"Collaboration with informal caregivers in the care of people with dementia: the experience of community nurses"

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INTRODUCTION

More than 270.000 Dutch people are currently diagnosed with dementia[1], and it is expected this number will continue to grow in the future till about half a million people in 2040[1]. In 2013, 70% of this people were living at home[2] and in need of care from formal and informal caregivers.

Informal caregivers play an important role in the care of people with dementia, assisting care recipients in the basic activities of daily living (ADL), instrumental activities of daily living (IADL), medical- and emotional support, and comfort. Informal care is unpaid, and often involves a long period of care for ill relatives or friends[3]. However, it is also known that informal caregivers are at risk of problems in the physical, mental, social, and economic domains[4] due to the burden of caregiving. Perceived social support[5] and good collaboration with formal caregivers, such as community nurses, may help to prevent or reduce this burden[6,7,8].

In 2015 a reformation of healthcare in the Netherlands[9] took place to limit costs, with implications of an increased appeal to informal caregivers by the government. Due to these reforms, the community nurse now has an even more important role in the professional healthcare of the community than before, expanded to include responsibility for care assessment and assignment. Together with the care recipient, community nurses indicate the care which is needed for them in order to stay at home for as long as possible, a situation which often means help from informal caregivers[10]. In line with these reforms in healthcare, the Dutch government has expressed a desire for formal and informal caregivers to develop better collaboration[11] such as greater involvement by informal caregivers in the various activities of care.

However, some studies suggest collaboration between formal and informal caregivers has been limited thus far[12]. Poor communication, different ideas about care, the level of burden on informal caregivers, and a highly demanding care recipient, are all cited as threats in this collaboration. On the other hand, it is known that clear communication, good distribution of tasks, and a good relationship between the formal and informal caregiver are key aspects in making the collaboration a success[13-15].

Both formal and informal caregivers have suggested that collaboration is not always necessary when the older person is capable of having control of their own care network[13]. However, people with dementia are most often not capable of such control, due to cognitive problems. Little is known, at the present time, about the nature of collaboration between formal and informal caregivers in the specific context of the complex care of dementia patients living at home. It is necessary that this situation changes, and the collaboration better understood, in order to optimize care for this specific group of people as well as to ease the burden for their caregivers.

Aim

This study aims to gain insight into the experiences of collaboration between community nurses and informal caregivers in the care of people living with dementia in the Netherlands, from the perspective of the community nurse. The study also provides insight into the perceived barriers and facilitators in this collaboration.

METHOD

Study design

An explanatory sequential mixed methods cross-sectional design[16] is used in this study. This design gives the opportunity to explore the meaning of the quantitative results more fully, through the qualitative data. This design is appropriate for this study: the collection of quantitative data through an online survey allowed for exploration of the experiences of community nurses on the study topic; the qualitative data collected through semi-structured interviews (conducted with community nurses who had already participated in the quantitative data collection) allowed for deeper exploration of their experiences of collaboration, and the perceived barriers and facilitators in this area.

The study took place in the Netherlands between February 2017 and June 2017.

Population

The study population is community nurses in the Netherlands. In the Netherlands, 8800 community nurses[17] are spread over 2506 home care organisations[18].

Community nurses who were included in the study were those who are allowed to indicate the care, have clients with dementia, and collaborate with informal caregivers. Community nurses with an insufficient understanding of the Dutch language were excluded from the study.

According to Sudman[19] a minimum of 100 elements for a major group is necessary in the quantitative sample. For qualitative analysis, between six and eight participants of a homogenous group is seen as a sufficient sample size[20]. Because the community nurse population are of the same educational level and do the same work, the group can be seen as homogenous. The minimum sample size for the qualitative aspect of data collection will therefore be six; six interviews was regarded as sufficient to explore meaningful themes and useful interpretations[21].

Data collection

Quantitative data – Online survey

The 'Collaborationthermometer' was developed by the researchgroups Innovating with Older Adults, and Social Innovation[22]. The tool gives insight into how community nurses score

themselves on different factors regarding collaboration. The combination of the use of evidence-based literature about collaboration, and practical testing of the applied relevance of the factors, makes good face validity of the Collaborationthermometer. Furthermore, the internal consistency is good. However, the tool has not been validated, or officially tested for reliability. Given the absence of any other comparable or validated instrument, and the fact that the Collaborationthermometer suits the current research question and has high face validity, it was selected for the quantitative data collection in this study.

According to the Collaborationthermometer, the nine factors related to collaboration are: distribution of tasks, needing each other, regularity of contact, handling issues of inequality, trust, see somebody else's perspective, conflicting interests, ethical issues, and evaluating collaboration. Each factor consists of subfactors which respondents can answer on, with a Likertscale ranging from 1-10 (1 is not good at all, 10 is very good) or 1-5 (1 is strongly disagree, 5 is strongly agree).

Qualitative data – Interviews

Semi-structured interviews were conducted for the qualitative data collection. The topic list started with an opening question about how the community nurse experiences collaboration with informal caregivers of people with dementia, in a general sense. Thereafter, the interview continued to questions about the different factors of collaboration, based on the Collaborationthermometer, but the researcher was alert to other aspects that might also be raised. The topic list helped the interviewer to collect the same type of data at each interview[20].

Procedures

Quantitative aspect – Online survey

Community nurses were asked by email to fill in the online survey. The researcher sent an email to contacts at three Universities of Applied Sciences, those of Leeuwarden, Zwolle, and Utrecht, and these contacts in turn sent the email to their network of community nurses. The email was also sent to all Masterstudents of Nursing Science at the University of Utrecht. In addition, the researcher used her own network of community nurses for dissemination of the email, requesting that they forward the email to their own network of community nurses.

Qualitative aspect – Interviews

Community nurses who agreed to participate in the interviews added their contact information to the survey, enabling the researcher to contact them. Of the community nurses who agreed to take part in the interview, selection was made by extreme case selection, based on the total score of the online survey. The three community nurses who scored highest and the three who scored lowest in the online survey were selected for participation.

The interviews took place in a location chosen by the interviewee, so that they felt comfortable, and able to speak openly. Each interview was audiotaped for analysis.

The first interview was conducted as a test, given the researcher's little experience in interviewing. The interview guide and some of the interview techniques were adapted, based on the feedback of researcher C.S. on the test interview.

Ethical issues

This research does not involves the Medical Research Involving Human Subjects Act (WMO), because this research does not concerns medical/scientific research and participants are no subject to procedures or are required to follow rules of behaviour[23].This study was conducted in accordance with the guiding principles of the Declaration of Helsinki (2013)[24], and the Dutch Personal Data Protection Act[25].

Data analysis

Quantitative analysis

The results of the online survey were automatically imported by Excel. The researcher transformed the Excel document in SPSS, version 24 (IBM, Armonk, NY, USA), and the data was analysed with SPSS, by using descriptive statistics (mean, range, and standard deviation) to describe the participants and the factors and subfactors of collaboration. By splitting the scores of the 1-10 Likertscale by half they were rendered equal with the 1-5 scale, in order to calculate the mean. The researcher gained insight into community nurses' perspective concerning the factors of collaboration by analysing the quantitative data in this way.

Qualitative analysis

For analyzing the qualitative data, thematic analysis was performed[26]. With this analysis, important themes within the data were identified, and then further analysed for interpretations.

First, the audiotaped semi-structured interviews were anonymously transcribed by the researcher. Through the process of transcribing the collected data, the researcher became familiar with the data[20,26].

Second, the coding process was performed by the researcher, by ascribing an initial code to specific pieces of data[20,26]. The coding process was performed independently by two researchers, for the purposes of comparison.

Finally, the codes were linked to themes about collaboration with informal caregivers of people with dementia, and to the barriers and facilitators of collaboration.

After the data was analysed, a summary was written and sent to each participant, to check that they concurred with it (membercheck)[20].

The computersoftware NVIVO (QSR international, Victoria, Australia) was used for data analysis.

RESULTS

Participants

One hundred and twenty community nurses filled in the online survey on collaboration, of which six participated in the interviews. It is unclear how many community nurses were contacted in total, because of the snowball method used for spreading the online survey.

Demographic characteristics

The mean age of the 120 participants was 41.1 years, with a range of 22-63. The mean age of the interviewees was 45 years, with a range of 22-57. Most respondents (112) of the online survey were female and all interviewees were female. The participants' working experience as a nurse in years (mean of 16.4 years for the survey respondents; mean of 18.1 years for the interviewees) exceeded their working experience as a community nurse (mean of 8.1 years for the survey respondents; mean of 8.9 years for the interviewees). Most of the community nurses worked in rural areas (n=79); and all the interviewees worked in rural areas. The total number of clients with dementia per nurse was on average 11.9; for the interviewees this was 11. The number of caregivers of which the community nurse had contact was on average 11.6; and 8.8 respectively. One participant in the online survey did not fill in the number of clients she had with dementia, but she did fill in that she had many such clients, and that she had contact with all the informal caregivers of these people. One interviewee had recently moved to a new job, and had not yet had contact with the caregivers. However, she was able to discuss collaboration with informal caregivers, from her previous workplace experience.

Table 1 shows the demographic characteristics of the participants.

Quantitative aspect – Online Survey

Findings

On average, community nurses scored collaboration with informal caregivers at 7.5, with a standard deviation of .72. See table 2 for all outcomes of the online survey.

Task distribution between community nurses and informal caregivers was scored at 3.9. Community nurses 'agreed' that there is clarity of task distribution (4.3) and that they were able to evaluate task distribution with caregivers if needed (4.3).

'Needing each other' was in general scored with a 4. Information exchange with caregivers drew a high score (4.3).

Regularity of contact was scored with a 4. There was agreement about ensuring a quick response for caregivers (4.3). The lowest score on the subfactors was that given for whether

there was a fixed time for deliberation with informal caregivers, which got a 2.6, with a standard deviation of 1.02.

Community nurses scored 'handling inequality' with an average of 4.1.

Community nurses were mostly aware of the shortage of information for, and experience of, caregivers (4.3).

Community nurses scored 'trust' as a high factor, giving it an average of 4.2, with a standard deviation of .25. Keeping to appointments (4.5) and honesty about their knowledge, skills, and tasks (4.4) yielded the highest scores.

The score on the factor 'seeing somebody else's perspective' was 4 on average, with the score for understanding the caregiver's situation ranked at 4.4.

Community nurses scored the factor 'conflicting interests' at 3.8. Community nurses agreed that they help support the client's interests (4.2).

The factor 'ethical issues' was scored at an average of 3.8. On every subfactor 3 or more, nurses filled in 'not applicable'; therefore, this factor scored mostly 'not applicable'. If community nurses faced ethical dilemmas, they discussed these issues with caregivers most of the time (4.1).

Evaluation of collaboration with informal caregivers scored on average the lowest of all the factors, at 3.7, the lowest score being given for taking a structured moment to evaluate collaboration (3.4, with a standard deviation of .98).

Qualitative aspect – Interviews

Findings

Collaboration in general

The experience of collaboration with informal caregivers was reported as generally positive by the community nurses, but variable, given the differences in levels of participation of the informal caregivers. These differences in participation often arise because of a poor relationship between the caregiver and the person with dementia, difficulties accepting the situation by the caregiver, the caregiver living at a distance, and overburdening of the caregiver. These factors are experienced as barriers to collaboration.

Facilitators of collaboration were recognised as: being transparent (open and honest) in communication with informal caregivers, and getting to know each other. Community nurses remarked that there is a tension between whether to have contact with caregivers professionally, or informally, as a friend.

Clarity in task distribution

Community nurses mentioned the importance of clarity in task distribution for effective collaboration to take place. Managing the expectations of caregivers, and making

agreements, are necessary in achieving this, because caregivers sometimes have unrealistic expectations. It is about searching for consensus in terms of who does what, because this is not always strictly clear; it is a continual process of adaptation.

> *"Yes, that never ends, because when you and the other person both think that you know everything, at some point you will fall flat on your face." (p1)*
>
> Box 1

Community nurses and informal caregivers needing each other

All interviewees mentioned that informal caregivers and community nurses need each other in order to allow the person with dementia to live at home for as long as possible. Information from the caregivers about the care recipient is necessary for good care.

> *"…people with dementia are going to show upredictable behaviour. So it is nice to have someone who knows the person with dementia and knows how you should deal with this person and what you should or should not do." (p3)*
>
> Box 2

It is experienced as a facilitator of collaboration that nurses and caregivers need each other, because it means that neither are alone in the care, and they can feel supported by each other. This contributes to a stronger collaboration.

The importance of contact

Contact is important for collaboration. However, contact with informal caregivers can be varying, depending on their level of participation. The frequency and type of contact is adapted in response to what the caregiver wants. Contact with informal caregivers is mainly unstructured, occurring when necessary (for instance, if there is a change in the care recipient's status).

> *"At the moment we bump into things or go awry, then we sit down and work out how to proceed." (p4)*
>
> Box 3

Interviewees commented that unstructured contact feels more natural than structured contact. Facilitators for good contact include keeping caregivers informed, and being easy to reach for each other.

Using inequality

Community nurses experience a different level of emotional involvement than informal caregivers, as well as having different types of knowledge. This may lead to different ideas about care, which was remarked as a barrier in collaboration.

However, communicating about differences in knowledge, and using each other's knowledge, is seen as a facilitator in collaboration.

> *"We have different knowledge. I mean the knowledge of the caregiver is more about who the client is. That knowledge we have to a lesser extent, but that is the fun of collaboration. It needs to come together, and then you have to organize tailor-made care for the care recipient." (p1)*
>
> Box 4

Trust is crucial

Trust is experienced as the most important factor in collaboration. Without trust, collaboration is not possible.

> *"Trust, that is what it is about. Yes… that is the foundation of everything." (p3)*
>
> Box 5

Getting to know each other, being transparent (open and honest), keeping to appointments, and showing expertise all facilitate trust, and thus collaboration. There is often little trust in the beginning, but it is something which grows in time.

Sympathy improves trust

Community nurses show empathy and understanding and this in turn improves levels of trust, and therefore collaboration. The life experience of community nurses is a facilitator to understanding the informal caregiver better. Interviewees also mentioned the importance of showing interest in the informal caregiver, in order to get to know them better, and to improve trust.

> *"And that we can sometimes say to caregivers that it is difficult or that we do not have all the answers, as well." (p1)*
>
> Box 6

Conflicting interests may threaten collaboration

All community nurses interviewed recognized the problem of conflicting interests in the care of people with dementia. Conflicting interests can hinder communication, and thus collaboration. All interviewees highlighted the importance of keeping communicated with

informal caregivers, and taking the time to resolve conflicting interests, in order to proceed in a good way with the collaboration. It was stated that it may help to involve other professionals, such as the general practitioner or the case manager, in handling this issue.

> *"Sometimes we shelter behind the general practitioner's back. Like if they say it, then it…*
> *it has a lot more weight." (p6)*
>
> Box 7

Discussing ethical issues

Informal caregivers are mostly not aware of ethical issues concerning care. Community nurses bring this subject up if serious issues become apparent. It is important to be able to discuss ethical issues, and to communicate openly and honestly about them, to sustain trust in the collaboration.

> *"You have to make it discussable, because when you don't, it stays in the atmosphere*
> *between you. You have to make it discussable in order to be totally open with each other."*
> *(p3)*
>
> Box 8

Evaluating collaboration in an unstructured way

Evaluation of collaboration is seen as important for ongoing learning and achieving goals. However, there are no structured times for evaluation, except for twice a year, which many home care organisations use as a guideline. Community nurses and informal caregivers often evaluate only in a casual way, or when necessary.

> *"If it's not that intense, it can be once every half year. But when it is intense, it can be*
> *every time you see each other to check if things are going okay." (p2)*
>
> Box 9

DISCUSSION

This study has shown that the experiences of community nurses regarding collaboration with informal caregivers of people with dementia are generally positive, but also variable. The facilitators of collaboration were identified as: transparent communication, know each other, clear taskdistribution, needing each other, contact, sharing knowledge, trust, sympathy, and evaluation. Barriers were found in the area of conflicting interests, and reduced participation on the part of caregivers.

The factors and subfactors which scored high in the Collaborationthermometer were mentioned in the interviews as being important factors in collaboration. In this way, the interviews supported and deepened the results of the online survey, and helped clarify which factors were facilitators, and which barriers to collaboration.

According to some studies, collaboration between formal and informal caregivers in elderly care is limited[12]. This is in contrast with the findings of this study, in which community nurses stated that there is collaboration with informal caregivers of people with dementia. An explanation for this discrepancy may be that informal caregivers are more often involved with people with dementia compared to other care recipients who are capable of having control of their own care network.

This study is in line with other studies[13-15] in that it confirms that good communication, good distribution of tasks, and sustaining a good relationship with informal caregivers are all facilitators of collaboration. This study affirms, in addition, that getting to know each other, recognising the need for each other, contact, using each other's knowledge, trust, sympathy with the caregiver, and evaluating the collaboration, are also notable facilitators. The facilitators of having unstructured contact and evaluation with informal caregivers is in line with a study about case managers dementia, which states that case managers evaluate care based on the needs of the client, and informal caregivers in a continuous and informal way[27].

In line with earlier research, this study highlights that different ideas about the care (conflicting interests), overburdened caregivers, and poor communication are all barriers to collaboration[13-15]. A high demanding care recipient was not found as a barrier of collaboration as it has been in earlier studies[13]. This study adds that another barrier to collaboration is reduced participation in care by the caregiver.

According to this study's findings, in order to succeed in collaboration, community nurses are required to demonstrate a number of competencies and skills, especially regarding communication techniques.This is in line with a study on the subject of interprofessional collaboration, which states that competencies in communication and a good understanding of one's role are important for effective collaboration, and for achieving positive outcomes in the care of the elderly[28].

A strength of this study is its mixed methods design, in that this made it possible to achieve triangulation in the study, and to deepen understanding of the results of the online survey through use of interviews. Furthermore, the coding of the data by two independent researchers, the intercoder agreement, and the member check (no community nurses had adverse remarks on the accuracy of the summaries provided), as well as the fact that this research was peer reviewed several times, all constitute strengths of this study.

Some limitations to the study can also be identified. There was no data saturation achieved; however, the six interviews were sufficient to explain the quantitative results in more detail,

and to allow for exploration of meaningful themes. Also, the researcher was rather inexperienced in interviewing, which is why a test interview was conducted, and to improve the quality of the subsequent interviews through adaptation of the interview techniques. The high scores given with the Collaborationthermometer may have indicated socially desirable responses in this self-reported online survey, as well as in the interviews. In order to gain clarity about this, further observational research is needed. Furthermore, this study only investigated the perspectives of community nurses; the perspectives of informal caregivers are missing. It is known that informal caregivers of people with dementia do not always receive the professional support they need[8]. This may be because of poor collaboration, or the lack of professional support may influence collaboration in a negative way. It is therefore important that the experience of collaboration from the perspective of informal caregivers also be explored, as a point of contrast, and to gain more insight into the aspects of collaboration which merit more attention.

In conclusion, this study explored there is collaboration between community nurses and informal caregivers of people with dementia, and found that on the whole this experience is positive. This is an encouraging finding, as community nurses and informal caregivers increasingly need to work together. According to the nurses themselves, the facilitators of collaboration are mainly related to communication, task distribution, needing each other, and good levels of contact, of which trust is a major requirement. The barriers to collaboration are identified as relating to conflicting interests and reduced participation by the caregiver. Community nurses need to be supported in acquiring education in key competencies and skills to maintain and strengthen collaboration with informal caregivers, and universities and home care organisations could play an important role in this respect.

It is recommended that further, observational research be carried out to gain more insight into collaboration between community nurses and informal caregivers, and to explore the experiences of informal caregivers of people with dementia, to optimize collaboration in the future.

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TABLES

Table 1 Demographic characteristics		
	Online Survey **N=120**	**Interviews** **N=6**
Age (years) Mean (SD, range)	41.1 (12.3; 22-63)	45.0 (13.5; 22-57)
Gender (female) n (%)	112 (93.3)	6 (100)
Working experience as a nurse (years) Mean (SD, range)	16.4 (11.7; 0.5-44)	18.1 (10.8; 1.5-32)
Working experience as a district nurse (years) Mean (SD, range)	8.1 (7.6; 0-36)	8.92 (8.6; 1-22)
Working area, n (%) -Urban area -Rural area -Urban area and rural area	29 (24.2) 79 (65.8) 12 (10.0)	0 (0.0) 6 (100.0) 0 (0.0)
Number of clients with dementia per nurse Mean (SD, range)	11.9 (14.0; 0-80)*	11.0 (7.4; 4-25)
Contact with informal caregivers (number) Mean (SD, range)	11.6 (13.2 ; 0-80)*	8.8 (6.2; 0-18)

*missing data: 1.

Table 2 Outcomes online survey	
	Mean (SD)
Collaboration overall	**7.5 (.72)**
Distribution of tasks	**3.9 (.34)**
How is the distribution of tasks between you and caregivers?*	7.1 (.73)
It is clear to me what my tasks are compared with caregivers.	4.3 (.57)
The tasks of the caregivers are clear to me.	4.0 (.66)
During evaluation it is noticed there is clarity about who is does what.	4.0 (.73) N/A: 2
I know of any caregivers what he/she can do and which knowledge they have.	3.5 (.84)
I do my tasks and if possible I leave work for the caregivers.	4.0 (.77)
I let go the discussed tasks of the caregivers.	4.1 (.74) N/A: 1
Caregivers ask timely for my help if tasks are my responsibility.	3.4 (.94)
I evaluate the distribution of tasks with caregivers if needed.	4.3 (.63) N/A: 3
Needing each other	**4.0 (.23)**
Do you know as a professional why you need caregivers?*	7.7 (1.05)
I know at what tasks caregivers can be involved in my work.	4.1 (.61)
I know exactly what caregivers do.	3.6 (.77)
I ask to caregivers work in order to adapt my work.	3.9 (.81) N/A: 1
My information is important to caregivers to do their work.	4.1 (.60)
I exchange information, knowledge and ideas towards caregivers.	4.3 (.63)
The tasks I do are important for caregivers to do their tasks.	4.1 (.70)
Regularity of contact	**4.0 (.61)**
How satisfied are you about the frequency of contact with caregivers?*	7.0 (1.33)
I have regular contact with caregivers.	4.0 (.80) N/A: 1
I have names and contact-information of all caregivers with me.	4.3 (.73)
I let caregivers know when they can reach me.	4.4 (.63)
When caregivers want to contact me, I react quickly.	4.5 (.53)
I take into account the agendas of the caregivers by planning appointments.	4.3 (.54) N/A: 1
I have a fixed time for deliberation with caregivers.	2.6 (1.02) N/A: 3
I contact caregivers for deliberation if needed.	4.4 (.58)
I plan my work in order to be present at caregivers deliberations.	3.8 (.89) N/A: 4
Issues of inequality	**4.1 (.26)**
How satisfied are you with the way you handle inequality between you and caregivers?*	7.2 (.99)
I am aware of the shortage in information and experience which caregivers can have.	4.3 (.57)
I am aware of the shortage in information I can have in comparison with caregivers.	4.2 (.57)
I invite caregivers explicitly for their input.	4.3 (.69)

I feel that caregivers take me serious when I make my points.	4.1 (.58) N/A:1
I involve the (different) caregivers in making decisions.	4.2 (.70) N/A: 1
Caregivers involve my by their decisions.	3.8 (.71) N/A: 2
Trust	**4.2 (.25)**
How is the trust between you and the caregivers?*	7.5 (.79)
I feel a 'connection' with caregivers.	3.9 (.63)
I stick to the appointments I made with caregivers.	4.5 (.52)
I discuss it when I fail to meet appointments.	4.4 (.56) N/A: 1
I trust caregivers in what they can and their knowledge.	4.1 (.59)
I trust caregivers that they have a good contribution.	4.4 (.61)
I am honest about my knowledge, skills and task performance.	4.4 (.51)
I dare to be vulnerable in the collaboration with caregivers.	4.2 (.66)
I give space to caregivers to be honest about their knowledge, skills and work.	4.4 (.51)
See somebody else's perspective	**4.0 (.37)**
Can you and the caregivers see somebody else's perspective?*	6.9 (1.10)
I am interested in the caregivers.	4.2 (.59)
Caregivers are interested in me.	3.4 (.72)
I understand the situation in which the caregiver are.	4.4 (.49)
I experience understanding of the caregiver for the situation in which I am in my professional role.	3.8 (.66)
As a caregiver has a different opinion, I ask open questions and question through.	4.2 (.56)
If I have a different opinion, I find a sensitive way to transfer.	4.2 (.51)
As a caregiver has a different opinion, I listen without judging.	4.1 (.60)
If someone is emotional, I show empathy.	4.3 (.51)
Conflicting interests	**3.8 (.31)**
How well do you handle conflicting interests in cooperation with caregivers?*	6.8 (.82)
It happens that my interest as a professional is different from the caregiver or concerned client.	3.9 (.65) N/A: 1
If we divide the work, I start from the client's interest and then I go out of the interests of the caregivers.	3.9 (.73)
If caregivers wants to do work at the expense of the client, I help the client in his interest.	4.2 (.56) N/A:1
If I do work at the expense of the client, caregivers tell me.	3.4 (.76) N/A: 4
If I experience a conflict of interest in collaboration with caregivers, I discuss that.	4.0 (.57)
We have clear agreements to avoid conflicting interests in the work.	3.5 (.71) N/A: 3
Ethical issues	**3.8 (.22)**
How do you cope with ethical issues with caregivers?*	7.0 (.97)
I discuss the ethical side of how we deal with each other and those involved with the caregivers.	3.9 (.70) N/A: 3
When I face an ethical issue, I discuss it with caregivers.	4.1 (.56) N/A: 3
If caregivers face an ethical issue, they discuss it with me.	3.6 (.70) N/A:4
We solve ethical issues well in our collaboration.	3.8 (.62) N/A: 3

The client's interest goes above differences in opinion on ethical issues.	4.0 (.64) N/A: 2
In our code, our values of the support are described in an understandable way for caregivers.	3.6 (.67) N/A: 5
Evaluating collaboration	**3.7 (.24)**
To what extent do you reflect on how you work with carergivers?*	6.9 (1.04)
I take time to speak about our way of working and communicating together with caregivers.	3.9 (.77) N/A: 1
I ask caregivers in a conversation how they experience my work.	3.7 (.85)
I take a structured moment to ask how caregivers experience the collaboration with me.	3.4 (.98) N/A: 3
I give feedback to caregivers about how they act.	3.7 (.77) N/A: 2
Caregivers give feedback to me about how I act.	3.6 (.76) N/A: 1
I change my actions or process as a result of the feedback or evaluation.	4.0 (.69) N/A: 2
I inform caregivers about changes I have made as a result of evaluation or feedback.	4.0 (.67) N/A: 4

NB. All answering categories range from 1 – 5 (1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree), except those with *. * ranges from 1 – 10 (1 is not good at all, 10 is very good). N/A is the number of filling in not applicable. Missing data is 0.