

Volume 8, No. 1
April, 2025

e-ISSN : 2685-1997
p-ISSN : 2685-9068

REAL in Nursing Journal (RNJ)

Research of Education and Art Link in Nursing Journal

<https://ojs.fdk.ac.id/index.php/Nursing/index>

A Qualitative Study of Teamwork among Care Providers in the Implementation of Interprofessional Collaboration in Hospitals

Mera Delima¹, Regidor III Dioso², Tanti Anggreiniboti³, Anferi Devitra⁴



**UNIVERSITAS
FORT DE KOCK
BUKITTINGGI**

Nursing Study Program
Universitas Fort de Kock Bukittinggi, Indonesia

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ABSTRACT

Background: Interprofessional collaboration is a key element in providing high-quality patient care. Interprofessional Collaboration (IPC) practice is a form of collaborative cooperation between health workers to ensure optimal patient care. Professional Care Providers (PCP) with different professional backgrounds are required to contribute individually and in teams. This study aims to determine the description of team collaboration practices between PCP in implementing Interprofessional Collaboration at the Hospital. **Methods:** This study used a qualitative design with a phenomenological approach to explore interprofessional collaboration practices at the Hospital. Data collection was carried out through in-depth interviews and Focus Group Discussions. The collected data were recorded, transcribed, and analyzed using thematic analysis. The research informants numbered 12 people, consisting of 3 hospital services in charge of doctors, 3 nurses, 3 pharmacists, and 3 dietitians. The study took place in October-November 2024. **Results:** The result of the study showed that interprofessional collaboration at the Hospital had not been running optimally. Joint visit activities involving the four professions were very rare. The number of pharmacists and dietitians who should support collaboration were not sufficient in quantity. The clinical competence of nurses in supporting collaboration was still not fulfilled. Most PCP did not understand the concept of IPC well, the dominance of collaboration tended to occur among doctors and nurses, while other professions were less involved. Factors that hinder the optimization of IPC include a lack of understanding of the concept of collaboration, the small number of certain health workers such as pharmacists and dietitians, and the lack of special training related to IPC. **Conclusion:** Hospitals need to make efforts to improve understanding and implementation of interprofessional collaboration through education, training, and strengthening policies that support IPC practices. Socialization of regulations and implementation of Interprofessional Collaboration needs to be carried out periodically so that PCP understands the concept of IPC well. Routine evaluation is also important to ensure the effectiveness and sustainability of interprofessional collaboration in health services.

Keywords:

Interprofessional collaboration, professional care providers, teamwork.

Corresponding author:

Mera Delima

meradelima72@gmail.com

¹Universitas Perintis Indonesia

²Lincoln University College,
Malaysia

duke@lincoln.edu.my

³Universitas Perintis
Indonesia,

tantibotia@hotmail.com

⁴Dr. Drs. M. Hatta, Brain
Hospital Indonesian,
devitra74@gmail.com

Introduction

Interprofessional Collaboration (IPC) occurs when multiple healthcare professionals collaborate with patients,

families, other professionals, and the general public to provide high-quality care (WHO 2010). The process of



fostering effective collaboration between educators, practitioners, and patients/families/communities to provide optimal healthcare services with a focus on health, safety, and quality of life is a process of building and maintaining effective collaborative relationships between clinicians, practitioners, and patients/ families/ communities to provide optimal health care, with respect, trust, shared decision-making roles, and collaboration (Cadet et al. 2024). Improving the quality of healthcare is one of the major challenges in the global healthcare system. Collaboration between health professionals has been identified as one of the effective approaches to ensure patients receive comprehensive and holistic care. This concept is known as Interprofessional Collaboration (IPC), which involves active communication, coordination, and collaboration among multiple healthcare professionals to achieve common goals in patient care (WHO 2010). In the context of hospitals, IPC plays an important role in improving service efficiency, reducing medical risks, and increasing patient satisfaction (Seaton et al. 2021).

However, the implementation of IPC in hospitals still faces various obstacles. Research shows that the main obstacles to implementing IPC include differences in a professional culture, ineffective communication, and entrenched hierarchies in health organizations (Gilchrist, Kholvadia, and Burdick 2024). These obstacles can hurt coordination

between members of the care team, thereby reducing service effectiveness. In addition, the high work pressure and time constraints are also inhibiting factors in building collaborative relationships between health professionals (Pun 2022).

In Indonesia, IPC practices are becoming increasingly relevant with the increasingly complex needs of public health services. Data from the Ministry of Health shows that the incidence of patient safety incidents in several hospitals is still quite high, which is largely due to the lack of effective communication among members of the care team (Sukawan, Meilany, and Rahma 2021). Optimal implementation of IPC is expected to reduce these incidents by encouraging a multidisciplinary approach to providing patient care.

Interprofessional care team (IPC) practice in hospitals is one form of strategic IPC implementation. The IPC team involves various health professionals, such as doctors, nurses, pharmacists, physiotherapists, and nutritionists, who work together to ensure continuity of patient care. Research by Dahlberg and Dahlgren (2015) shows that teams with strong collaboration tend to provide better clinical outcomes than teams with low levels of collaboration. However, the success of the IPC team is highly dependent on factors such as leadership support, interprofessional training, and the existence of adequate support systems (Bosch and Mansell 2015).

IPC is an interdisciplinary team with interprofessional coordination where IPC is positioned to work as a team that surrounds the patient, with independent tasks, collaboration, and delegative tasks. In this case, IPC is required to have adequate professional competence and interprofessional collaboration competence. The Doctor in Charge of Services as the team leader plays a role in preparing the care framework, coordinating, collaborating, synthesizing, interpreting, reviewing, and integrating patient care (SNARS 2018).

Although the literature shows many benefits of IPC, there is a need to understand how this practice is implemented in Indonesian hospitals. Previous studies have focused more on developed countries, with little attention to the local context, especially in terms of organizational culture and different health systems (Fathya, Effendy, and Prabandari 2021). This creates a significant knowledge gap regarding the implementation of IPC in Indonesian hospitals, especially at the operational level of the Professional care team. Bukittinggi Hospital is a type B regional referral hospital that has been accredited by KARS since 2022 and continues to strive to improve the quality of its services. Regulations regarding interprofessional collaboration practices have been regulated in the "Patient Service Guidelines". However, from the researcher's findings, these actions have not been implemented optimally. There has been no activity in sharing roles, knowledge, and authority of certain

professions to make decisions about patient care together. Decision-making is still dominated by the Doctor in Charge of the Patient. Other PCPs involved in care tend to only carry out and follow instructions from the doctor in charge of services. The expected role and contribution in the implementation of collaboration have not been seen. The results of the researcher's observations through integrated patient progress notes and interviews with several room heads showed that 90% of pharmacy personnel in the Hospital had not optimally recorded the results of their care in integrated patient progress notes. This means that pharmacy personnel have not carried out patient care individually, let alone collaboratively. The head of the pharmacist profession said that pharmacists currently have not carried out care independently, let alone collaboratively. Working in interprofessional collaboration will not be realized if the Care Provider Professional (PCP) does not carry out care individually and together. This phenomenon is interesting to study, how is the picture of the existence of the team and the practice of cooperation between PCPs that occurs at Bukittinggi Hospital? so that a professional work culture mechanism is created according to the concept of interprofessional collaboration? This study aims to determine the picture of the practice of cooperation between PCPs in the implementation of Interprofessional Collaboration in Hospitals.

Urgency of the Research:

This research is important because suboptimal collaboration between health professionals can have a direct impact on patient safety and quality of care. Ineffective IPC risks cause miscommunication, fragmentation of services, and low patient satisfaction. In the context of Bukittinggi Hospital, IPC practices that have not been implemented according to standards are the basis for the need to identify obstacles and potential improvements.

Novelty:

This research offers novelty in the local context by: 1) Exploring IPC practices in accredited type B hospitals in Indonesia that still face implementation obstacles. 2) Focusing on operational collaboration between PCPs in the patient care room, not just on formal policies or regulations. 3) Using a qualitative approach to capture the dynamics and perceptions of professionals in IPC practices in depth.

Methods

Research design

This study is a qualitative study with a phenomenological approach. The selection of this qualitative method is because the researcher wants to explore the problem by obtaining phenomena that occur in team practice and teamwork that are considered to have contributed to the low implementation of IPC at Bukittinggi Hospital.

Setting and samples

The number of hospitals in Bukittinggi City is: six hospitals with varying types, and the estimated number of health workers in all Bukittinggi hospitals is around 980 Health Workers (Bukittinggi City Health Worker Profile, 2023). One of the Hospitals in Bukittinggi City was chosen for this study because it has a unique and specific health service focus on handling neurology and brain cases. This is relevant for research that requires interprofessional collaboration (IPC) in patient management with multidisciplinary needs (D'Amour and Oandasan 2005).

This study was conducted in October-November 2024. The informants in this qualitative study were Professional Care Providers (PCPs), consisting of doctors, nurses, pharmacists, and nutritionists. The informants were selected using a purposive sampling technique based on the following inclusion criteria: 1) Doctors who have a valid Practice License, have signed the Clinical Authority Details, have worked for more than two years at Bukittinggi Regional Hospital, and are willing to participate. 2) Clinical Nurse III, who has a valid Practice License, has signed the Clinical Authority Details, has worked for more than two years, and is willing to participate; 3) Pharmacists who meet the same criteria; and 4) Nutritionists with the same qualifications.

The participants were approached and selected based on their availability and willingness to be interviewed, without prioritizing one profession over another. The interviews were conducted

individually (one-on-one) to allow for in-depth exploration of their experiences and perspectives. Participants were interviewed in a random order, depending on their availability at the time of data collection—some doctors were interviewed before nurses, while in other cases, nurses or pharmacists were interviewed first. This approach ensured flexibility in data collection while maintaining the depth and richness of qualitative insights.

Data analysis

Data collection was carried out in two stages. The first stage was 12 in-depth interviews using an interview guide in the form of an outline of questions referring to the WHO framework for Interprofessional Collaboration (IPC) and the IPC core competencies based on the Institute of Medicine (IOM) in the Report of an Expert Panel. The information obtained was recorded and transcribed verbatim. Data collection was carried out until information saturation was achieved. Data from the interviews were analyzed using thematic analysis techniques according to the Braun and Clarke (2021) approach which includes open coding, theme grouping, and interpretation.

Data collection was carried out in two stages. The first stage involved 12 in-depth interviews using a semi-structured interview guide consisting of open-ended questions referring to the WHO framework for Interprofessional Collaboration (IPC) and the IPC core competencies based on the Institute of Medicine (IOM) in the *Report of an*

Expert Panel. The interviews were conducted one-on-one and recorded with consent, then transcribed verbatim. Data collection continued until data saturation was reached. The interview data were analyzed thematically using the Braun and Clarke (2021) approach, which includes open coding, theme grouping, and interpretation.

The second stage of data collection was a Focus Group Discussion (FGD) conducted only once, involving four participants selected from the initial interviewees based on the richness and relevance of the information they provided. Not all participants joined the FGD—only those who were deemed to offer the most insight based on the preliminary analysis. The FGD aimed to confirm, clarify, and deepen the emerging themes from the interviews.

To address potential bias in the FGD, the researcher ensured that all participants had equal opportunities to speak and avoided dominant voices overshadowing others. The discussion was guided neutrally, with questions structured to elicit further reflection rather than lead responses. FGD data were also analyzed using the same thematic method. The results of both stages were integrated using the method of triangulation to enhance the credibility, consistency, and depth of the findings.

Trustworthiness/rigor (applies to qualitative studies)

To maintain the trustworthiness and accuracy of qualitative data, this study applies the following strategies according

to Nowell et al. (2017): Credibility: Data is collected until information saturation is achieved. Information is recorded, transcribed verbatim, and analyzed using triangulation methods to combine the results of in-depth interviews and FGDs. Confirmation of findings is carried out through FGDs with competent informants. Transferability: Researchers provide an in-depth description of the research context, including informant profiles and data collection processes, allowing readers to understand the relevance of the results in other contexts. Dependability: The data analysis and collection process is documented in detail to ensure that the research steps can be replicated by other researchers. Confirmability: Validation of results is carried out through data triangulation and discussions with members of the research team to ensure consistent and objective interpretation.

Ethical considerations.

This study has gone through an ethical review process and was approved by the RSOMH Bukittinggi Research Ethics Committee with approval number No: 002555/KEP.RSOMH Bukittinggi/2024. Before data collection, informants were given a research information sheet

explaining the purpose, benefits, methods, and their rights as participants. The researcher explained that participation was voluntary, and informants could withdraw at any time without any consequences. Written consent was obtained from each participant after they had read and understood the information provided. The confidentiality and anonymity of informants were maintained by not including personal identities in the research report. Data were used only for this study and were stored securely by the privacy policy.

Result

Characteristics of informants

The informants of this study were 12 people aged between 25-64 years. The gender of the informants was 9 women and 3 men, with the highest level of education being a bachelor's degree (50.0%), and most of the informants were married (83.3%). Based on their profession, informants with the profession of DPJP, nurse, pharmacist, and dietician were 3 people each (25%). Most informants had a working period of more than 10 years, namely 8 people (66.7%). (Table 1)

Table 1. Characteristics of informants

Characteristics	Frequency	Percentage (%)
Age 25-64 years: Adult (productive age range) according to WHO, 2020.	12	100,0



Characteristics	Frequency	Percentage (%)
Gender		
Female	3	25,0
Male	9	75,0
Education		
Diploma	2	16,7
S1	4	33,3
S2	6	50,0
Marital Status		
Married	10	83,3
Not Married	2	16,7
Profession		
Doctors	3	25,0
Nurse	3	25,0
Pharmacist	3	25,0
Nutritionist	3	25,0
Work Period		
< 5 Years	0	0
5 5 - 10 Years	4	33,3
> 10 years	8	66,7

Source: Primary Data

PCP Team Training and Teamwork in Hospitals

The researcher checked the data repeatedly and the themes that emerged according to the implementation of the team and interprofessional teamwork refer to the IPC implementation

framework by (WHO 2010) and IOM at the Interprofessional Education Collaborative Expert Panel. The results of the study obtained 4 themes on the implementation of the team and teamwork in IPC.

Table 2. Themes of Team Implementation and Teamwork in IPC

Code	Theme Content
1	Building teams, authority, and ineffective teamwork due to limited human resources (HR) of certain professions and time.
2	The participation of other health professionals in sharing solutions to patient care problems in certain situations is still lacking.
3	There is a consensus on ethical guidelines for patient care and teamwork from all aspects in the form of regulations that do not run as expected.
4	Implementing leadership practices in supporting collaborative practices and team effectiveness

Based on the results of the topic analysis in the in-depth interview approach, the researcher only found two themes that needed confirmation and digging deeper into the material collected, which the researcher thought to be very contributory to the implementation of IPC. These themes are themes 2 and 4.

1. Team building, authority, and ineffective teamwork due to the limited number of human resources and time

All PCPs feel that team building and teamwork that have been carried out so far are still ineffective due to limited human resources. Each PCP carries out independent care, but the implementation of collaboration is still rare. The implementation of teamwork in the form of direct collaboration is difficult due to limited human resources. The human resources in question are the professions of pharmacists and dietitians. The professionals that often interact are doctors, nurses, and dietitians. The four professions have never been seen together to visit patients together:

"What we have been doing so far is that some are done collectively, but there are also those that are done alone. If it is done together, when the person in charge, the doctor, together with the nurse, will provide care. If the pharmacy, after there is care, then the therapy will be given, then after it is given, the pharmacy will provide the medicine. And nutrition, after knowing the diagnosis, nutrition will also do it.

So it could be all at once, it could be not all at once" (09)

"We are doctors who always meet with nurses, if with pharmacists and dietitians, usually only once or twice at most for one patient" (11)

Informants also stated that the limited time in the medical profession also hampers the expected collaboration:

"It's not enough, not enough. Sometimes it's the doctor's schedule too. Sometimes the doctor, we don't blame them. Sometimes some are fast. But doctors might be busy in the polyclinic, sometimes it's already noon to the patient. Sometimes some are after noon. So if there is an agreed schedule at this time, this time. So we can, meaning it's still within the limits. Because if it's a nutritionist, delivering diet food is at the latest at 11 o'clock" (08)

2. The participation of other health professionals in sharing solutions to patient care problems in certain situations is still lacking

All PCPs said that the participation of the pharmacist profession in providing care and solving patient problems in the room, even in certain conditions, is almost non-existent. Pharmacists themselves admit this. Their absence is due to limited human resources and overlapping responsibilities given to them. In addition to the responsibility of carrying out clinical pharmacy, pharmacists also have managerial responsibilities. So that pharmacists do

not have time to carry out their clinical pharmacy care. As stated by the following pharmacist:

"Most of the usual ones in the room are only doctors, nurses, nutritionists who fill in the status. However, because the accreditation yesterday also granted authorization to pharmacists, pharmacists are present to fill in the status. The limitations of pharmacists mean we don't go into the field. Considering there are other jobs such as drug use reports, pharmacists also do that. So, to get involved in the room, there has been none in this hospital" (05).

However, there are a small number of informants who said that pharmacists have provided care, although rarely. As stated by informant 11 below:

"If it is difficult for pharmacists, usually their collaboration is rare. If there are indeed obstacles in providing drug therapy to patients, usually we have to contact them ourselves (11)"

This difference is interesting for researchers to confirm and explore further through the implementation of FGD. The results of the FGD found that the majority of PCP said that the participation of other health professionals in sharing solutions to patient care problems in certain situations is still lacking. This confirms the information in the in-depth interview that the pharmacist profession has not yet carried out clinical pharmaceutical care either independently or collaboratively. This is illustrated by the following statement:

"If 90%, yes, two PCP are present, namely doctor and nurses. If with a dietician, maybe 75%, but if with a pharmacist, yes 0%. If all four are 0% because the highest 75% is 3 PCP who is present" (12).

3. There is a consensus on ethical guidelines for patient care and teamwork from all aspects in the form of regulations that do not run as expected

Most PCPs said that there are already regulations governing the implementation of collaboration in providing patient care, although the implementation has not run according to the established regulations. PCP does not know in detail what the contents of the regulation are. There has never been any socialization. This is by the statement from the following informant:

"I know about the policy for this collaboration, but I don't understand the exact details" (11)

Some informants said that there were no such regulations in the hospital. However, the implementation of the collaboration itself was already underway. This was conveyed by the following informant:

"Honestly, in the hospital, there is no policy regulated by derivatives of existing laws and regulations stipulated by the Regulation of the Minister of Health or the Ministry of Health, but in terms of implementation, we have done it in each profession" (03).

For researchers, this difference needs to be confirmed further through the implementation of FGDs to ensure that all PCP is aware of the regulations on teamwork that have been agreed upon and socialized to PCP. The results of the FGD found that only a small number of PCP were aware of the patient care guidelines and teamwork from all aspects. It just didn't go as expected due to the lack of socialization. This is by the following statement:

"I have read about interprofessional collaboration. But yeah... the socialization, we didn't know that the visit had to be done together, the important thing is that the message was conveyed" (12).

4. Implementing leadership practices in supporting collaborative practices and team effectiveness.

According to most informants, the decision maker for the overall care given to patients is the doctor. Informants feel that even though they work together, other professions play a more supporting role. The final decision is still given to the doctor:

"When a patient comes, the first person to see is the nurse. The nurse has a nursing diagnosis. The diagnosis will be followed up with the doctor. Then the doctor also has his diagnosis. That's the initial diagnosis. Then there is a supporting examiner, and the diagnosis is confirmed. Then it is adjusted for therapy including diet. Therapy is decided by the

doctor. Diet by the dietitian. The final decision is made by the doctor" (06)

Discussion

The results of the study showed that limited human resources, especially pharmacists and dietitians, were the main obstacles to implementing effective team collaboration. This condition causes the implementation of care to often be carried out independently by each profession, not together. This is the literature stating that the success of interprofessional collaboration (IPC) requires the availability of sufficient health workers to support the direct involvement of all parties in patient decision-making (Reeves et al. 2016).

Time constraints, especially for doctors who have busy schedules, are also a challenge in team collaboration. According to Fox, McAllum, and Ginoux (2024), coordinated time and schedule management are important elements in increasing the effectiveness of collaboration. Without good time coordination, opportunities for joint visits or direct discussions between professionals are limited.

All PCPs in the hospital felt that the team collaboration that had been carried out so far was still less effective due to the minimal presence of pharmacists in providing services both independently and in collaboration with other PCP. All pharmacists who were informants in this study admitted that their professional absence was due to a lack of human resources and overlapping of their clinical and managerial work. The role of

management in providing solutions to these problems is very important. The role of leaders as policymakers can improve cooperation between pharmacists and other PCP in providing care. From the results of the literature search, good service quality depends on professionals working together in interprofessional teams (Rokhmah and Anggorowati 2017). Research conducted at M. M. Dunda Hospital showed an increase in the relationship between doctors and pharmacists in the hospital in a 3-party collaboration model, where the Director is the party that strengthens the relationship (Hasan 2022).

The interview results showed that the presence of pharmacists in solving patient problems was very minimal, both independently and collaboratively. This is due to the overlapping responsibilities between clinical pharmacy and managerial tasks. The literature supports this finding, where Appleton et al. (2023) stated that pharmacists often face excessive workloads, reducing their participation in interprofessional teams. However, pharmacist participation in patient collaboration is important because it can improve the accuracy of therapy delivery and minimize drug errors (Zhang et al. 2023). As a solution, optimizing the division of tasks and strengthening the clinical role of pharmacists needs to be prioritized.

The participation of the pharmacist profession in providing care and solving patient problems in the room, even under certain conditions, can almost be said to be non-existent. Collaboration will not be optimal if there is even one part that is

not involved in the care provided. This is because the practice of collaboration itself is a process of communication activities and interprofessional decision-making where they can share their knowledge and skills to provide care for patients (Kenaszchuk 2013).

Pharmacist services are clinically closely related to the provision of pharmaceutical preparations to patients to provide effective, efficient, and safe care to patients. Not all professions understand this science. A study on optimizing the role of pharmacists in monitoring and evaluating patient safety incidents discovered that the integration of clinical pharmacy activities with patient safety activities is realized through an incident reporting system, clinical impact, problem-solving recommendations, and risk management (Kusharwanti, et. al 2014). Providing information on drug use, side effects, and drug interactions will also support the success of therapy. Handayani's research (2019) states that the provision of pharmaceutical care in this case counseling will be better (Handayani and Farida 2020).

Other PCPs at Hospital Bukittinggi also more often provide care independently. The limited time of doctors and dieticians who cannot always be in one treatment room makes it difficult to provide care at one time together. The collaboration that occurs tends to take place between professions. Doctors and nurses realize that they have key roles in providing care. As a result, the relationship between doctors and nurses represents the most continual and intensive PCP teamwork. In

research conducted by Utami (2016), doctors and nurses showed positive attitudes and had high interprofessional interactions and values in collaborative relationships (Utami and Hapsari 2016).

Arranging mutually agreed patient visiting times is one solution to implementing interprofessional teamwork in hospitals. The absence of joint visits between all professionals in the inpatient room also limited the exchange of knowledge and interpersonal relationships between professionals. According to Zwarenstein, Goldman, and Reeves (2009), joint rounds are joint visit activities between health professionals to evaluate health services that have been provided to patients and to create knowledge transfer between members of the profession.

Teamwork is also not ideal if carried out by PCP who do not have the competence to carry out interprofessional collaboration. The composition of nurses based on career level in the inpatient ward of the Hospital is not yet balanced. As a result, all clinical nurses with any career level may carry out collaborative care, and even make nursing care plans. According to PMK No. 40 of 2017 concerning the Development of Clinical Nurse Career Levels, nurses who have the competence to carry out interprofessional collaboration are nurses with a career level of clinical nurse III (Kemenkes. RI 2017). Conditions like this cause collaborative and scientific abilities between professionals in the team to become unbalanced where nurses carry out care outside their authority. This was also conveyed by Istirochah (2017) that

there are still many nurses who carry out tasks outside their authority where Clinical Nurse I carries out the authority of Clinical Nurse II and Clinical Nurse III, and vice versa (Istirochah and Santoso 2017).

Most informants acknowledged the existence of regulations governing interprofessional collaboration, but their implementation was not optimal due to a lack of socialization. According to research by Reeves, et. al (2018), regulations without adequate training or socialization will be difficult to implement effectively. Unclear information about regulatory guidelines can create different interpretations and hinder collaboration. The existence of regulations should be accompanied by training and operational guidelines to improve each profession's understanding of effective collaboration (Saragih et al. 2024).

Socialization is critical in enabling PCP to comprehend and apply regulations in service units. The implementation of socialization that does not involve all professions and all PCP is ineffective because the message to be conveyed is not known by all service providers. The results of research on optimizing the role and function of the leader of the room in implementing the socialization of regulations and standard operating procedures for patient safety show that understanding standard operating procedures will change a person's behavior for the better, and there is a fairly strong relationship between the quality of standard operating procedures and performance (Dina Warashati, Enie Novieastari 2020).

Almost all PCPs stated that the doctor is the primary person in charge of the patient and makes the final decision regarding the care to be provided. The Doctor is considered a leader in the care given to a patient. Decisions taken by the Doctor as team leader should take into account the opinions and recommendations of other PCPs. The Doctor in Charge of Services as a team leader plays a role in developing a care framework, coordinating, collaborating, synthesizing, interpreting, reviewing, and integrating patient care (Komite Akreditasi Rumah Sakit 2020).

The final decision in patient care is held by the Doctor, while other professions are considered more as supporters. Leadership concentrated on one profession may impede the efficacy of team collaboration (Reeves et al., 2018). According to the literature, a transformational leadership approach can support better interprofessional collaboration by encouraging active participation from all team members in decision-making (Lyubovnikova et al. 2018). In addition, Practice and Outcomes (2016) recommends that leadership in interprofessional teams should be inclusive and encourage equal contributions from all professions. This can increase mutual trust and collective responsibility within the team.

The strength of this study lies in its use of a qualitative approach with in-depth interviews and focus group discussions (FGDs), allowing for rich, contextual insights into the real experiences of healthcare professionals in implementing interprofessional

collaboration. The triangulation of data from different professional perspectives enhances the credibility of the findings. However, the limitation of this study is its focus on only one hospital in a specific geographic region, which may reduce the generalizability of the findings to other hospitals or healthcare systems with different organizational cultures and resources.

Conclusion

The results of this study illustrate that teamwork and interprofessional collaboration at Bukittinggi Hospital are not yet optimal because the role of the pharmacist profession in collaborative care is still minimal. So joint visit activities involving the four professions have not been optimally carried out. The human resources of the pharmacist and dietician professions needed to carry out collaboration are not sufficient in terms of quantity and quality of competence. The dominance of teamwork is carried out by the doctor-nurse profession.

Suggestions for the Hospital: The introduction of interprofessional collaboration should be socialized so that the PCP understands what collaboration should be. Regulation socialization and teamwork implementation training through IPC must also be carried out regularly. Hospital Management must also prepare a monitoring and evaluation plan for the implementation of IPC. Management is also responsible for ensuring that enough human resources are available for pharmacists and dieticians to provide clinical care in the inpatient

setting. Similarly, the distribution of nurses based on clinical ability is necessary for interprofessional interaction. So that the four professions may work together to give patients the best possible integrated care.

Acknowledgement

This research can be carried out well thanks to the assistance of various parties, for that the researcher would like to thank the Chancellor of Universitas Perintis Indonesia (Upertis), the Dean of the Faculty of Health Sciences Upertis, the Head of LPPM Upertis, The Hospital Director, Hospital Research Manager, Head of Hospital Inpatient Installation, and Hospital PCP were involved and provided good cooperation in this research.

Conflict of Interest

The authors declare no conflict of interest in this research.

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