skill of detecting the persons understanding of the given information or any lack of knowledge.

Table 1.
Indicators of shared decision making according to MAPPIN´SDM (Kasper et al. 2012) (continued)

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10. "*Evaluation of the professionals´ understanding*", deals with the same as indicator no 9, but with focus at the professionals´ understanding or lack of knowledge about the persons´ viewpoints.

11. *"Opportunity for questions from the person"* deals with the importance of providing opportunities for the person to ask questions and express things that he or she has not fully understood. This means that the person should be invited to ask questions or ask questions spontaneously.

12. *"Opportunity for questions from professionals",* deals with the same topic as no 11 but with focus at the professionals´ opportunity to gain deeper understanding of the persons situation or viewpoint.

13. "*Supporting strategies of decision-making*" highlights the importance of professionals to coach and guide the person in his/her decision-making process and to find decision-making strategies that are useful for him/her.

14. *"Indicate decision"*, refers to the stage of the process where a decision is made and reflect the skill of making this stage explicit and clear. The choices should be clear as well as the decisions that have been made. If a decision can´t be made, or is deferred, this should be clear as well.

15. *"Follow-up arrangements (e.g. steps for implementing the decision, review of decision or of deferment)*". This indicator reflects the importance of discussing and agree on how to implement and follow-up the decisions that have been made. It is not enough to refer to a new time for consultation, but the person needs to agree on how the decision will be evaluated and the criterions for the evaluation.

To explore if, and how these 15 indicators were reflected in the documents, passages in the text that could provide information regarding them were sorted into the main categories by the first author. The second author then read the text in each category to check for and agree to its accuracy. The analysis was then conducted inductively (Hsieh & Shannon, 2005) by sorting the text within the main categories into groups according to its similarities or differences in how the main category was reflected. This was conducted by the first author. The authors then met to discuss and agree to the subcategories and came to an agreement on their content.

Both authors have experience of caring for older people as registered nurses and of conducting qualitative analyses inductively and deductively.

Results

The 15 persons whose shared care plans were included in this study had a mean age of 86.1 years (range 69-97 years) where six were women. Twelve lived in municipality I and three lived in municipality II.

Overall Description and Impression of the Care Plans

All the plans were written by a registered nurse in the municipality. Ten of the plans had the same headings and layout (A) while another set of headings were used in four plans (B) and one plan used a third set of headings (C) (Table 2). All the plans had a heading about those who participated at the care planning meeting, the interventions that were planned for, follow-up and who was responsible for the interventions.

Table 2.
Headings and subheadings used in the shared care plans

Headings used in 10 of the care plans (A)
Agreement registered
Participants
Enrollment information
- My present situation is like this (experiences, needs, wishes, expectations on this planning)
- I´d like to have it like this (overall goals)
- What principals is responsible for the plan?
- Planned follow-up
- The timeframe for planned actions
- Did the individual participate at the meeting? If not, give the reason for this.

What shall be done and who is responsible for what
The individual
- What I shall do (the individual)
- Agreement. The individual has agreed to the establishment of the plan

What others shall do (e.g: family members or other authorities)
- Participants:
- What others shall do

Table 2.
Headings and subheadings used in the shared care plans (continued)

The municipality
- Participants:
- What the municipality shall do

The county council
- Participants:

What professionals within the county council shall do:

How I think my needs and expectations might change in the future (eventual future scenarios)

Headings used in four care plans (B)
Planning
Date
Present
The reason for care planning
Place (additional in one plan)
Planed psychosocial and physical interventions
Planned actions (additional in one plan)
Emergency interventions
Follow-up
Responsible occupational therapist
Responsible physiotherapist
Responsible nurse

Headings used in one care plan (C)
Care plan
Date
Present
Place
Current diagnosis
Current interventions
Summary
Who does what
Follow-up

The use of headings did not always facilitate the readability or the comprehensibility of the plans. The information indicated by the headings could either be provided under the wrong heading or not provided at all. In the example below the heading deals with the interventions that were planned for,

but the text is about the older person´s current situation and thoughts about this.

"Planned psychosocial and physical interventions: X has activation planned 2 times a week but do not think it is enough, feels alone in the apartment, has no one to talk to" (SCP no 1).

Fulfilment of Policy Requirements

Collaboration between the county council and the municipality. According to the documents, professionals from both the county council and the municipality had been present at the care planning meetings. The professionals that represented the county council were primary care physicians (in 13/ out of 15 meetings), physician from advanced home care (1/15) and registered nurses from advanced home care (2/15). The professionals representing municipal home nursing care were registered nurses (15/15), occupational therapists (7/15), physiotherapists (8/15), a head nurse (1/15) and registered nurses specialised in dementia care (2/15). Professionals representing municipal social services were auxiliary nurses (6/15), a section director (1/15), home help officers (3/15) and a trustee (1/15). Municipal social services were represented at nine of the 15 meetings. This implies that six of the plans were established in collaboration between health care staff only. Decisions about social services had been deferred in some of these cases. According to the plans there were 3-9 persons present at the care planning meetings (median = 7).

The plans had one or several headings to specify who participated at the meeting. Even though ten of the plans had headings to specify who represented each authority (Table 2) this was not always clear. The attendances were either presented several times under several headings or just gathered under one heading without making it clear what authority they represented.

Agreement and participation of the older person and family members. The person´s agreement was documented in ten of the plans through a ticked box stating *"The individual has agreed to the establishment of the plan"*. In these documents there was also a heading stating *"Agreement is registered"*, followed by the date when this was done. How or what the person had agreed to was not specified further. There was no agreement documented in five of

the plans and there was no heading or ticking of box for this purpose in these plans.

According to the documents, all the older persons except for one had been present at the care planning meeting, and this information was found under headings stating "participants*"* or *"*present*"*. Ten of the plans also had a heading for the specification of the reasons why the individual had not participated (Table 2). One person was documented as present but due to aphasia, other family members were documented as spokespersons. The one person who was not present at the meeting was documented as suffering from Alzheimer's disease and it was unclear whether this person had been invited to the meeting or asked for agreement to the establishment of the plan, which was not documented in this case. This plan did not have a heading for specification of whether the individual had participated in the meeting or for clarification of the reasons for not participating.

Next of kin were present in 14 of the meetings and they were documented as wife/husband, daughter/son, grandchild, daughter in law, nephew, or good friend. The older person´s agreement or disagreement to their participation was not documented in any of the plans and there was no heading or ticking of box for this purpose. In the one case where next of kin were not present at the meeting this was documented as there was not anyone to invite.

Interventions required and responsibility. All the care plans had one or several headings regarding the interventions that were planned for but no heading for describing why these interventions were required (Table 2). The interventions were sometimes stated in general terms without further specification , *"*provide good and secure care at the right level", "home service staff continue to provide care to X in relation to X needs*"*. The needs of the person and the interventions that were planned for were often described under different headings and sometimes the needs did not have any interventions described in relation to them or vice versa. This made it difficult to see why the described interventions were required. For example: in one case, palliative care was planned for without a statement of a need for this specific form of care. In six of the plans it was documented whether the individual wished to go to the hospital or not but without a clarification of why this specific problem had been brought up at the meeting and documented. Whether the individual wished for cardiopulmonary resuscitation (CPR) in case of an cardiac arrest was expressed in two of the plans as: *"*The question regarding

CPR is answered by X with a decline*"* and "the individual and family members does not wish for CPR", but without any description of why this question had been brought up.

The responsibility of each authority was documented under headings stating: *"What professionals within the county council/municipality shall do"* or "who does what*",* however, the information was sometimes provided under the wrong heading which made it difficult to find and comprehend. For example; actions provided by the municipality could be described under the heading stating: "What professionals within the county council shall do*"* and vice versa or specified through mentioning the professionals but without a clarification of their organisational belonging.

> <u>Who performs what</u>:
> - Responsible physician at the Health Care Centre X write necessary documents
> -and ordinate medicine for the provision of good palliative care
> -Responsible nurse answers for good care and that the wishes of X and relatives are fulfilled (SCP no 2).

What care others than the municipality or the county council should provide for was specified in eight of the plans under the heading stating: "What others shall do". No other care providers than the older person and next of kin were mentioned here. <u>"What others should do (e.g. relative, other authority)</u>: X's daughter has applied for a dependent parent allowance. Relatives take care of the collection of medicine from the pharmacy*".* (SCP no 8)

The principal with the overall responsibility for the plan was specified in ten of the documents. In five of these it was stated the name of the persons, their profession, and the organisation they worked for. In the rest of the plans this was either not mentioned at all or specified by naming the persons and their profession but not their organisational belonging.

Shared Decision Making. The headings used in the care plans was not focused on clarifying the decision-making process. Six out of the 15 aspects of SDM were reflected in the documents and they constitute the main categories in the result: defining the problem, the equipoise statement, expectations and worries, evaluations of person´s understanding, indicate decision and follow-up arrangements (Table 3). Four of the main categories

have subcategories showing the various ways these aspects of SDM were reflected in the documents.

Table 3.
Categories and subcategories in relation to SDM

Categories
Subcategories
1. Defining the problem
• *Problem defined by the professionals*
• *A general goal for the meeting*
• *Description of the person´s health status, diagnosis and/or social situation*
• *Description of the person´s worries, problems, satisfaction or dissatisfaction with current situation*
• *Description of the person´s wishes and expectations*
2. The equipoise statement *One or several options presented*
• *The options has been mentioned but not documented*
7. Expectations and worries
9. Evaluation of person´s understanding
14. Indicate decision
• *Clearly stated decisions*
• *Decisions expressed in general term or as wishes*
15. Follow-up arrangements
• *Doing and responsibility*
• *Planned follow-up*

Defining the problem. According to SDM, the problems should be elucidated and defined from the patient´s and the professional's perspective. The neutral or passive language used in the documents made it difficult to determine who had mentioned the facts that were documented. Even if some of the documents had a heading stating: "My present situation is like this*"* it was not always clear if it was the professionals, the older person, next of kin or all together who had drawn attention to the facts that were documented. "My present situation is like this (experiences, needs, wishes, expectations on

this planning): Generalised prostate cancer with bone metastases in palliative stage˝ (SCP no 13).

It was difficult to detect the specific problem or problems that had been targeted at the care planning meeting and there was no heading that focused at defining the problem per se. The information was provided in accordance to the headings and, thus, focused more or less on describing the current diagnosis, the goals for the meeting, the situation of the older person and/or the person´s thoughts, opinions or wishes (Table 2). This category consists of five subcategories reflecting the various ways that a focus for the care planning meeting were described in the documents: problem defined by professionals, a general goal for the meeting, descriptions of the person´s health status, diagnosis and/or social situation, descriptions of the person´s worries, problems, satisfaction or dissatisfaction with current situation and description of the person´s wishes and expectations. These various ways of describing a problem were often mixed within the same care plan, which made it difficult to sort out what problem that had been focused upon and why.

Problem defined by professionals. The problem, and what decisions that had to be made during the care planning meeting was clearly stated in one care plan. It was also made clear that the problem was defined by the professionals.

> It has also emerged that she has a component in her blood where the specialist has recommended further examinations. This examination seems to be extensive, therefore, Dr. Y and I as PN (patient nurse) believe that we should discuss possible further examinations together with X and her nephew XY (SCP no 1).

A general goal for the meeting. Instead of describing a problem, some of the care plans had a general and vaguely formulated goal for the meeting. The urgency of the problem or what decisions that had to be made were not specified. "Reason for care planning: to plan future care and to improve X's quality of life" (SCP no 4).

Description of the person's health status, diagnosis and/or social situation. The care plans comprised descriptions of the older persons´ health status, diagnosis, and/or social situation but without making it clear what problem that had been focused upon at the meeting, or what purpose this information had served in the care planning process.

> Husband X has taken care of his wife Y since she became ill, has only had help with showering once a week. X has been granted alternating housing on F (accommodation) in A (village), the decision has been made but not the time for start-up. Shall stay at F (accommodation) for 1 week and at home 3 weeks (SCP no 3).

Descriptions of the person´s worries, problems, satisfaction, or dissatisfaction. The experiences of the older person and/or the next of kin were documented as factors that they "have experienced, expressed, felt" and so on. Even though they could be expressed as problematic to the person it was not made clear whether they had been targeted for a decision-making process or not. In some cases, they were left without further comments and sometimes they had intervention planned for in relation to them. Why one problem, worry, or dissatisfaction had been targeted and not the other was not made clear. Some experiences were also expressed in positive terms, making it even more difficult to see the purpose of this information in the decision-making process and to sort out what problems that had been focused upon and why.

> X has said repeatedly during spring that he is tired, has no energy, cannot walk because no shoes fit. Has lost all social contacts. Wife Y helps him with everything at home every day of the week. Only receives help with blood samples, wife Y take him by car when needed. It is hard and strenuous for her because he is a big person and has trouble moving around (SCP no 4).

Description of the person´s wishes and expectations. The wishes and expectations of the older person were documented in terms of what the person "wants" or "would like to". Even though these descriptions were not formulated as problems they could be described as the starting point for the decision-making process. In the quote below the wishes are expressed in specific tasks that had interventions planned for in relation to those which made it clear that they had been focused upon in the decision-making process.

> <u>I would like to have it like this (overall goal)</u> Painless. Take a walk more often in the hallway. Get a brake installed on the walking frame. A wheelchair that fits him. Wish that the family physician

> takes responsibility for all his medications except those prescribed by the dialysis ward or the hematologist. Get his flu vaccine here at A (accommodation). Have a shower twice a week (SCP no 14).

The wishes and expectations could also be expressed in more general terms and without any interventions planned for in relation to them. What purpose this information served in the care planning process was then unclear.

> <u>I would like to have it like this (overall goal)</u>: I still have the hope of regaining my functions in the left arm and leg, my dream is to be able to live as I did before. If no progress is made and my life situation changes, I want to live at accommodation A until life ends (SCP no 11).

The equipoise-statement. The alternatives in how to deal with the problems were only presented from the perspective of the professionals. The meaning and consequences of these alternatives for the older person were not documented. This category has two subcategories reflecting the two ways that options were documented: one or several alternatives presented, alternatives have been mentioned but not documented.

One or several alternatives presented. Options in care were documented and specified in relation to a specific problem the older person had expressed. These options were presented from the perspective of the professionals and not the older person or family members.

> <u>Planned psychosocial and physical interventions</u>: Physiotherapist X informs that there is a special rehabilitation team in A (community) where he may have the opportunity to exercise if he shows interest himself and starts walking at home. The couple are encouraged to visit a special shoe store in A for trying out shoes that fit (SCP no 4).

Alternatives has been mentioned but not documented. This subcategory shows that it has been documented in the care plans that options were mentioned by professionals during the care planning meeting but that options were not documented. "Dr. X goes through what other medical examinations that may be considered" (SCP no 1).

Expectations and worries. This category deals with the person´s thoughts and preferences regarding the alternatives that are presented. It has no subcategories since it was only reflected in one of the care plans. "Y does not think it seems very difficult and wants to start the examination, thinks she can cope with it. Nephew Z thinks it is her own decision and if it does not work, she can end the examination" (SCP no 1).

Evaluation of person´s understanding. This indicator has no subcategories since it was reflected in one care plan. The person´s understanding was, in this case, evaluated in relation to one specific medical condition, which can be seen in the quote: "Understands that his heart is failing and that he sometimes gets fluid in the lungs that requires Furix intravenously. He has learned to live with it" (SCP no 9).

Indicate a decision. The headings used in the plans were not always helpful in detecting the decisions that had been made during the meeting. This category comprises of two subcategories reflecting the various ways that decisions were documented in the care plans: clearly stated decisions and decisions expressed in general term or as wishes.

Clearly stated decisions. This subcategory shows that the decisions that were made during the care planning meeting were documented in the care plans as matters that were "decided" or "agreed on" or as interventions that shall or shall not be conducted after the meeting, as in this quote: "Interventions: We agree on that Y may try without compressionstockings for 2-3 days" (SCP no 10).

These decisions could be clearly related to a documented problem or wish of the person; although, sometimes they were not. The decisions were often documented under several headings or under a heading concerned with something else which made them difficult to find. Some of the decisions that were documented were about alteration of medications made by the physician during the meeting. The reason for the alterations could be left out completely or clearly stated as in the quote: "Dr. xx increases the dose of Furix, discontinues Bisoprolol and Oxascand only when needed. X wishes to change Impugan to Furix and Dr. xx executes this" (SCP no 9).

Decisions expressed in general term or as wishes. This subcategory shows how decisions were expressed in general terms or as the older persons´ and/or family members´ wishes. This made it difficult to know whether there was a decision made and whether it was a mutual decision or not. "Current interventions: The individual and family members do not wish for CPR". (SCP no 2)

Follow-up arrangements. Information regarding follow up arrangements were found under headings stating "Who does what", "What professionals in the municipality shall do", "What the professionals in the county council shall do"*, "*What others shall do (next of kin or other authorities)" and "Follow-up". The two subcategories show the various ways this information was documented in the care plans: doing and responsibility as well as planned follow-up.

Doing and responsibly. The strategies to implement a decision were described as actions or as tasks that a professional or a principal was responsible to carry out after the meeting. Sometimes the older person and/or the family members were also appointed as responsible to carry through certain tasks. The actions or responsibilities were described as very specific tasks or in general terms, as in the quote below.

> "What care providers in the county shall do. Kidney medicine ward in Y (short name for a city) takes care of kidney problems. Diabetes nurse in Y (short name for a city) / in consultation with a doctor treats diabetes illness. Psychiatric care in Y (short name for a city), Dr x xx calls 1time / year for follow-up of mental health. Responsible doctors, in addition to specialist care, are Dr xx and xx at Y (name of healthcare center) in Y (name of city)" (SCP No 7).

Planned follow- up. In all the plans, except for one, there were headings stating "Follow up", "Planned follow up" or "Time schedule for the actions in the plan". The arrangements for follow-up were often described in general terms and when they should be done, but without a specification of what should be evaluated, how or by whom. The older person´s agreement or understanding to the arrangements were not documented in any of the plans. "Schedule for the interventions in the plan * Incontinence training must be

followed up continuously. Pain from the legs should be followed up by the physiotherapist continuously" (SCP No 6).

Discussion

Discussion of the Methodology

Documents in the form of SCPs constituted the data in this study. These documents can be considered as the most tangible outcome of the legislation that regulates the establishment of SCPs. Written documents are valuable in research since they are easily collected, cost efficient and not effected by the researcher or the research project (Bowen, 2009). However, the documents cannot be a complete coverage of a complex social and communicational interaction as a care planning process (Bowen, 2009). Decisions may also be experienced as shared by the patient even though theoretically important components are not present (Shay & Lafata, 2014). Thus, no firm conclusions can be made from the documents regarding SDM during the actual care planning meeting, only about the ways that SDM is reflected in the documents.

The analysis was performed using directed content analysis (Hsieh & Shannon, 2005) where the observer instrument of MAPPIN`SDM (Kasper et al., 2012) was used in the construction of main categories. There are several instruments measuring SDM from the perspective of the patient and tools to guide or evaluate practitioners in clinical practice (Bouniols et al., 2016; Scholl et al., 2011). MAPPIN`SDM was chosen since it is one of very few instruments that is constructed to be used from the perspective of an observer (Geessink et al., 2018; Kienlin et al., 2017). The use of predefined categories in the sorting of data maximises agreement between coders which enhance trustworthiness in this study (Cavanagh, 1997). The MAPPIN`SDM also has a manual for coding which enhanced the agreement between coders. Trustworthiness was also enhanced through the use of quotes in the result to show that it is well grounded in data and through investigator triangulation, meaning that both authors took an active part in the analysis (Lincoln & Guba, 1985). Both authors also have experience of the interprofessional care planning for older people and of conducting qualitative analyses which also strengthen trustworthiness of the study.

Discussion of the Results

The policy requirement about the collaboration between the two principles was fulfilled since professionals from both the municipality and the county council participated in the establishment of the care plans. Municipal social services were, however, not represented at six of the 15 meetings; meaning that they were conducted in collaboration between health care professionals only. In some cases, this meant that decisions regarding social services had to be postponed. It is noteworthy that a representative from social services was missing at some of the meetings since a median of seven people were present. Older people are often outnumbered by the professionals at the care planning meeting which makes it difficult for them to raise objections and to make their wishes heard (Kristensson et al., 2018; Sundström et al., 2013). The absence of a person who can make decisions at the care planning meeting is also a common obstacle for an efficient care planning process (Sundström et al., 2013) and should be avoided. This makes it important that the professionals are summoned to the meeting based on their relevance to the care planning process and not only as representatives of the two principals. Thus, it would be valuable if the care plans focused upon the description of why certain professionals are summoned to the meeting and not only at describing who and their organisational belonging. This might serve as guarantee that the most relevant professionals are gathered at the meeting so that necessary decisions can be made without outnumbering the older person. Such conduct would be more in line with the person-centred care planning process that the government is aiming for, in which the needs and interests of the older person are put in focus and not only the policy requirements.

The paragraph state that the care plan shall be established if the individual agrees to it. This requirement was fulfilled in ten of the plans and documented through ticking a box. How and what the person had agreed to was, however, not specified further and five of the plans did not contain any information about the agreement at all. This lack of information about the person´s agreement in the documents may partly be explained by the paragraph that does not require that this information is documented. The paragraph also states that the SCP shall be established if the principals deem it as necessary, which can be interpreted as the professionals can make this decision without involving the person. Previous research show that older persons and their family members often are excluded in the decisions that proceed the care

planning meeting i.e. that a care planning meeting is needed, where the meeting shall take place as well as who to invite besides relatives (Kristensson et al., 2018). Professionals have also been shown to discuss and agree upon the aim and the agenda for the care planning meeting without involving the older persons or their family members, who attend the meeting unprepared and cannot argue for their own needs or preferences (Hedqvist et al., 2020; Kristensson et al., 2018; Sundström et al., 2013). Thus, the person´s decision to agree to the establishment of the plan is not a matter of just saying yes or no or of ticking a box in a document. It signifies an opportunity to be involved in the decision that a SCP is needed and to influence the decisions that are made before the care planning meeting. The decision-making process that proceeds the older person's agreement to the establishment of the plan needs to be acknowledged more in the written care plans to make sure that they are involved in decisions throughout the care planning process.

The decision-making process was sparingly documented in the SCPs established for older people and nine out of 15 indicators of SDM were not reflected at all (no 3,4,5,6,8,10,11,12,13). Two indicators (no 7, 9) were only reflected in one care plan (Table 3). Some of the indicators that were not reflected upon concerned with the communication about the person´s level of involvement in the care planning process. This form of meta-communication is rarely observed in encounters between professionals and patients (Kasper et al., 2012) which may explain why this was not documented. The general lack of documentation about the decision-making process, and SDM may however be explained by the templates that did not focus upon this. The templates that are used in care plans are of significance for the information that is provided (Elgan & Kallmen, 2020; Vagholkar et al., 2007) and the use of a template to support SDM in the establishment of SCPs might contribute to a documentation that is more focused upon describing the decision-making process. A template to facilitate SDM has been shown to be effective in the encounter between professionals and patients (Schafer et al., 2016), but more research is needed to investigate the effects of such a template in the care planning process and in the documentation in SCPs.

One of the governmental intention with SCPs was to improve the involvement and influence of patients and family members in the care planning process (The Swedish Parlament, 2008; The Swedish Parliamentary Committee on Health and Welfare, 2009). All but one of the older persons had participated at the care planning meeting and next of kin were present at all

the meetings except for one. To be present at the meeting is, however, not a guarantee for an active involvement and participation in decision-making (Tritter, 2009). An important element in SDM is the mutual definition of the problem that shall be targeted in the decision-making process (Kasper et al., 2012). The main category, defining the problem, shows that it was difficult to detect the problems that had been targeted at the care planning meeting. Only one care plan had a clearly stated problem and this problem was defined by the professionals. Even though the subcategories show that the older persons had been given the opportunity to express their thoughts and opinions at the meeting, it was not always clear what purpose this information had served in the care planning process. All the problems that were described from the persons´ point of view did not have any interventions planned for in relation to them. This may reflect a conduct that Tritter (2009) refers to as indirect involvement i.e. a decision-making process where the patient provides the professionals with information that they can choose from in the process of making a final decision. Berglund et al. (2012) found that professionals tended to steer the care planning meeting towards predefined goals and that issues that were brought up by the older person were neglected if they did not fit into these predefined goals. Knutsson (2020) found that professionals tend to ignore what the person is saying at the meeting and not to take this seriously. The alternatives in care were presented from the perspective of the professionals only. This may be an indication of what Kasper et al (2012) refers to as a "cosmetic communication" (Appendix S4, page 20) where the person is given one option to agree to and, thus, have not really been part of the decision making process. The decisions that were made at the care planning meeting were sometimes expressed in general terms or as wishes which made them unclear to a reader. Since decisions are often made implicitly, it may be difficult for a person to know when and what decisions that are made during the meeting (Barr & Elwyn, 2016) which makes it very important that both the problems and the decisions are clearly stated in the documents.

Conclusions

The policy requirement as well as the governmental intention regarding the collaboration between the two principals was fulfilled. However, it is important that the professionals are of relevance to the care planning process

and not only regarded as representatives of the two principals. To consider why certain professionals are summoned to the meeting and not only who and their organizational belonging may guarantee that necessary decisions can be made without outnumbering the older person. The policy requirement about the person´s agreement to the establishment of the plan was fulfilled in ten of the plans but the decision-making process proceeding the agreement needs to be acknowledged more to make sure that the person is involved throughout the care planning process. The decision-making process was sparingly reflected in the SCPs established for older people and the templates that were used did not support a care-planning process or a documentation based on SDM. If the establishment of SCPs are expected to improve the influence of patients and family members in the care planning process it is necessary to put more focus upon the decision-making process at the meetings as well as in the written plans. The use of a template to support SDM might support such conduct, but more research is needed to investigate the effects of such a template in the process of establishing SCPs for older people.

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Conflict of Interest

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