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Toward a conceptual framework for the interdisciplinary function-focused care in nursing homes

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Abstract

Aim: To develop a conceptual framework to structure the shared roles and tasks of interdisciplinary teams for efficient function-focused care of nursing home (NH) residents.

Methods: A qualitative study using focus groups. Two focus group interviews were conducted on NH practitioners and professors. Focus group 1 consisted of six practitioners with more than 5 years of practical experience in NHs. Focus group 2 consisted of six professors with more than 5 years of educational experience in geriatrics or gerontology and who are capable of adopting theoretical approaches to older adults' functions.

Results: The post-acute care-rehabilitation quality framework furnished the underlying structure for the focus group interview questionnaire to develop the shared interdisciplinary function-focused care framework. The focus of the framework is how resident care processes should be based on individuality of the residents and include holistic continuous assessments, integration of care, and professional interventions by each discipline. An interdisciplinary process involves setting shared goals, communicating and coordinating roles and tasks of interdisciplinary teams, and providing complementary care. Shared final outcomes are defined as improving residents' independence and quality of life and reducing hospital transfer and admission rates.

Conclusion: In this study, we have developed the first conceptual framework of interdisciplinary function-focused care in NHs, which will provide an evidence-based foundation for integrated and continuous function-focused care for NH residents. The results of this study will contribute to efficient communication among the interdisciplinary teams and improvement of the outcomes of function-focused care subjects.

KEYWORDS

focus groups, geriatric nursing, interdisciplinary studies, nursing homes, qualitative research

1 | INTRODUCTION

Asia is witnessing a rapidly growing population of older people both in size and speed while aging is a globally recognized phenomenon (Horioka, Morgan, Niimi, & Wan, 2018; Rishworth & Elliott, 2019). Japan was the first country in Asia to introduce the Long-term Care Insurance Act in 2000, followed by South Korea's Long-term Care Insurance in 2008 which allowed for facilities such as nursing homes (NHs) where older people are admitted to receive

care (Iwagami & Tamiya, 2019; National Health Insurance Service, 2018). A NH is a residential space for older people in the last chapter of life, and it can be the place where they spend the longest period of their lives, depending on the functional and the physical-cognitive status of the subject (de Mazières et al., 2017). According to the national insurance standards in Japan and South Korea, NH residents are classified into levels 1 to 5 based on their physical-cognitive status and multiple types of care are provided to the ones with complex health problems (Iwagami & Tamiya, 2019; Park, Lim, Kim, Lee, & Chang, 2018). Pursuing the optimal functional status is also the focus of care in NHs for older people (Resnick, Galik, Boltz, & Pretzer-Aboff, 2011).

An interdisciplinary approach is especially emphasized in NHs because it can improve physical, social, and cognitive functioning of the frail residents with complex health status (de Mazières et al., 2017). Care goals should be based on a foundation of accurately assessed care needs. The interdisciplinary team should consistently support these goals with continuous and integrated care (Lemieux-Charles & McGuire, 2006; Nazir et al., 2013). Function-focused care is a philosophy of care that focuses on evaluating the older adult's underlying capabilities for function and physical activity, and helping him or her optimize and maintain functional abilities and increase time spent in physical activity. This philosophy of care is one that views physical function as a dynamic process with opportunities for practitioners to promote functions for residents of varying levels of capability. Function-focused care has mostly been used in NHs to achieve the highest possible levels of self-care and independence for residents (Galik, Resnick, Hammersla, & Brightwater, 2014; Resnick, Galik, Boltz, & Pretzer-Aboff, 2011; Resnick, Galik, Gruber-Baldini, & Zimmerman, 2011).

Federal Regulations Section 483, mandates "an interdisciplinary approach for NH care planning. It requires evaluations by an interdisciplinary team that includes the physician, a registered nurse, and other appropriate staff in disciplines as determined by the resident's needs" (U.S. Government Publishing Office [GPO], 2011). However, the Federal Guidelines do not define specific details of the organization and operation of care services for older people (Nazir et al., 2013).

de Mazières et al. (2017) suggested providing multidomain intervention, which includes nurses, nursing assistants, geriatricians, pharmacists, psychologists, dieticians, physiotherapists, and occupational therapists as an interdisciplinary team to prevent deterioration in the functioning of older people in NHs. Nazir, Bernard, Myers, and Abrahamson (2015) and Abrahamson, Myers, and Nazir (2017) proposed an interdisciplinary team for post-acute care (PAC) in a skilled nursing facility, which includes patients/residents and their families, physicians, physical/occupational therapists, social workers, nurse practitioners, nurses, nursing assistants, and nursing care providers. All members of the interdisciplinary team participate in care planning meetings to set goals, exchange feedback, and evaluate team performance through regular meetings. Such team-approach care can help avoid redundant care, provide systematic care, and reduce time and costs by clarifying division and collaboration (Kushner, Peters, & Johnson-Greene, 2015; Siebens Patient Care Communications, 2017). In South Korea and Japan, in fact, multiple caregivers such as physicians, nurses, nursing assistants, professional caregivers, care managers, social workers, and physical/occupational therapists are working together to provide functional care to the residents.

However, practical knowledge and evidence for the role of the interdisciplinary function-focused care in NHs are unclear, that is, which members (who) of the care team perform which care tasks (what) and why (Nazir et al., 2013). Therefore, the purpose of this study is to develop a preliminary conceptual framework that structures the shared roles and tasks of interdisciplinary teams for function-focused care of residents in NHs.

2 | METHODS

This study was conducted in three steps. In the first step, a literature review was undertaken to identify a model or framework for NH interdisciplinary function-focused care. In the second step, focus group interviews were conducted with NH practitioners and professors to develop the preliminary conceptual framework. In the last step, the framework was finally revised through consultation with the expert group and evaluation of the content validity.

2.1 | Step 1: Literature review

In order to perform a literature review for an interdisciplinary function-focused care model or framework for older people in NHs, we searched for keywords such as (model or framework) AND (function* or function-focused care) AND (*disciplinary) AND (older people or nursing homes), through the Web of Science (WOS), Pubmed, MEDLINE, and CINAHL, for the period between 2000 and 2017. The inclusion criteria were the studies that: (a) focused on populations of older people in NHs; (b) addressed function-focused care; (c) included interdisciplinary approaches; and (d) presented a model or framework. The exclusion criteria were studies that: (a) focused on a single discipline; and (b) did not have a model or framework present. However, there were no

studies found under the above mentioned search terms in the inclusion criteria. Therefore, we manually researched the proposed model or framework of care for function in each academic field and two researchers independently reviewed and screened these studies based on their titles, abstracts, and full texts. After sufficient discussion, we succeeded in discovering the PAC-rehab quality framework (Jesus & Hoenig, 2015), referenced in this study, which we agreed was the most suitable for our conceptual framework development.

This framework has been developed as an evidence-based conceptual framework to consistently deliver, measure, and improve the quality of post-acute rehabilitation therapy. This framework is applicable to long-term care facilities, and suggests that care for function should be provided with consideration of interdisciplinary concepts. However, its focus is on rehabilitation rather than comprehensive function-focused care, and the study targets patients in need of rehabilitation, not older people. The framework needs to be supplemented and reconstructed in order to be applicable to a conceptual framework for the shared roles and tasks of interdisciplinary teams in function-focused care in NHs.

2.2 | Step 2: Development of a preliminary conceptual framework

Focus group interviews are often used to identify perspectives for an appropriate and effective care plan among various health services (Barbour, 2007). In particular, multidisciplinary research teams in focus groups can provide fresh insights. Therefore, in this study, a focus group interview was selected as a research method to develop a framework for interdisciplinary function-focused care in NHs.

2.2.1 | Participants

Purposive sampling was used to recruit participants suitable for the study purpose (Morgan, 1997). Considering the homogeneity and segmentation of participants, we divided them into two groups: practitioners and professors assigned to each group. Focus group 1 consisted of six practitioners with more than 5 years of practical experience in NHs. Focus group 2 consisted of six professors with more than 5 years of educational experience in geriatrics or gerontology and who are capable of adopting theoretical approaches to older adults' functions. Table 1 indicates the characteristics of the participants in each group.

2.2.2 | Data collection

The focus group interviews were semi-structured and guided by key questions (Barbour, 2007). The key questions were formulated based on the PAC-rehab quality framework selected at the literature review stage (Jesus &

TABLE 1 Characteristics of participants in the two groups

Characteristics	Group 1: practitioners in nursing homes ($n = 6$)	Group 2: professors ($n = 6$)
Age	Mean 40.3 (*SD* 13.0)	Mean 51.5 (*SD* 5.3)
Gender	Female 6	Male 1
		Female 5
Occupation	Nurse 2	Nursing professor 2
	Physical therapist 1	Physical therapy professor 1
	Occupational therapist 1	Occupational therapy professor 1
	Social worker 1	Social welfare professor 1
	Nutritionist 1	Nutrition professor 1
Education level	Bachelors 3	PhD 5
	Associate of Arts 3	Masters 1
Total years of educational experience in geriatrics or gerontology	—	Mean 13.3 (*SD* 7.5)
Total years of clinical experience	Mean 10.4 (*SD* 7.5)	Mean 14.2 (*SD* 8.9)
Total years of nursing home experience for function in nursing homes	Mean 5.0 (*SD* 2.7)	—

TABLE 2 Focus group interview questionnaire (based on PAC-rehab quality framework, Jesus & Hoenig, 2015)

	Elements based on PACs	Focus group interview questionnaire items
1	Outcomes	What are the goals of the shared interdisciplinary function-focused care for improving the functioning of elderly people living in nursing homes?
2	Process: patient care process	What categories should be included to develop a shared interdisciplinary function-focused care framework for improving the functioning of the elderly in nursing homes? Can you describe in detail? And who do you think should take charge of it for any reason?
3		What kind of care area and contents (e.g., assessment, intervention) are needed for interdisciplinary function-focused care for improving the functioning of the elderly living in nursing homes, based on your practical experience?
4	Process: interprofessional processes	In what areas do you require cooperation when assessing subjects?
5		What specific areas of cooperation do you need when providing intervention to your subjects?
6		What kind of and what degree/amount of information do you think other experts should receive regarding the care I have provided to the residents on the shared interdisciplinary function-focused care for the improvement of the elderly residents in nursing homes?
7		What collaborative care do you expect other experts to provide for interdisciplinary function-focused care for the elderly in the nursing care facility?
8		What do you think are the strategies and methods for interdisciplinary function-focused care for improving the functioning of the elderly residing in nursing homes?
9	Structure: personnel, facilities and equipment, organizational management	What personnel, facilities and equipment, organizational management do you think are needed/necessary for interdisciplinary function-focused care for improving the functioning of the elderly residing in nursing homes?
10		Why do you think it is difficult to carry out shared interdisciplinary function-focused care to improve the functioning of the elderly living in nursing homes?

Hoenig, 2015) (Table 2). The practitioners were asked about their experiences and interdisciplinary perspectives on function-focused care in NHs. The purpose of the study was explained to all participants, and they voluntarily completed and signed a demographic questionnaire and informed consent. Participants were assured that the information they provided would remain confidential. Focus group interviews took place at the university's conference room from February to March 2017. Each focus group interview was approximately 80–120 min long, recorded on a digital recording device, and later on transcribed verbatim. The study was approved by the Institutional Review Board of Korea University.

2.2.3 | Data analysis

The framework analysis of Ritchie and Spencer (1994) was employed in analyzing the data gleaned from the focus group interviews. According to Ritchie and Lewis (2003), framework analysis helps to build a hierarchical thematic framework to classify data into key themes and emergent categories. The approach has the virtue of being clear and evident regarding a thematic methodology (Ward, Furber, Tierney, & Swallow, 2013). It shows transparent and simple results and derives conclusions that can be easily related to the original data (Johnston, Milligan, Foster, & Kearney, 2012).

We used the following five steps of framework analysis for the analysis of our study: (a) familiarization; (b) identifying a thematic framework; (c) indexing; (d) charting; and (e) mapping and interpretation. All steps were conducted manually by one researcher, and then verified by two researchers. Data were read, discussed, analyzed, and cross-compared by these researchers to ensure that all data were captured and interpreted accurately in the analysis.

2.3 | Step 3: Validation test of the framework by experts

The contents of items in the framework were verified by six experts, which consisted of two nursing professors, one practitioner from a NH, one physical therapy professor, one occupational therapy professor, and one social welfare professor. Based on the preliminary framework developed, a content validity questionnaire was designed, and the validity of the three domains (structure, process, and outcomes), five sub-domains (resident's care process, interdisciplinary process, patient-centeredness, the focus of evaluation by discipline, and shared final outcomes), and 20 preliminary framework items were verified. A validity test was used to determine content validity with a five-point Likert response scale. Any recommendations were commented on each question, and then an index for content validity (CVI) was computed. Those with more than 80% agreement were selected as appropriate (Lynn, 1986). Furthermore, through an iterative process, experts provided consultations to establish the face validity of the framework development process and to help the researchers modify the framework.

3 | RESULTS

Figure 1 provides an overview of the elements involved in the framework and their relationships. As in the PAC-rehab quality framework (Jesus & Hoenig, 2015), the structure, process, and outcomes (SPO) model of Donabedian (1988) is the overall structure for our conceptual framework. The final framework was derived as follows.

3.1 | Structure

The structure is composed of personnel, facilities and equipment, organizational management, environmental context, and external healthcare environment. In our framework (for interdisciplinary function-focused care in NHs), personnel are the members of an interdisciplinary team such as a nurse, a physical therapist, an occupational therapist, a social worker, and a nutritionist providing function-focused care to residents. Facilities and equipment can include electronic infrastructure and software such as integrated systems to support the decision-making process, and internal and external consulting or communication. Organizational management, such as organizational training for function-focused care or interdisciplinary team meetings, plays an important role in implementing the interdisciplinary function-focused care more easily within the NH.

The environmental context includes a home-like therapeutic environment that helps the residents build emotional stability and actively participate in adapting to the environment and care provided in NHs, an appropriate place or time for multidisciplinary communication, and the availability of volunteers who can continually support function-focused care. The external healthcare environment includes external organizations that conduct NH certification assessments or cooperative medical or rehabilitation organizations within the community.

> "Our interdisciplinary team not only conducts case studies but has regular meetings where we share newly gathered information of the residents and discuss plans and execution for each discipline, which makes it possible for interdisciplinary function-focused care to be implemented in our organization." (Group 1, Social worker)

3.2 | Process

Process refers to practitioners' actions that affect the residents' outcomes, which is composed of residents' care process and interdisciplinary process. Residents' care process involves practitioners' actions that directly contact residents and affect their function. There are four components: tailored care based on individuality of the residents, holistic and continuous assessment, coordination of care, and professional intervention by disciplines.

3.2.1 | Residents' care process

Tailored care based on individuality of the residents. The function-focused care processes for NH residents should be able to provide tailored care based on the individuality of the residents. It is when considering not only universal traits of frailty and chronic illnesses, but individual characteristics of older residents when tailored care with a focus on unique problems and needs becomes available, even if they share a similar residual functional capacity.

> "The most important thing in terms of functional improvement is tailored care. Identifying the residents' needs is what matters. For instance, residents show high satisfaction when we identify their previous hobbies or occupations and reflect these in the programs." (Group 1, Occupational therapist)

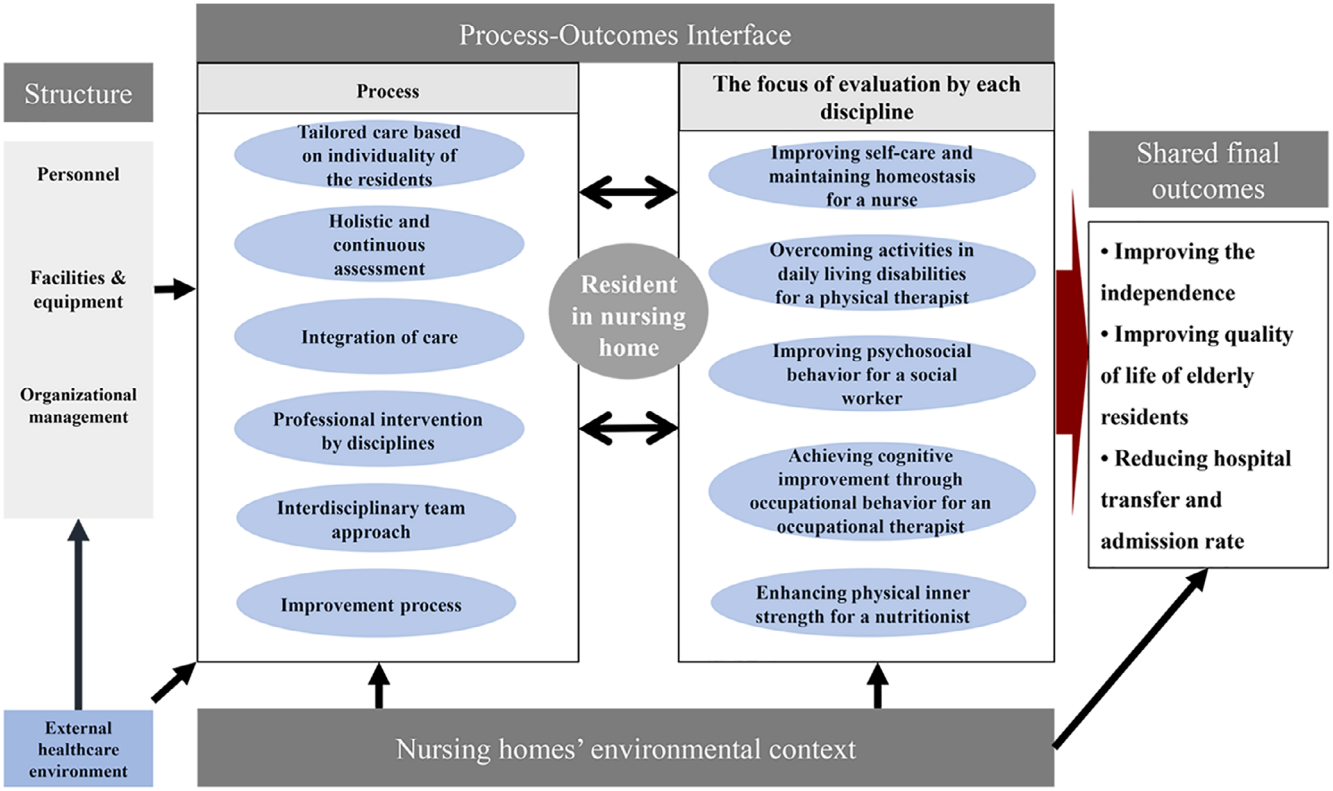

FIGURE 1 Conceptual framework for the shared interdisciplinary teams in function-focused care in nursing homes

Holistic and continuous assessment. The function-focused care processes for NH residents should perform a holistic assessment through sharing interdisciplinary assessment data throughout the disciplines as well as among individual disciplines. For example, a nurse makes an assessment on activities of daily living (ADL), cognitive function, communication, pain, range of motion (ROM), physical needs, spiritual/psychosocial needs, medication, and underlying diseases, while a physical therapist performs an assessment on muscular strength, gait, ROM, physical needs, pain, ADL, cognitive function, and communication. They are required to share the data that are not aspects of the common assessment areas as well as data from the common areas such as spiritual/psychosocial needs, medication, underlying diseases (nurse), muscular strength, gait, and ROM (physical therapist). Also, the functional status of an older resident changes over time. Interdisciplinary function-focused care in NHs, therefore, should focus on following up with comparisons and changes in the residents' status through continuous assessment to identify undiscovered problems and needs.

> "When a physical therapist performs a risk assessment for falling down before gait training, he or she checks with the nurse for information on medication and underlying diseases. Everyone on the team is aware of the information." (Group 1, Physical therapist)

Integration of care. Integration of care in the function-focused care processes for NH residents refers to the process of identifying and integrating documentation or medical records such as assessment data for outpatients or long-term care insurance institutions, external lab test reports, or referrals, as well as internal records related to function, in order to maintain and optimize the functional capabilities of older residents.

> "As much as we need to check on the assessment charts of other practitioners at the NH, we make copies of or scan the test results in case the resident has completed a pulmonary function test or a swallowing exam at an outpatient clinic and use them for a handover procedure." (Group 1, Nurse 1)

Professional intervention by disciplines. The function-focused care processes in NHs should maintain the optimal functional status of the residents by providing the utmost level of specialized interventions by each

discipline. A nurse, for instance, provides medication and ADL training, and a social worker engages in programs or counseling for socialization of the residents.

> "Because NHs do not have all the occupations available, their roles could be somewhat flexible; however, detailed interventions related to the residents' functions must be provided with expertise from each discipline." (Group 2, Physical therapy professor)

3.2.2 | Interdisciplinary process

Interdisciplinary team approach. Interdisciplinary function-focused care in NHs provides interventions by sharing roles based on sufficient communication regarding expectations on the professional roles of their own and of other disciplines in order to achieve the established goals. Also, interdisciplinary function-focused care in NHs solves problems by providing complementary care through information sharing on the care plans of each discipline and interdisciplinary consultation.

> "If, for example, a resident doesn't eat as much as before and experiences general weakness and a decline of overall function, we nutritionists check on the types of food and the form of intake. We then consult nurses and physical therapists on any recent changes in swallowing or hand movement, or any decline in muscular strength, and if there is a problem, we make a request for an intervention." (Group 1, Nutritionist)

Improvement process. Interdisciplinary function-focused care in NHs should integrate the viewpoints of each discipline to set priorities for each resident. The functional status of residents finds balance when care is provided, focusing on the functional problems and needs based on shared priorities. Also, in the interdisciplinary function-focused care in NHs, the goals of each discipline and the shared goals should be established through a process mediated by a coordinator, and the goals should be balanced across disciplines.

> "We work on the plans together for a particular resident in a case study or in a meeting and in the process, we listen to how the interdisciplinary team views the agenda in order to address the most critical problems first." (Group 1, Social worker)

3.3 | Patient-centeredness

Interdisciplinary assessments and interventions in interdisciplinary function-focused care in NHs are centered on the residents. The residents can be categorized based on their residual functional capacity, and tailored care is provided, reflecting the functional assessments, interventions, and goals designed for each category. Function-focused care must be carried on continuously from the moment of admission to the moment of discharge or death.

> "We provide an interdisciplinary function-focused care, large and small, from the moment of admission and to the moment of death in order to maintain the optimal status of the residents' residual functional capacity." (Group 1, Nurse 1)

3.4 | Outcomes

Outcomes refer to the positive effects derived from healthcare. In order to reflect the viewpoints and complexities of each discipline, the outcomes are broken down into immediate intermediate outcomes, which are the focus of evaluation by each discipline, and the shared final outcomes, which are shared goals across the interdisciplinary function-focused care system.

3.4.1 | The focus of evaluation by discipline

The focus of evaluation for each discipline in the function-focused care in NHs is as follows: improving self-care and maintaining homeostasis for nurses, overcoming ADL disabilities for physical therapists, improving psychosocial behavior for social workers, achieving cognitive improvement through occupational behavior for occupational therapists, and enhancing physical inner strength for nutritionists.

> "Basically, the focus of evaluation of a physical therapist and an occupational therapist is as follows. The physical therapist looks into the ability to overcome disorders in daily living, developed by increased activity based on mobility, stability, gross motion, and ADL, while the occupational therapist pays attention to the improvement of cognitive function through fine motor function and

occupational behavior." (Group 2, Physical therapy professor)

"I believe for a nurse, the most crucial aspect is to promote self-care and to maintain homeostasis of the residents whereas for a nutritionist, it is to enhance the inner strength of the person because in the end it is the body that needs to support the functional maintenance." (Group 1, Nurse 1)

3.4.2 | Shared final outcomes

What the shared final outcomes ultimately aim at are improving the independence and quality of life of older residents and reducing hospital transfer and admission rates through interdisciplinary function-focused care.

"The goals we all share are to make sure that the tasks we perform are effectively implemented so that the residents can move on their own, feel better, and experience changes in their daily lives, which will ultimately improve the quality of life." (Group 1, Occupational therapist)

"When the residents show functional improvements, it eventually leads to less frequency of ER transfer and hospitalization. All sorts of functional impairment call for higher chance of hospitalization." (Group 1, Nurse 2)

4 | DISCUSSION

In this study, we conducted focus group interviews based on the PAC-rehab quality framework, which served as a reference for our framework at the literature review stage (Jesus & Hoenig, 2015). Within this framework, we then identified who takes charge in what type of structure in the interdisciplinary function-focused care of the residents in NHs, and were able to develop a preliminary conceptual framework and verify its validity. In the process of developing the framework, professors were involved as well as practitioners of the interdisciplinary teams at NHs. This conceptual framework has thus been developed based both on theoretical and practical perspectives, and therefore provides guidelines for interdisciplinary practitioners on how to best implement function-focused care philosophies in real-world NH settings.

The major differences from the PAC-rehab quality framework which is the reference of our framework are as follows (Jesus & Hoenig, 2015). First, since the PAC-rehab quality framework solely focuses on rehabilitation, the personnel in the structure were defined as licensed rehabilitation providers. However, in our framework the personnel involve a comprehensive interdisciplinary group that provides function-focused care to the NH residents: nurses, physical therapists, occupational therapists, social workers, and nutritionists.

In the process, the care subject has been modified from rehabilitation patients to NH residents, and the care provider from rehabilitation experts (team) to interdisciplinary practitioners. The residents' care process has been derived from the patient care process, and likewise, the interdisciplinary processes from the professional processes. The holistic and continuous assessment of our framework has been derived from the amount and timing of rehabilitation in the patient care process of the PAC-rehab quality framework. While the PAC-rehab quality framework emphasizes the initiation, timeliness, frequency, intensity, and duration of interventions, our framework takes a view of multifaceted and holistic assessments that enable us to ascertain the undiscovered needs which are difficult to find through the results of a single discipline. Continuous assessments also allow us to ascertain the resident's status that changes every moment, which provides a basis for placing our focus on assessment instead of intervention.

The specific interventions have been modified to professional interventions by each discipline in our framework. The term coordination of care also has been altered to integration of care. The guidelines suggested in the PAC-rehab quality framework have not been derived from our framework, supposedly because existing models or guidelines that could provide guidance to interdisciplinary function-focused care have been absent. Our framework will provide an evidence-based foundation for integrated and continuous function-focused care for NH residents.

In the PAC-rehab quality framework, interprofessional processes involve the processes in which the rehabilitation team practitioners complement each other's actions and collaborate to coordinate care and ultimately optimize patient outcomes. Our framework, similarly, has developed interdisciplinary processes in which practitioners have sufficient communications on their expectations and roles of each discipline, share information, and provide consultations in the process of setting care plans with an interdisciplinary team approach in order to provide complementary care to the residents.

The improvement process in the PAC-rehab quality framework pursues quality improvement through monitoring

the performance of rehabilitation providers and comparison/comparisons with peer providers. However, in our framework the process where interdisciplinary practitioners work together to establish shared priorities and goals has turned out to be more effective than having each discipline work independently.

Lastly, the immediate and intermediate outcomes in the PAC-rehab quality framework include body structure, functional capacity, and psychosocial behavior due to the framework's focus on functional recovery through rehabilitation, while in our framework, the focus areas of each discipline's assessment have been derived in the short term. These results are in agreement with previous research findings identifying the regularity of information sharing in managing daily function for older adults in NHs, with a special focus on interdisciplinary cooperation. Park's study (2019) demonstrated "Independent sharing to clarify the responsibilities and roles of each practitioner" and the keywords extracted from the analysis included the assessment and evaluation of each discipline. Reducing hospital transfer and admission rates were proposed as the final outcome. The terms – function-focused care and restorative care – were interchangeably used, which were fundamentally referred to as having a goal of preventing the residents from functional impairment. The final outcome was deemed crucial because in case the resident experienced severe functional deterioration, the chances were high that he/she would be transferred or hospitalized.

The limitations of this study are as follows. First, literature reviews have limitations due to the number of studies identified for this research and the possibilities that relevant studies had not been included in the search results because of the search terms we used, or because they were simply not listed in the databases we had access to. Second, the focus group interviews were conducted only once for each group, and participants such as physicians, pharmacists, and psychotherapists suggested in the research studies performed overseas were excluded because they do not reside at NHs or directly provide function-focused care. However, we designed a practitioner group of nurses, physical/occupational therapists, social workers, and nutritionists, considering the distribution of personnel that provide function-focused care at most NHs. The framework has been solidified in the process of the second group (professors) interviews, where we explained the elements derived from the first group (practitioners) interviews, discussed additional thoughts, and held a debriefing session. Third, test results of the implementation of this conceptual framework in NHs have not been included. For instance, further research is required to find out whether NH residents experience functional improvement, by analyzing patient outcomes such as quality of life, independence in ADL, psychological well-being, and social functioning, after having implemented the framework for a certain period. Furthermore, as the current findings are applicable only to the samples in South Korea, there is room for the proposed framework to be refined in a global setting.

5 | CONCLUSION

In this study, we have developed the first conceptual framework of interdisciplinary function-focused care in NHs, which will provide an evidence-based foundation for integrated and continuous function-focused care for NH residents. The results of this study will contribute to efficient communication among interdisciplinary teams to optimize and maintain residents' functional abilities. This conceptual framework for NHs, furthermore, can be applicable to educational and integrated systems for practitioners of interdisciplinary function-focused care.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

AUTHOR CONTRIBUTIONS

Study design: S.O.C and M.S.K.

Data collection and analysis: M.S.K, S.J.L, M.S.P, E.J, and S.O.C.

Manuscript authorship: M.S.K and S.O.C.

Critical manuscript revisions: M.S.K and S.O.C.

AUTHORSHIP STATEMENT

All authors meet the authorship criteria, and they all agree with the content of the manuscript.

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