Enhancing Organizational collaboration and Leadership in healthcare settings: insights from Rehabilitation professionals

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Abstract

Intro: This study explores how managers can foster positive working relationships and enhance communication within rehabilitation teams with a particular focus on strategies to improve these interactions in the Swedish healthcare context.
Purpose: The aim is to investigate how healthcare managers support rehabilitation staff, specifically occupational therapists and physiotherapists in their daily work relationships and workload. The study examines the tools and strategies managers use to promote communication, cooperation, and conflict management within rehab teams, as perceived by both managers and staff.
Method: A qualitative approach was employed using semi-structured interviews with rehab professionals and managers. The analysis was guided by Integral Theory's AQAL model (all-quadrants, all levels), which provides a comprehensive framework encompassing subjective, intersubjective, objective and intersubjective perspectives. Additionally, the Job Demands- Resources (JDR) model was applied to interpret experiences of stress and support within these dimensions.
Analyse and result: Findings reveal that rehabilitation staff often feel insufficiently supported by their managers, and communications among rehab colleagues is generally weak. Persistent negative work routines and unclear role boundaries were identified as obstacles to effective collaboration. Managers reported limited time to engage with and address conflicts within rehab teams.
Conclusion: Effective communication is a crucial component of interprofessional collaboration and essential for meeting patients´s needs. However, this study highlights a gap between healthcare managers´s understanding and the actual conflict dynamics and support needs within rehabilitation teams. Enhancing managerial awareness and targeted strategies could improve team cohesion and working conditions.

Keywords: Healthcare, occupational therapists, physiotherapist, managers, Rehabilitation teams, communication skills, conflicts.

Table of contents

1. Introduction

Healthcare systems worldwide face increasing challenges due to demographic shifts, rising patient expectations, and the growing complexity of health needs. To address these demands, interprofessional collaboration has become essential in ensuring effective and coordinated care across disciplines (Reeves et al., 2017). Particularly within rehabilitation teams composed of occupational therapists and physiotherapists. It is argued that effective cooperation between these professionals not only enhances patient outcomes but also plays a vital role in maintaining a healthy work environment within healthcare organizations (West et al., 2015).

From a leadership and organizational perspective, it is crucial that leaders in higher managerial positions have a clear understanding of how their rehabilitation staff work and collaborate. Without this insight, they risk overlooking key factors that influence team dynamics, employee satisfaction, and, ultimately, the quality of patient care. Research highlights that successful collaboration in healthcare heavily depends on leadership practices that foster clear communication, shared goals, and supportive working conditions (Rosen et al., 2018).

Among the few studies conducted on rehabilitation professionals, it has been shown that occupational therapists and physiotherapists often experience uneven workload distribution, which contributes to low morale, frustration, and staff turnover (Chipeta et al., 2016). Despite the critical importance of their work, the organizational conditions that support or hinder their collaboration and job satisfaction remain underexplored. Drawing from my own professional experience working in both regional and municipal healthcare, I have repeatedly observed challenges related to workload management, interprofessional relationships, and the support provided by managers and leaders. Questions frequently arise about how managers and leaders can actively promote positive work relations and whether rehabilitation professionals receive the organizational support and leadership training they need to collaborate effectively.

Current organizational models often fail to provide the necessary structures and support systems to enable long-term improvements in team-work. In Sweden, the healthcare system is divided between regions and municipalities, creating a complex organizational structure. Regions are primarily responsible for providing healthcare

services, including hospitals and specialist care, while municipalities manage elderly care, home healthcare, and disability services (Morén & Ramberg, 2024). This division places additional demands on leadership within each sector to ensure that collaboration across professional boundaries is maintained. This study will focus on the regional healthcare context, where rehabilitation teams work closely within hospitals and outpatient clinics. In particular I focus on how leadership and broader managerial levels and organizational structures shape their working conditions, interprofessional collaboration, and overall team dynamics.

Despite extensive research on leadership in general healthcare settings, there remains a gap regarding how leadership specifically affects the collaboration and working conditions of rehabilitation professionals. Studies such as those by Rosen et al. (2018) suggest that teamwork and leadership are closely linked, yet few have investigated this relationship among occupational therapists and physiotherapists in Sweden. This thesis seeks to address this gap by exploring how leadership practices and organizational structures can enhance collaboration, communication, and work satisfaction within rehabilitation teams.

1.1 Problematization

Establishing and maintaining effective working relationships in healthcare environments is crucial for delivering high-quality, patient-centred care. This is particularly important for rehabilitation professionals, such as occupational therapists and physiotherapists, whose roles require close collaboration across professional boundaries (Reeves et al., 2017). Despite the increasing emphasis on teamwork in healthcare, there are limited understanding of how managers and leaders support these professionals in their daily work, particularly regarding communication, workload, and team dynamics. According to the Swedish Association of Occupational Therapists, effective leadership is essential for promoting interprofessional collaboration and ensuring that rehabilitation teams function optimally to meet patient needs. This underscores the necessity of exploring how management practices influence collaboration and performance within rehabilitation teams (Gitell, 2016; O´Daniel & Rosenstein 2008). This highlights the necessity of exploring how management practices influence collaboration and performance within rehabilitation teams.

While much of the literature highlights the importance of interprofessional

collaboration, there is a lack of research that focuses on how leadership and organizational structures influence these collaborative efforts within rehabilitation teams. Few studies have systematically examined this relationship, particularly in the nordic context (Hewitt et al., 2014; Anderson & Tengblad, 2018). Rosen et al. (2018) emphasize that effective teamwork in healthcare is not solely dependent on individual competencies but is significantly shaped by organizational culture and leadership. Leaders play a key role in modelling team behaviours, reinforcing shared goals, and creating an environment where communication, psychological safety, and mutual respect can flourish.

Despite this, current organizational models often fail to provide the necessary structures and support systems to enable long-term improvement in teamwork. In Swedish healthcare, the division of responsibilities between regional and municipal levels adds further complexity. Managers in these systems face structural and bureaucratic challenges that can hinder their ability to foster cohesive team environments.

Rehabilitation teams, in particular, navigate overlapping responsibilities and differing professional frameworks. Occupational therapists and physiotherapists often work under different conditions, with limited shared routines which may affect how they interpret roles, communicate and coordinate care. These organizational and professional boundaries can create challenges that are essential to the recovery and long-term wellbeing of patients, reduce efficiency and increase the risk of misunderstanding. Moreover, there is a growing concern about the psychosocial work environment of the rehabilitation professionals. High workloads, unclear leadership support and fragmented communication pathways can lead to stress. This aligns with findings from Bakker & Demerouti (2017) and Montgomery et al. (2020), who showed a lack of resources and support increases burnout among healthcare professionals. However, the working conditions and support structures remain underexplored in leadership and organizational research.

To better understand how leadership functions as a resource in this context, this study applies the Job Demands-Resource (JDR), (Bakker & Demerouti, 2006). The model provides a framework for analysing how organizational resources such as managerial support will buffer job demands and promote motivation, engagement, and well-being among healthcare professionals. Previous research has demonstrated that high job demands combined with insufficient resources can lead to burnout, whereas adequate

resources promote engagement and well-being (Shaufeli & Taris, 2014; Lesener et al., 2019). This theoretical perspective helps clarify how leadership practices may contribute to sustainable and effective collaboration in rehabilitation teams.

This thesis aims to address this gap by exploring how managers in the healthcare sector can support and enhance collaboration within rehabilitation teams. By focusing on occupational therapists and physiotherapists, the research contributes to profession-specific knowledge, while informing broader discussions about leadership, organizational behavior, and sustainable work environments in public healthcare.

1.2 AIM of the study

This thesis aims to investigate how managers in the healthcare sector support collaboration and work conditions within rehabilitation teams, focusing specifically on occupational therapists and physiotherapists. These two professions often work closely together in hospitals and other care settings such as public clinics, yet limited research has examined how leadership practices shape their ability to collaborate effectively. The study investigates how leadership influences interprofessional communication, team dynamics, role clarity, and the psychosocial work environment, all of which are critical for sustainable and high-quality care delivery. The Job Demands- Resources (JDR) model Bakker and demerouti (2006) is used to analyse how managerial actions function as job resources that can buffer stress, increase motivation, and foster engagement. The study contributes to a deeper understanding of leadership as an organizational resource and highlights its importance in the context of the interprofessional collaboration within rehabilitation teams. Additionally, previous research has shown that leadership in healthcare organizations plays a significant role in shaping team behaviour, improving communication, and fostering a supportive work environment (Rosen et al., 2018), which aligns with the focus of this study.

This study seeks to answer the following research question:

1.3 Research questions

How do managers in the regional healthcare sector support work relations and the psychosocial work environment of rehabilitation professionals, particularly occupational and physiotherapists within their teams?

2. Background

The global health workforce shortage leaves more than 18 million jobs open by 2030 (WHO, 2019). Although low- and middle-income countries feel the worst effects of this shortage, all countries face the challenge of maintaining a healthy workforce sufficient to meet patients' needs. In an article by Vinberg et al. (2015), researchers from various fields argue that the workplace is one of the most significant environments affecting health. This study shows how health can be achieved in the workplace through a wide spectrum of factors, such as management principles, organizational culture, a part of the entire workforce, and the balance between job demands and control at work. Lindquist (2023), a healthcare strategist, asserts that HR can employ various goals and strategies. Healthcare, including establishing, maintaining, and communicating a positive workplace culture.

2.1 HRM: human resource management

Human resource management (HRM) plays a crucial role in healthcare and other service sectors, where service quality is closely tied to employees competence and performance. HRM goes beyond administrative functions and is also a strategic leadership tool used to shape organizational culture, work environments, and employee engagement (Shantz et al., 2016; Eronen et al., 2024).

Organizations are often viewed as systems designed solely for productivity. However, as Eronen et al. (2024) and Van De Voorde et al. (2012) argue, organizations are also social systems that serve human development. People participate in them not only to perform tasks but to meet social, psychological and professional needs: When these needs are not met, employees may disengage and leave the organization (Lindquvist, 2023).

Within regional healthcare, HRM becomes particularly important in supporting collaboration among occupational therapists and physiotherapists - professions that rely on team-based care and mutual trust. Managers serve as a key link between HRM strategies and everyday practice. Their decisions can directly influence team dynamics, communication and psychosocial well-being at work.

Previous research emphasizes the importance of HRM in producing positive outcomes

for patients, staff, and organizations alike. For example Shantz et al. (2016) developed a model showing how HRM practices, when perceived positively by employees, can lead to improved care quality and safety. A key component of their model is employee commitment, which acts as a mediator between HRM and organizational outcomes.

This framework aligns conceptually with the Job Demands-Resources (JDR) model, which will be applied in this study. According to Bakker and demerouti (2006), the balance between job demands and available resources affects both stress levels and engagement. HRM practices can be understood as a key organizational resource that contributes to a healthy and productive work environment, particularly when implemented through effective leadership.

2.2 Rehab professions and roles

In hospital-based healthcare occupational therapists and physiotherapists play key roles in the rehabilitation process, often working closely together in interdisciplinary teams. Occupational therapists typically assess and train patients in activities of daily living, provide assistive devices, and evaluate the home environment (Sveriges arbetsterapeuter, 2024). Physiotherapists focus on physical training and functional assessments (Växjö kommun, 2024). While these roles are based on professional education and division of responsibility, they often intersect and require active coordination in practice.

However, the success of this collaboration is not merely a matter of professional competence; it also depends on how leadership within the organization enables and supports interprofessional work. Research shows that managers play a crucial role in clarifying role boundaries, facilitating communication, and ensuring that team members have conditions needed for collaboration (Braithwaite et al., 2020). When leadership fails to provide structural and relational support, team dynamics can suffer, resulting in role ambiguity and reduced patient outcomes.

Braithwaite et al. (2020) emphasize that health professionals' ability to collaborate is embedded in organizational systems, and that leadership must actively foster a culture that supports mutual respect, shared goals and clear division of tasks. This aligns with Carlstörms & Berlins´s (2004) view that interprofessional teams require not only individual commitment but also understanding of goals and structures leadership to succeed. Thus, the organizational and leadership context is fundamental to how

occupational therapists and physiotherapists can fulfil their roles and contribute to effective rehabilitation.

3. Literature Review

3.1 Interpersonal conflict in healthcare setting

Guidroz et al. (2012) describe interpersonal conflict as a subtle form of aggression, which may include overt behavoiurs or more covert forms, such as gossip or exclusion. These behaviours can erode trust, weaken team cohesion, and diminish patient care quality. For rehab staff, whose work often depends on shared assessments and mutual trust, such breakdowns are particularly harmful. Addressing these conflicts requires leaders who are attuned to team dynamics and can mediate issues proactively. In this context, leadership is not just a managerial function but a relational practice that shapes the conditions for cooperation and respect across professional boundaries.

Interpersonal conflict is a common challenge in healthcare settings, often stemming from communication breakdown, role ambiguity, and power imbalances within teams (Kim et al., 2017) These conflicts can be particularly pronounced in interprofessional collaborations where different professions such as occupational therapists and physiotherapists must coordinate complex care. Leaders play a crucial role in this by fostering open communication. However, leadership involvement in addressing conflict among rehab professionals remains underexplored in research.

Kim et al. (2017) emphasize that unclear expectations about task completion, limited feedback and inadequate information sharing can lead to significant tension. These issues are often amplified by hierarchical structures and differing areas and expertise. In the case of occupational therapists and physiotherapists overlapping responsibilities in rehabilitation can create friction unless defined leadership strategies are in place to support collaborations. Leaders who practice participative or transformational leadership styles may be more successful in creating a culture where team members feel valued and conflicts are addressed constructively.

Organizational factors, such as inefficient workflows, limited resources and unclear policy frameworks, also contribute to tension. Leaders are central in addressing these structural issues by ensuring fair task distribution and clear communication pathways.

Still, research tends to focus on nurses and physicians, leaving a knowledge gap regarding how leadership supports allied health professionals like rehab staff. (Guidroz et al. 2012).

According to Kim et al. (2017) communication breakdown is an important source of interpersonal conflict that occurs when there is a lack of feedback from each other and clear expectations regarding task completion or information exchange. This may occur due to power differences in positions, expertise, and roles. Power in this case is defined as strategies used by leaders to influence subordinate or subordinate positions to achieve important goals.

3.2 Psychosocial work environment

The psychosocial work environment is another aspect of what affects communication and cooperation. It is also a motivating factor when a supportive psychosocial work environment is present. Stansfeld and Candy (2006) describe how the psychosocial work characteristics are linked to psychological processes to the social work environment, which can be an important cause of illness. The author describes two different parts of the key dimension of the psychosocial work environment: psychological job demands and decision latitude.

Research has investigated how these factors influence workers. This is because they have done long-standing studies on high levels of requirements. High work pace and conflict-related demands has been found to predict common mental disorders, including moderate depressive and anxiety disorders. Conversely, high levels of social support at work by colleagues and supervisors have been shown to protect mental health, as evidenced as both in cross-sectional and longitudinal studies.

The psychosocial work environment plays a central role in shaping collaboration, communication, and overall team functioning in healthcare settings. For rehabilitation professionals, such as occupational therapists and physiotherapists, whose work relies heavily on mutual trust and shared decision-making, a supportive work climate is particularly crucial. Leadership is a key determinant of this environment, as managers influence how staff experience workload, autonomy, and social support.

According to Stansfeld and Candy (2006), psychosocial work characteristics include psychological demands and decision latitude, both of which are closely tied to

stress-related illness. High psychological demands such as a fast work-pace environment, role conflict, and emotional strain have been linked to an increased risk of common mental disorders, including depression and anxiety. These effects are especially concerning in healthcare teams where poor mental health can impair teamwork and quality of care.

However, Stansfeld and Candy also emphasize the protective role of high social support from colleagues. Supportive leadership characterized by clear communication, participatory decision-making, and emotional responsiveness can buffer the negative effects of stressors and foster a psychologically safe environment. This aligns with the Job Demands-Resources (JDR) model (Bakker & Demerouti, 2016), which suggests that job resources such as strong leadership can ease job demands and promote engagement.

Despite this, there is limited research specifically focusing on how leaders in regional healthcare settings actively shape the psychosocial work environment for allied health professionals like rehabilitation staff. Greater attention to this area could help identify leadership practices that enhance not only employee well-being but also team cohesion and care outcomes.

3.3 Interprofessional communication between healthcare workers

In the review of this study by Foronda et al. (2016) the communication between the hospital nursing staff was examined, the differences in communication styles appeared due to frustrations of this. Interprofessional communication skills can be significantly improved with training including the use of simulation and communication tools. Communication genres are not limited to oral or written forms they also include body language, attitude and tone of voice. In this, like many other studies, doctors are examined as usual but not rehab staff, this may be because the studies that are done in some countries do not have the rehab groups as a priority in care. For example, they were able to demonstrate in this study how doctors and nurses are generally trained to have different communication styles, which has led to frustrations (Foronda et al., 2016).

In another article by Saridi et al. (2021) describe in more detail that the workplace is an environment for the employee to engage in different and interactive relationships with thier colleagues, which can affect an individual one's life positively or negatively. The

article also claims that the hospital environment is already a special milieu characterized by diversity of people, relationships, professional categories and mutual dependencies and conflicts. Saridi et al. (2021) also show that direct conflicts in the workplace have an impact on the psycho-emotional state of workers and indirectly on the productivity of both individual workers and the organization as a whole. In particular, conflicts between healthcare professionals seem to have a negative impact on the quality of healthcare provided to the public. One factor contributing to worsening conditions in recent years is how the economic crisis has intersected in healthcare challenges, learning to increase financial pressures.

Research has also shown that conflicts develop when there is poor communication between the healthcare staff, clear work stress and unclear hierarchy. In addition, research has shown that conflicts occur between health workers with all types of hierarchy and in all specialties in a hospital. Intraprofessional conflicts are linked to impaired patient-centered care and that interproffessional conflicts are associated with more delays (Saridi et al., 2021).

Discussing interprofessional collaboration within rehabilitation teams is important for several reasons. By working together physiotherapists and occupational therapists can better coordinate care efforts reducing the risk of overlap and improving continuity of care. An article by Foronda et al. (2016) shows that the connection between miscommunication has been well documented and that ineffective communication in care results in late treatment. Foronda et al. (2016) also mentions that improving the effectiveness of communication in healthcare is a global priority. The literature has also highlighted the importance of interprofessional work and its training.

Foronda et al. (2016) examined communication among hospital nursing staff and found that differences in communication styles often lead to frustration and conflict. They emphasize that interprofessional communication skills can be significantly improved through training, including the use of simulation and communication tools. Communication is not only oral or written but also includes body language, attitude, and tone of voice. However, like many studies, this research focuses mainly on doctors and nurses, while rehabilitation professionals such as occupational therapists and physiotherapists are often overlooked. This lack of focus may be because rehabilitation teams are not prioritized in healthcare research in some countries (Foronda et al., 2016).

Saridi et al. (2021) describe hospitals as a complex environment with diverse professionals, relationships and inherit dependencies and conflicts. The study highlights that workplace conflicts negatively affect the psycho-emotional state of healthcare workers and reduce both individual and organizational productivity. Conflicts among healthcare professions especially deteriorate the quality of care provided to patients. Economic crises exacerbating financial pressures in healthcare also contribute to increased stress and conflict (Saridi et al., 2021).

Poor communication, work-related stress, and unclear hierarchies are identified as key sources of conflict across all levels and specialties in hospitals. Interprofessional conflicts impair patient-centered care, while interpersonal conflicts cause delays in treatment (Saridi et al., 2021). In this context leadership plays a role in how they facilitate effective communication and collaboration, especially within interprofessional rehabilitation teams. Leaders adopt participative or transformational leadership styles that can create environments where team members feel valued, conflicts are addressed constructively, and care coordinated improvements. For rehabilitation professionals who rely on coordinated assessments and shared decision-making, effective leadership is essential to reduce communication barriers and promote teamwork Foronda et al., 2016). Improving communication within healthcare is a global priority and leadership is a key to driving this change (Foronoda et al., 2016).

3.4 Multidisciplinary team

Haig and LeBreck (2000) describe how important and unique the team approach is to patient care in rehabilitation medicine, yet they remain poorly studied. Almost two decades ago, the literature on teams was reviewed, and even then, few articles were found that applied a research model. This limited base led the author of the article to conclude that teamwork improves patient outcomes. One point that Haig and LeBreck (2000) also mentions is that in this research area there is a need to rise above a multidisciplinary model, but these are still poorly defined concepts in the medical literature. multidisciplinary teams, involve different specialists work independently with the patient, while interdisciplinary requires therapists to communicate throughout the patient care process with well-defined roles according to their training. Thus, each

therapist performs the work required for the patient's goals.

The meaning of the multidisciplinary team is thus to bring together professions towards a common goal. These are characterized by the fact that the members of the team carry out their activities individually. By collaborating in a more interdisciplinary way, they help make efficient use of resources. By working more effectively as a team, the healthcare staff can effectively better utilize the resources and competence of each individual. On one hand, it has been very difficult to find previous studies on exactly how the rehab staff communicate and what the reality between them looks like. In addition, the information about how managers can support rehab staff is even weaker. On the other hand, there are general studies that have investigated how doctors and nurses are met by managers and what kind of support they receive from their managers. So, it has been difficult for them to be able to trigger what kind of support the rehab staff get, especially since they are the only group within hospice care that works so closely together both in the office and with the patient.

Olupeliyawa et al. (2009), in a literature study on teamwork in healthcare and health care education, concluded that teamwork is necessary to provide effective healthcare and to reduce the risks of mistakes being made. Teamwork improves patient as well as staff satisfaction. A healthcare team is a team effort between different professions that complement each other, can collaborate and communicate, and can make joint decisions towards improved patient care.

Blomqvist (2009) has come to the conclusion in a literature study on multi-professional work teams that the members of such a team can see teamwork as appropriate when it comes to giving high quality care for patients with complex care needs. The purpose of a multi-professional work team is to create an important forum in terms of decisions and coordination in patient care. But the team members can also see a threat to professional independence, and you can perceive teamwork in different ways, which can make working in the team difficult. The risk also exists that the different professions want to

Compete with each other when addressing patients' care needs, which can lead to poorer team cohesion. One prerequisite for good teamwork is that you have a common care ideology and a common picture of what good quality care is. Being unclear about what the ideology of care and objectives are can lead to problems in the team. The members need to create a clear image of each other's roles and competence. The study also shows

that the distribution of influence in the team is an important part of how the work takes shape. Equality is needed in the discussions that are conducted and in the decisions to be made. It has been concluded that, traditionally, high-status professions speak more than low-status professions. Multi-professional collaboration is an essential quality aspect of rehabilitation. Working in teams increases communication and cooperation between the professions, but there can also be difficulties in working in teams, which means the work should be well structured (Blomqvist, 2009).

Multidisciplinary teamwork is a central component in rehabilitation care, aiming to unite various professional groups around shared goals to support patient recovery. Haig and Lebreck (200) emphasize the importance and uniqueness of the team-based approach in rehabilitation medicine, yet they also point out that this area remains under researched. Despite earlier literature reviews acknowledging that effective teamwork is linked to improved patient outcomes, there is still a lack of structured research models specifically addressing how such teamwork operates in practice. The authors further argue that the field must progress beyond traditional multidisciplinary models, in which professionals work independently towards more integrated forms of collaboration although such concepts remain vaguely defined in the medical literature.

In typical multidisciplinary teams professionals carry out their respective tasks based on their own expertise, often menial coordination. This can hinder continuity of care and limit the potential for holistic treatment. A more collaborative and structured approach would allow health professionals to make better use of each other's competencies and ensure a more efficient use of resources. Here the team leader must ensure that all professionals including physiotherapists and occupational therapists feel equally involved in decision making processes.

Olupeliyawa et al. (2009), concluded in their literature review that teamwork is essential for providing safe and effective healthcare and minimizing the risk of errors. Successful teamwork is linked not only to better patient outcomes but also higher levels of staff satisfaction. However, such outcomes depend on a shared understanding of care goals, transparent communication and interpersonal trust. In rehabilitation settings, Where several professions are closely involved in patient care, this collaboration becomes even more critical. Effective leadership is therefore needed to support the team in managing complexity, clarifying responsibilities and reducing overlap tasks.

Blomqvist (2009) highlights the dual nature of multiprofessional collaboration: while

some team members see it as essential for providing high-quality care to patients with complex needs, others may view it as a threat to professional autonomy. Diverging views and teamwork can make collaboration more challenging. For instance competition between professions or uncertainty about one's roles can harm team cohesions. One Prerequisite for successful collaboration in a shared care ideology is a collective understanding of what quality care entails. Without it confusion and conflict may arise within the team. According to Blomqvist (2009), establishing equality in discussions and decision-making is also essential. Traditional hierarchies can lead to imbalances in influence, where status professions dominate while remain unheard.

Moreover, there is a noticeable gap in the literature regarding the specific experiences of the rehabilitation staff. While much research has been conducted on physicians and nurses, physiotherapists and occupational therapists are often underrepresented. As a result, little is known about how they communicate within the teams or the kind managerial support they revise. This is particularly concerning in hospice or palliative settings where rehabilitation staff frequently work in close proximity both with each other and with patients. Understanding their unique conditions for collaboration is therefore crucial.

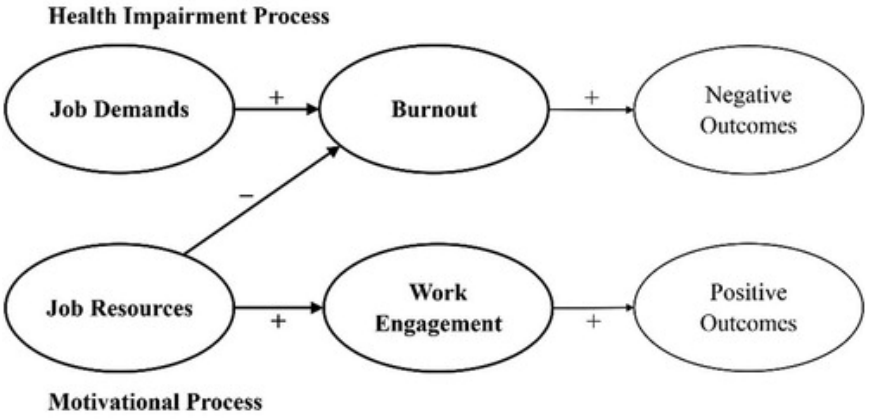
In conclusion, effective multidisciplinary teamwork in rehabilitation settings does not emerge sponentsionsly it must be actively supported. Leadership plays a central role in this process by facilitating role clarity, encouraging collaboration and ensuring that each profession's contribution is valued. A more structured and inclusive team approach, supported by competent leadership, is key to achieving efficient work processes and improved patient outcomes.

4. Theory

4.1 Theoretical framework JDR-model:

The main theoretical framework for this study is the Job Demands-Resources (JDR) model, which helps to understand the relationship between work environment factors and employee well-being. However, due to the complex nature of interprofessional collaboration and leadership in healthcare, the AQAL model from integral theory is used as an analytical structure to ensure a holistic perspective. The AQAL model does not replace the JDR model but is used to organise and contextualise the data in relation to the JDR model´s concepts of demands and resources.

Fig.1. *The Job demands- Resources (JD-R) model (Bauer et al., 2014, p. 46).*



JDR is an abbreviation that stands for Job Demand Resources. The Job demands-Resources (JDR) model presented, by Bauer et al. (2014), offers a theoretical framework within work and organizational psychology to understand and explain how various job-related factors affect employee´s health, well-being, and performance in the workplace. The model highlights that Job Demands create tension and strain, while job resources serve to motivate employees by balancing these demands (Bakker & Demerouti, 2006). This integrative approach combines a positive focus on work engagement with a negative focus on burnout, making it a balanced and comprehensive framework applicable across diverse organizational contexts (Schaufeli, 2017).

The JDR model was chosen for this study because it provides a useful lens through which to understand the workplace realities of rehabilitation professionals and healthcare managers. The model`s focus on balance between job demands and resources makes it particularly relevant for examining issues related to stress, support, and collaboration. Central themes in the interviews. Since the aim of this study is to explore how professionals precise conflict management leadership and support at work the JDR model enables a structured yet flexible interpretation of these complex psychosocial processes.

The JDR model is a valuable tool for analyzing possible imbalances between demands and resources and for uncovering underlying reasons behind them. (Huo & Boxall 2017), describe two main processes in the model. The first, the motivation process,

occurs when individuals are stimulated by feedback, job control and support from colleagues, along with personal resources unique to the individual. The second, the health impairment process, happens when job demands become excessive, leading to depleted energy reserves if sufficient recovery time is not available. This can ultimately result in burnout.

Importantly, the (JDR) model emphasizes that resources do not only serve to counterbalance demands but also actively contribute to motivation (Bakker & Demerouti, 2006; Lesener et al., 2016; Roczniewska et al., 2022). The specific resources that motivate employees vary depending on their context and environment. For instance, a work environment that fosters feedback and development, alongside support from colleagues and managers, constitutes important resources that enhance motivation within the JDR framework (Bakker & Demerouti, 2006).

On the other hand, Job Demand such as high workload, stress, conflicts and unclear job expectations can negatively affect employees' well-being (Bauer et al., 2014). Job resources, including autonomy, a positive climate, and social support play a crucial role in improving productivity, engagement and overall health at work (Bauer et al., 2014).

4.2 JDR model in the workplace (critical review)

The JDR model has been developed over time and used to serve as a conceptual framework for empirical studies on employees' propensity to innovate. While a certain level of stimulation can be beneficial, an excessively high level of challenge can become a stress factor and then lead to burnout and hinder innovation (Bauet et al., 2014).

Overall the JDR model provides valuable insights into how personal, environmental and job-related factors interact within the workplace. However, it has also faced criticism. Bauer et al. (2014) identify key issues that deserve attention.

The first issue concerns conceptual clarity. Critics argue that the model lacks precise boundaries, leading to ambiguity in defining job demands and resources. This lack of clarity complicates consistent measurement and operational across studies. The second issue involves casual relationships. The model focuses on accusation between demands, resources, and outcomes but insufficient addresses the directionality and causality of these connections. There is a need for more research to understand how demands and

resources influence each other over time and jointly affect employee outcomes. (Bauer et al., 2014).

The third criticism highlights modifying factors. Although the model acknowledges individual and contextual moderators, some scholars argue that these factors are not fully integrated limiting the models´s explanatory power (Bauer et al., 2014). The fourth issue relates to measurement challenges. Existing tools that assess job demands, resources, and outcomes may lack validity and reliability, pointing to a need for improved measurement instruments within the JDR framework (Bauer et al., 2014).

Fifth, concerns about generalizability arise because the model was primarily developed and tested in Western context. This raises questions about the applicability in diverse cultural and organizational settings. Thus, cross-cultural research is essential to validate the model´s broader relevance. Lastly, the model offers limited guidance on intervention strategies. While it effectively explains work-related well being, there is a shortage of practical recommendations on how to improve workplace health and performance of practical recommendations on how to improve workplace health and performance based on the model, indicating an importance for future research.

Previous studies suggest that work demands, tasks and personal resources vary greatly depending on the specific job individual. This inherent flexibility is both a strength and limitation; it allows the model to be adapted across contexts but can reduce its generalizability.

In this thesis the JDR model plays a central role in systematically examining how job demands and resources affect rehabilitation staff and the support they receive from healthcare managers. By following the relationships and process illustrated in figure 1, this framework enables a step by step analysis of how job demands, stress and well-being and ill-health influence communication cooperation and managerial support within rehabilitation teams. Therefore, the JDR model is especially well-suited to analyzing the empirical data in this study.

The JDR model was not only used to frame initial understanding of job stress and support mechanisms, but also guided thematic analysis by helping to categorize data according to the dimensions of demands and resources. This theoretical lens helped reveal how organizational support, leadership styles and communication influenced employee well-being and collaboration within rehabilitation teams.

5. Methodology

The purpose of this chapter is to present the methodological process step by step, providing transparency and justification.

5.1 Method plan

In this project, the aim is to explore the experiences and perceptions of employees who work in rehab teams, as well as managers regarding the workplace's strategies for handling conflicts and working methods. Understanding these aspects is crucial for organizations that want to improve employee satisfaction and productivity. To achieve this goal, semi-structured interviews were chosen as a preliminary methodological approach.

The interviews were conducted with occupational therapists, physiotherapists, and managers in the healthcare sector, working regionally. Among interviews two of them were occupational therapists, two were physiotherapists, and there were three healthcare managers. Semi-structured interviews were selected as the primary research method for several reasons. First and foremost, they offer a flexible and adaptable format that allows for in-depth exploration of participants, perspectives, and experiences, unlike structures that follow a rigid set of predetermined questions (Busetto et al., 2020).

The qualitative interview data were then processed using thematic analysis, a tool to identify patterns by analyzing, interpreting, and describing themes. Jason and Glenwick (2016) describe thematic as a flexible method carried out in different ways (Alvinius, 2023). An inductive approach means that theme development is empirically guided, meaning conclusions are drawn directly from the collected data.

The chosen qualitative design, based on semistructures interviews aligns with the research question by enabling an in-depth understanding of managers support interprofessional collaboration within rehabilitation teams. This approach allows participants to describe their lived experiences and perceptions, which are essential for exploring leadership dynamics and organizational challenges in context. The use of AQAL model as an analytical framework provides a structured way to interpret the data across individual, interpersonal, organizational, and systematic dimensions, ensuring that the analysis captures the complexity of collaboration in healthcare, Thus, the methodological. Choices directly support the aim of identifying how leadership

practices influence team dynamics and professional well- being.

5.2 Data collection

In the framework of this research, I conducted seven semi-structured qualitative interviews with both rehab professionals and managers within the healthcare industry. Managers were interviewed to gain insight into their perspective to the support provided to rehab personnel. Rehab staff were interviewed to get a holistic perspective on the actual support they receive from their managers and their experiences with it. The interviews lasted between 45 and 80 minutes. 6 out of 7 interviews took place on the digital platform Zoom, and one was in person. Interviews were pre-recorded with the consent of interviewees and transcribed afterwards. The interviewees will be referred to by different letters (A, B, C, D, etc.) that are not associated with their real names because the interviews are confidential. All interviews were conducted in Swedish and transcribed in Swedish.

To ensure a trusted and open dialogue, all interview results will be presented anonymously using gender-neutral language. Thus, instead of the pronoun he or she, I will be using the pronoun they. As I am not looking into the gender aspect of this work, I will save some interpretational biases by avoiding using gender-specific pronouns. The semi-structured interview format was chosen to allow the maximum freedom of the dialogue and at the same time less influence of my pre-understandings from my side as a researcher.

The AQAL model was chosen as a tool for structuring and sorting the empirical material because it offers a comprehensive framework that includes both individual and collective as well as internal and external perspectives. The multidimensional view helped me systematically organize the interview data into meaningful categories that reflect the complexity of the organizational life. The model was particularly useful for this study because it enabled me to examine how communication, conflict management, leadership and collaboration are experienced by both managers and rehab staff across different dimensions of the workplace. In this way the AQAL models supported the research aim by guiding the thematic sorting in a way that aligned with the study's focus on relationship, roles and organizational support.

5.3 AQAL- model

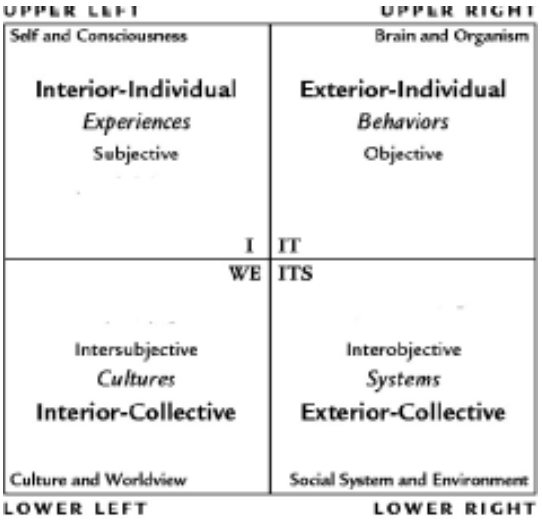


Figure 2. *Four Quadrants model Walsh & Wilber 2010, p. 48).*

In preparation for the interviews, I have divided the questions according to AQAL quadrants (see Figure 2). The AQAL quadrants are a schematic representation of the four dimensions or perspectives through which reality can be understood. The AQAL model, developed by philosopher Ken Wilber, is a framework for understanding and analyzing reality through four main quadrants or dimensions: subjective (inner individual), objective (outer individual), intersubjective (inner collective), and interobjective (outer collective) Walsh and Wilber (2010).

The AQAl model was chosen as an analytical framework because it enables a multidimensional understanding of complex human and organizational experiences. Its structures diving perspectives into Subjective (“I”), intersubjective (“We”), objective (“It”), and interobjectice (“its”) offers a comprehensive lens through which both individual and organizational experiences can be explored. This aligns well with the aim of this study, which is to understand how workplace strategies can support and communicate are perceived by rehab staff and managers in regional healthcare. This theme reflects a lack of Job Resources in terms of mutual support and psychological safety, as conceptualised in the JDR model.

The model helped structure the interview questions in a way that captured different levels of experience: personal perceptions and feelings, group norms and team dynamics, observable practices and leadership behaviors and a broader organizational systems and strategies. In doing so the AQAL framework supported a systematic and

holistic exploration of the research question making it possible to identify recurring patterns, contradictions and contextual influences in participant's responses. By applying this model, I was better able to connect the empirical material to the core issues of support, collaboration, and leadership in rehab teams.

Thus, in the upper-left “I” quadrant, I was asking participants to describe their personal experience with the organization, how they feel about their role, and how they would describe the overall mood and atmosphere in the organization. In the lower-left “We” quadrant, questions related to the organizational culture and norms, the value system, and interaction with and between different teams were asked. In the upper-right “it” quadrant, I discussed with participants organizational processes and managerial practices, identifying some examples. Lastly, in the lower-right “Its” quadrant, questions related to strategies, decision-making, and leadership were discussed.

Additionally, across all quadrants, where relevant and necessary, general questions about change, what it is, and how it is perceived, as well as definitions of leadership, were asked to ensure that the interviewer and the interview had a common understanding of the terminology. The outcomes of the interviews were analyzed first by dividing relevant parts of the interviews into the four AQAL quadrants in an Excel file. In the next step, I was looking for common patterns for my interpretations as well as the contradictions in providing answers to the same questions among all the interviewees. In the third step, these common patterns or contradictions were analyzed using the second AQAL element at all levels.

During the analysis process, I used both my Ipad and the NVivo software to work with the interview transcripts in parallel. On the ipad, I took the field note during the interviews, which allowed for an initial intuitive understanding of the participants' expressions, tone and emphasis. These reflections complemented the more structured work in NVivo, where I coded and organized the data thematically. The combination of these tools enabled me to move between detailed quotes, my own interpretations and broader patterns. In this way my understanding of the material was deepend and I was able to identify nuances and connections that might have been missed in a more one-dimensional analysis.

Three out of seven interviews took place with the healthcare managers. The selection of departments was made based on two criteria, that the departments were operated regionally and that the departments operated rehab teams that could represent

physiotherapists and occupational therapists that the purpose of the study was to investigate.The respondents consisted only of women; it is possible that important information has been lost, as the men's perspective has not been taken into account, which may also have influenced the result (Polit and Beck, 2008).

1.Transcription and data engagement early in the process.

2. First read transcripts without taking notes.

3. Re-read and start taking notes.

4. First review of codes – interpretations in relation to transcripts.

5. Second review of codes – Interpretations in relation to theories and concepts.

6. Reflect on implications of findings.

To reveal the underlying meanings behind what was shared with me in the interviews, I used coding, which is the most commonly used analysis method in organizational studies (Reissner & Whittle, 2022). The structure of my analysis process was inspired by Bryman (2016). Moreover, the transcript included pauses, fumbled words, laughter, and coughing, as recommended by Reissner & Whittle (2022). Overall, I made sure that during the coding, the context of what was being shared was maintained, as this is one of the key advantages of qualitative analysis. For the coding, I moved between using the software Nvivo and the notes on my iPad from the interviews and working through the transcripts. This way of sorting the data, identifying themes, and coding allowed me to find the deeper meaning in what was being shared with me.

There have been some limitations, such as the fact that the study has not been able to include more managers from other regional departments because they had a lack of time to do an interview, and the fact that these managers came from different parts of the city of Malmö. The author thinks that it would differ a bit from the different cities in Sweden in terms of work relations and other perspectives like resources and workload. Another difficulty of my work was looking for the research and what was there before. Particularly within the healthcare staff, many professional groups have been studied. But the rehab group did not find as much literature. So you could say that I didn't have much to work with. However, I have been able to gain insight into how both rehab and

the managers experience communication and accessibility to contact HR within care to compensate for this in my study.

5.4 Selection of interview participants

The focus of this project has been to create an understanding of how different social conditions, communication, and the workplace can have such a big impact on work. At the same time, create an understanding of managers and what support they need to provide. In order to be able to collect this data, there was a criterion that one had to have an occupational therapist or physiotherapist profession and that one had worked in regional care. Likewise for the managers, but also that they have had a long experience working within the regional health care system in their daily organizations. This enabled me to diversify and increase my sample size and opened me to a richer and thicker description of the experiences of professional professionals who offered multiple perspectives on this complex issue (Patten and Newhart 2018).

Meaning unit	Condensed sentence unit	Code	under category	Category
Unclear roles between occupational therapist and physiotherapist colleagues that become problematic and difficult to handle cause communication to decrease and misunderstanding to increase	“Become more and more blurred roles for someone other than the other rehab staff, as there is a lack of communication ”	Misunderstandings	Care conditions among all	Healthcare personnel = worse care

Deeper meaning was reached by interpreting the interview data through multiple analytical perspectives. First, themes were identified inductively using thematic analysis. Then, the AQAL model was applied to position these themes within different

dimensions of human and organizational experience. Finally, the JDR model was used to interpret how specific organizational resources and demands influenced collaboration. This triangulation of perspectives allowed for a more comprehensive understanding of the data, beyond that a single theoretical lens could provide.

Table 1. *The analysis process*

5.5 Ethical consideration

Ethical Principles for Doing Qualitative Health Research" underscores the pivotal role of ethical principles in qualitative health research (Morse, 2007). Central to this is respect for participants' autonomy, dignity, and rights, ensuring their well-being throughout the research process. Justice and equity are prioritized, promoting fair access to research opportunities and addressing power imbalances. Upholding beneficence and non-maleficence, researchers strive to minimize risks and maximize benefits for participants. Integrity and transparency are paramount, requiring honesty and accountability in all research interactions.

Research that has to do with people or society involves ethical problems. Respect for fellow human beings is a fundamental starting point for all research. This means that the work protects the physical and psychological integrity of those who contribute information. The duty of confidentiality must be strictly observed, and it must be ensured that other people cannot find out who the defendant is. They must also not be tricked into participating but must decide for themselves whether they want to participate. Which was ensured through the information letters that the author chose to send out. Continuous ethical reflection guides researchers in navigating complex ethical dilemmas, ensuring that research is conducted with the highest ethical standards and utmost respect for participants' rights and well-being (Morse, 2007). To ensure that the work follows certain ethical rules. Verbal consent was given before the interview. For the confidentiality requirement, an information letter has been sent out see Appendix 1.

6. Analysis and Results

In this chapter, the empirical data from the interviews are presented and analysed. The Analyse is structures used using the four quadrants of the AQAL model Walsh & Wilber (2010). Which provide a framework for exploring individual experiences, team

dynamics, organizational structures, and systematic factors. Subjective, intersubjective, objective and interobjective which comprehend a comprehensive framework for exploring individual experiences, team dynamics, organizational structures and systematic factors. Within each quadrant the Job Demand Resources (JDR) is applied to interpret how rehabilitation staff experience job demands, such a workload and role ambiguity, and job resources, such as managerial support and professional development. This combined approach enables a holistic understanding of how leadership and organizational conditions influence interprofessional collaboration within the rehabilitation team. The following sections are organized according to the AQAL quadrants, where themes derived from the interviews are analysed through the lens of the JDR model.

6.1 Quadrant (Experience of professional identity and role identity)

The analysis first outlines the employees perceptions of both professions and their collaboration and communication, followed by an examination of factors influencing these relationships with colleagues and managers. The relationship with the rehab staff has been reviewed in the literature overview, and it can be deduced that there is not much information about their relationship with each other or with the managers. Most of those who have been investigated have been nurses and doctors and or other staff such as coordinators or assistant nurses. When asked what the collaboration and communication looks like, the participants answered differently. This is because the people interviewed were workers in different departments. B: stated, for example, that:

> The communication and cooperation differed quite a lot from the internship period compared to the current job. It's my first workplace since graduating and I really didn't think it would be like this. There has been a lot of instability and conflicts. (Respondent B)

Several respondents described situations characterized by blame and unwillingness to cooperate. It was also noted that everyone has their own idea of how collaboration between occupational therapists works and they can differ a lot depending on which hospital the patient belongs to. It also becomes clear that the collaboration affects each individual in a way. In order to understand what cooperation and communication means to rehab staff, they have had to be able to understand the other's tasks, adapt, create good strategies, and have a common plan for the patients. The responses indicate

that individual personality traits play a significant role in collaboration and communication A: mentions that

> When you don't click as a person right from the start, It can lead to poorer communication between physiotherapists and the occupational therapists (Respondent A). This statement illustrates how interpersonal compatibility influences communication within rehabilitation teams. Several respondents described experience of limited support, suggesting that lack of understanding from managers contribute to challenges in cooperation When asked if there had been any conflicts in the rehab teams and how they had been handled by the managers, they were answered by several that the managers were not really familiar with the rehab staff's communication. C:

> I think they are very individual depending on where you work and they can probably be difficult to generalize. However, my experience of the conflicts has varied. For example, the conflicts between the rehab members were intense. Managers were busy and did not engage professional help to resolve the conflicts. (Respondent C)

What most of the rehab staff shared in common was that the underlying culture the rehab staff had created in the past changed as a new candidate. Respondent B:

> “As a new employee I had to adapt to the environment and figure out how to establish myself. Feeling unwelcome made collaboration difficult. The first few weeks I had to adapt myself by the environment and by how the offices sucked. But also how I had to see to it myself to establish myself in the new ones. Every now and then, when I felt that I was not welcome from the beginning by those I will be working most closely with, I immediately understood how difficult collaboration is”. They struck me for the first time that having met and known people before makes it easier to understand the semantics of some of their phrases or why they use certain linguistic expressions and what can be hidden behind them. Or having to read through the lines which made it take extra

> long (Respondent B)

According to Kim et al. (2017), when someone is treated disrespectfully, from being impolite to engaging in severe bullying, they may feel alone and embarrassed among their peers. It consequently has an impact on the interpersonal dynamics among the rehab professionals. In healthcare teams, power dynamics and hierarchical systems are especially affected from an interpersonal standpoint. This aligns with the respondents account, illustrating how early manifestation of bullying may influence not only the individual but also the overall team dynamics. Bullying often takes place in settings where those in positions of authority exercise their control over those beneath them. These problems are made worse by a lack of mutual respect and poor communication among team members. The findings highlight the need for organizational strategies and policies that address and reduce bullying in healthcare settings. Another respondent D answered the same question with:

> For me to learn their way of working, they also affected my relationship with other professions. This as I did not have a stable foundation with the colleagues with whom I was expected to have a close collaboration. Other healthcare staff had expectations of me both as rehab staff but also that we should be a cohesive team. When they were already there was an expectation on me that I would bring my questions to the rehab team about how things are done. Even then, I felt trapped, questioned about patient prioritization, and experienced condescending attitudes. Managers were under pressure due to staff turnover, which led to rushed recruitment. (Respondent D)

As a result, recruitment is not so thorough, you employ staff that the managers do not feel familiar with or that you do not have time to ask for references for that person, Respondent C:

> You do not have time to visit a day at work to meet the colleagues and see the tasks that may differ from one department to another within the region,

> instead they were hired and they became direct bullying from their side towards me, even now a year later I can still feel how they exclude me and each other. You can therefore say that they are not exactly peaceful and they have created more and more frustration between everyone in rehab. (Respondent C)

A comparison between respondent C and D reveals similar experiences regarding communication challenges and team dynamic (Respondents D)

> Once you have created a perception of the other staff in rehabilitation and established a communication pattern, it can be difficult to change. Communication is often not only about words, but also about tone of voice, facial expressions, and gestures. (Respondent D). This quotation highlights patterns and interpersonal perceptions shape everyday collaboration within rehabilitation teams. From a leadership perspective, this indicates how managers play a crucial role in facilitating reflective communication practices and addressing dysfunctional interaction patterns. In this way managerial actions influence work relations and the psychosocial work environment which directly relates to the research question.

6.2 Quadrant 2 (Communication patterns and interprofessional understanding)

In the upper right quadrant is about observing behavior and documenting various factors etc. that could show specific challenges and obstacles that can affect the rehabilitation process objectively. Among other things, a lack of resources is identified. In addition, they reveal that there has been a lack of coordination and communication between different care providers and that units contributed to delays in care. B: mentions that:

> After rounding patients with healthcare stuff, planning was affected due to poor communication. Discussions about prioritization slowed down. (Respondent B)

> It felt heavy and difficult to decide which patients to prioritize. Lack of time

> and physical constraints made the work environment challenging. (Respondent B).

Efficiency and communication are affected by workload and lack of resources. Health information technology (HIT) can improve efficiency and reduce errors. Within in turn impacts healthcare costs and long term savings (Chaudhry et al., 2006). This section shows how managerial behaviors and organizational structures support the psychosocial work environment thereby addressing the research question.

6.3 Quadrant 3 (Organizational structures affecting collaboration)

This quadrat explores the shared values, cultural norms, and interpersonal relationships that shape how rehabilitation staff collaborate and communicate. The analysis focuses on how team culture, communication patterns, and organizational norms influence cooperation and cohesion among professionals.

The interviews revealed that limited resources and unclear coordination negatively affected collaboration between rehabilitation professionals. Respondents described how these conditions created frustration and impacted both teamwork and patient outcomes.

> (Respondent E) speaking from a managerial perspective, described how poor communication affected both staff and patients: "The poor cooperation among the rehab staff also affected the other healthcare staff. Even when we encountered obstacles, we didn't really help each other but just tried to make the best of the situation."

Environmental factors also played a role in shaping communication. The physical layout of the workplace made private patient interactions difficult, which in turn influenced the professions experience of stress.

The lower left quadrant identifies and compiles different behavioral phenomena relevant to the study. Focusing on how individuals interact with their surrounding, perform their tasks and behave in social situations. This quadrant also addresses external conditions such as organizational structures, financial resources and cultural

norms. Analyses of observable behaviors and documented factors revealed specific challenges and obstacles that affect the rehabilitation process objectively. Among other things, a lack of available resources for the employees, long waiting times for important rehabilitation processes for some patients were identified. This meant that patients had to stay longer in the hospital than they were expected to be. In addition, it emerged that a lack of coordination and communication between different care providers and units contributed to delays in care. E: responded from a managers perspective:

> Several events and situations were among the rehabilitation staff and patients. What you could also come to was that the poorer contact and communication affected the patient group for the department. The poor cooperation among the rehab staff also affected the other healthcare staff. They want to say that even if you encountered obstacles and challenges, you did not help each other, but you tried to make the best of the situation and not do much more. (Respondent E)

In another department, one of the employees mentions how the environment can limit the staff's work. Based on an organizational structure, there were several obstacles that also affected the collaboration.

> One respondent highlighted how the physical environment limited the communication with patients.
>
> A lot of times we didn't have enough space to talk to the patients individually. There was only a curtain between which made the patients uncomfortable (Respondent E).

This was another factor that affected the history taking where the rehab staff might not get all the information you needed to help the patient in the best way. Respondents described how, in new workplaces, it could be difficult for newly employed to navigate routines to contribute to environmental improvements, even when the overall structure was similar to previous settings.

Respondent C: described how staffing shortages created additional strain on rehabilitation teams: when many staff are on sick leave or on parental leave, the department must quickly find replacements. These situations often occur unexpectedly, and managers are not always prepared for them.

In the rehab teams, when working together, it is almost as if they are missing someone who compiles the entire work regarding rehab or discharge of the patient. This assessment cannot really be carried out by any other profession, neither physiotherapist or occupational therapist, which differs from other professions when you would call in another doctor, nurse or assistant nurse. (Respondent C)

Managers do not often have additional rehabilitation employees like other professional groups. Many times as a manager without many years of experience, it can also be a challenge that you don't know how or in what way you should show yourself to be available to the employees and that they should look at each other in order to have an open dialogue. They spend a lot of our time trying to figure out if they don't have enough personnel. Respondent F: A large part also deals with recruitment:

> One manager explained that recruitment decisions play a significant role in shaping team dynamics and organizational culture. I thought that you would be introduced to the statistics of how the department was managed in the past, e.g. employees, sick leave and maybe discuss what in the workplace can cause bad or missed communication. As a manager, I believe this has brought the organization as a whole but also the divisions forward faster. (Respondent F).

This analysis is something that can also be deduced from the JDR model, if the job requirements were felt to be difficult for the workers, it may be because they do not have enough resources and conditions for the personnel to be able to help by example the patients in the best way in this case. When neither the job requirements nor the work resources are available, this can affect the motivation process in such a way that the personnel become burnt out in their work and in this way affect their well-being at the workplace. A practical example of this is how one of the rehab staff who has been interviewed tells us that "It was evident from colleagues that some rehabilitation staff appeared physically exhausted" (Respondent G).

This of course affects the other staff in a negative way. Both their well-being and their mental illness, the commitment to the employees will no longer be the same. Something that another manager has also noticed in another workplace (Bakker and Demerouti, 2006).

> It's enough for them to be one or two people who have a bad energy and work ethic and they can affect the whole group. This sometimes led to increased conflictions and tension within the group, creating negative work habits and lower performance. "What I have been able to experience for many years in this industry is that they can change very quickly, depending on who they are. manages the organization. (Respondent G).

Depending on the organizational culture it has been in the organization, and how it has changed over time. It is the people themselves who really see to it that the rules and norms. These cultural norms define how strict or flexible the environment is, and can create insecurity when negative attitudes spread among staff. A strong organizational culture in healthcare also emphasizes the importance of ethical practices and accountability. Moreover, a supportive culture can lead to higher job satisfaction and retention rates among healthcare staff, which in turn reduces burnout and turnover, further contributing to consistent and high-quality care (Carney, 2011).

> One respondent with previous experience as a physiotherapist reflected on the transition to a managerial role, noting that communication and organizational culture. (Respondent G).

Something that the workplace also offers is to allow people to connect with others and create individual relationships, which means that people find their own way of creating a relationship with certain people more than others, especially if you work so closely together, they become either you create a very close and good bond together or you can't work together on a personal level, it becomes more difficult to communicate at work (Respondent G):

“You know which does not belong to the organization and sometimes it is difficult to know how to deal with this as a manager” (Respondent G).

In many cases, these dilemmas can be caused by pre-existing circumstances at work. Respondent C: mentions that:

> An interesting observation made by a colleague regarding the organization's culture that looks at the culture from a toxic-healthy but from a lens modern-old fashioned. This rehab colleague made an interesting link between the construction of the organizational culture in connection with the state of the mind of the people:
>
> This is how they are until I think you quite quickly fall out of the frame when you don't belong to a group or other colleagues and they are very organizationally guided by this. (Respondent C).

The way teams work can reveal whether the organizational culture is modern or more traditional, particularly regarding the conclusion of new colleagues and decision making.Analysis of the interview highlighted differences in patterns between a rehab colleague who had started a new job in a new department because the previous department had toxic behavior. Respondent D: mentions, among other things:

> They were generally much more male doctors, men as nurses and in the rehab staff, she experienced the department as much calmer and harmonious. In terms of age, they were very mixed between younger and older, in rehab they were younger staff, so to speak at the age of 25-30 which was positive. There were staff who were immediately nice and welcomed me into the group, they were only experienced as flexible to work with and adaptable both for their colleagues and for the patient work and there was nothing that was right or more without man just learning from their mistakes. (Respondent D).

These findings highlight the diversity of values underpinning collaboration. Interpreted through the JDR model, this suggested that when job resources are distributed appropriately, motivation and well-being are strengths among staff. This in itself, which can be seen in model figure 1, shows in the arrows that the positive well-being will lead

to positive outcomes. This corresponds to the interobjective quadrant, concentrating on observed organizational factors. JDR helps illuminate how workload and autonomy shape employees' work environment. This section highlights how rehabilitation professionals experience support and strain in their psychosocial work environment which links back to the research question regarding manager´s influence.

6.4 Quadrant 4 (System level factors shaping team conditions)

This quadrant focuses on the collective exterior of aspects of organizational transformation. It examines structural and systematic factors such as resource allocation, leadership strategies, and healthcare system organizations. These dimensions reveal structural obstacles and limitations that influence the rehabilitation process on a broader level. The analysis identifies insufficient financial resources and an overloaded healthcare system as key contributors to suboptimal care conditions and reduced treatment outcomes for patients. Furthermore, findings highlight the need for policy adjustments and organizational initiatives to promote more integrated and efficient rehabilitation care. Achieving more effective care requires ongoing evaluation of micro-level processes to identify and address specific areas for improvement.

Part of this may be to review what limitations and obstacles come in the way of the rehabilitation process being more planned for the patients. Respondent F:

> Due to the financial resources in the department, certain staff activities could not be maintained. For instance weekly breakfast for staff were discontinued, and discussions about new equipment were diprioritized (Respondent F).

Maintaining the health and comfort of the employees is an essential strategy for staff retention, as the work environment significantly affects well-being. However, challenges emerged when managers decided to expand the number of care units despite limited staffing. Respondents described how these decisions led to time pressure and

insufficient patient interaction, as available staff had to cover more patients than before. These challenges also contributed to communication difficulties, particularly when reporting was done hastily over the phone instead of in person meetings.

The staff who receive the report receive it via telephone and they happen very quickly in certain situations. (Respondent G).

> There were several occasions when the staff felt rushed due to the workload, especially before and during the summer when temporary staff were brought in to cover vacationally employees (Respondent G).

Much of the structure fails, the managers also state, the leadership appears in a different way. The organization is completely restructured when the interaction does not look the same as it "always has". As healthcare employees follow new people's behavior, actions, roles, positions and norms. It has a bigger change on the whole organization when so much changes in one department in such a short time so quickly. Analysis at the organizational level revealed that institutional changes can directly affect employees' willingness to remain at their workplace. Previous research supports this observation: Employees that support autonomy and support in their roles tend to demonstrate stronger organizational commitment and reduced turnover intentions (Richard and Edward, 2017).

Similarly, Hales et al. (2022) emphasize fostering autonomy where employees have influence over their work and decisions - are more likely to strengthen organizational commitment. Furthermore, social support among colleagues plays a critical role in mitigating turnover inhesion and enhancing motivation (Bufquin et al., 2017). Bufquin et al. (2017) also found that perceived competence alone does not predict organizational commitment unless job satisfaction is considered. Parmar et al. (2022) further demonstrate that lack of commitment increases the risk of emotional exhaustion and stress, which can lead to higher turnover. F: mentions:

> Ensuring sustained engagement in the workplace can be challenging for

> managers. Organizing after work events or similar initiatives may improve motivation but prioritizing resources to satisfy everyone can be difficult and sometimes burdensome (Respondent F).

Overall this quadrats illustrate how structural and systemic conditions such as financial limitations, staffing shortage and organizational change the effectiveness of rehabilitation teams. The analysis demonstrates that both leadership strategy and workplace culture influences engagement, motivation and long-term commitment. When job resources are aligned with staff needs, the risk of exhaustion and turnover decreases. contributing to a more sustainable and supporting healthcare environment. This belongs to the intersubjective, as it involves broader system structures. JDR clarifies how institutional policies create demands or provide resources. These results demonstrate how shared values, team culture and collaboration practices shape work relations, contributing to answering the research question as it also concerns collective norms, shared understanding and cultural aspects.

7. Discussion

7.1 Discussion of communication, leadership and organizational factors

This study explores how managers can support collaboration and manage workload within rehabilitation teams in a hospital setting. Through qualitative interviews and the application of the Job Demands-Resources (JDR) model and the AQAL model, several themes emerged regarding interpersonal dynamics, leadership and organizational challenges. Participants described widespread issues with communication, conflicts, and a lack of managerial support. These findings suggest that organizational structure and leadership approaches have a strong impact on staff well being, collaboration and ultimately the quality of patient care.

These communication challenges align with findings of Rosen et al. (2018), who highlight that unclear role expectations and insufficient managerial support negatively impact teamwork in healthcare. However, unlike their studies, our findings indicate that interpersonal conflicts are amplified by the lack of structured onboarding, which may be specific to rehabilitation teams in the Swedish hospital context.

A central finding in this study was the role of communication in shaping the everyday working conditions of rehabilitation staff. This finding aligns the strength of the connection to the research by showing how leadership and organizational structures affect team collaborations. This aligns with findings by Kim et al. (2017), who showed that lack of mutual understanding between healthcare professionals negatively affects team performance. Similarly, Eklof and Ahlborg (2016) found that targeted communication training improved collaboration and job satisfaction, which supports the relevance of addressing communication issues in rehabilitation teams. Several respondents (eg. Respondent A, Respondent B) described unclear expectations, misunderstandings, and even open conflict within teams, often linked to a lack of mutual understanding between professions or personalities. Respondent A notes poor personal compatibility was seen as a barrier to effective communication:

> ”When you don't click as a person right from the start, it's already a factor in poorer communication”

These experiences align with the interpersonal quadrant (“I”) in the AQAL model, which highlights the importance of subjective perspectives in team dynamics.

Furthermore, the JDR Model helps us to understand how poor communication functions as a Job Demand, draining energy and increasing emotional strain. This explicit linkage to the JDR model reinforces the theoretical application in the analysis.

This is supported by previous research. Eklof and Ahlborg (2016) found that targeted communication training led to better team dynamics and higher job satisfaction in healthcare settings. However, Respondent C and Respondent D also noted resistance to change, something echoed in this study, where staff are often unsupported in addressing long-lasting communication issues.

7.2 Leadership and Managerial Support

The role of leadership was another key issue. Respondent B and Respondent C expressed frustration over managers who were perceived as distant or unaware of the specific challenges faced by rehab staff. Respondent C explained:

“Conflicts between rehab members were quite intense… and no one took the initiative to engage professional help..:”

These examples explicitly illustrate the gap in the leadership support and directly connect to the research question about managerial influence on collaboration. Rosen et al. (2018), who emphasize that transformational leadership, characterized by presence, support and guidance, is crucial for team cohesion and effective collaboration. Similarly West et al. (2015) highlight that leaders' engagement directly affects staff well-being and organizational commitment.

Here the lack of managerial support is a clear resource deficit, as per the JDR model. When managers fail to respond to interpersonal problems, employees are left to navigate complex conflicts on their own, often leading to increased stress and potential burnout. Explicitly linking these observations to both JDR and AQAL strengthens the theoretical integration. In contrast, supportive leadership is characterized by presence, communication and emotional backing was specifically highlighted by Respondent F, as crucial for team cohesion. These findings underline the importance of transformational leadership in healthcare, where the leader´s role includes task coordination and emotional guidance.

The observed lack of managerial support mirrors prior research showing that insufficient resources increase burnout risk (Shaufeli & Taris, 2014: Lesener et al., 2019). Our study further demonstrates that supportive leadership not only mitigates stress but also facilitates interprofessional collaboration, emphasizing the practical importance of JDR- Informed management strategies.

7.3 Organizational Culture and Hierarchies

Several respondents (Respondent B and Respondent D) pointed to organizational culture as a barrier to collaboration. These findings reflect previous research showing that hierarchical structures and toxic team climates can reduce motivation and increase turnover (Bufquin et al., 2017; Parmar et al., 2022), reinforcing the importance of addressing both interpersonal and organizational factors in rehabilitation teams. Some described entering teams where informal norms, exclusion or power struggles made integration difficult. Respondent B shared:

“I was told on my first day ‘oh now she´s coming to our office and we're already running out of space’....”. These experiences reflect a toxic team climate and point to underlying cultural issues within the intersubjective AQAL quadrant (shared values, group norms). According to the JDR framework, such a climate can act as chronic demand that diminishes motivation and increases staff turnover.

Additionally, hierarchical structures within hospitals may reinforce power dynamics, where certain professions are privileged over others. This further complicates interdisciplinary collaboration and can foster mistrust or defensiveness between staff groups. The study also uncovered structural and systematic challenges, such as high staff turnover, poor recruitment practices, and insufficient onboarding. Respondent D described being placed in a team with little preparation, leading to misunderstandings and conflict. This reflects broader organizational issues that go beyond individual teams.

From a JDR perspective, lack of resources, job demands, and inadequate support systems contribute to an unsustainable work environment. Addressing these issues requires not only better leadership but also institutional changes in staffing, onboarding and workload distribution. The insights from this study confirm the complexity of working conditions within rehabilitation teams. By using both the JDR and AQAL models, the study provides a multifaceted view of how individuals experience interpersonal dynamics. organizational culture and leadership intersect.

Improving these areas will not only benefit the well being of staff but also ensure a more stable and effective healthcare system. Future research could explore interventions based on these findings and examine how leadership development, communication training and structural reforms impact both staff outcomes and patient care.

Overall these findings illustrate how managerial practices and organizational structures directly influence collaboration and workload management in rehabilitation teams, thereby answering the research question and highlighting areas for practical improvement.

8. Conclusion

This study contributed to a deeper understanding of collaboration and leadership within rehabilitation teams in hospital settings. Through a qualitative approach grounded in the AQAL model and the Job Demands-Resources (JDR) framework, the research has uncovered the multifaceted nature of communication, interpersonal dynamics and leadership in the context of healthcare organizations.

The findings indicate that communication is not a central component of interprofessional collaboration even in teams where daily work is not fully integrated. Participants described how misunderstandings, lack of clarity in roles , and unsolved interpersonal tension negatively influenced their work environment and professional relationships. In particular it became clear that healthcare managers often lack insight into the internal dynamics of rehabilitation teams, which leads to a disconnect between managers' decisions and everyday experiences of staff. This echoes precious research, such as Eklof & Ahlborg (2016), who found that structured communication interventions can significantly enhance teamwork, reduce conflicts and improve job satisfaction.

In addition the study shows that collaboration is not solely dependent on organizational structures or formal policies but also the personal qualities of team members and the prevailing workplace culture. Participations highlighted the importance of mutual respect, emotional safety and a shared understanding of roles as fundamental elements in fostering a cohesive work climate. These findings reinforce earlier studies that emphasize the role of interpersonal factors and team climate in supporting successful collaboration.

The AQAL model made it possible to explore these dynamics from a holistic perspective by integrating subjective experiences, interpersonal relation, organizational practices and systemic conditions. At the same time the JDR framework helped to illuminate how leadership and communication function both as demands and as vital resources in the daily work of healthcare professionals. The theoretical combination proved valuable in analyzing the interplay between individual and organizational levels.

While the participants offered meaningful insights, the findings also revealed several systematic challenges such as limited resources, lack of structured support for conflict resolution and insufficient opportunities for professional development. These issues not only influence the quality of collaboration but also contribute to staff dissatisfaction and high turnover rates.

From a practical standpoint , the results of this study underline the necessity of fostering a leadership culture grounded in openness, support and responsiveness. Healthcare organizations should invest in leadership training, communication development and structured feedback mechanisms in order to promote both staff well-being and patient care quality.

In conclusion, this study has shown that successful collaboration in rehabilitation teams requires more than organizational directives; it demands a comprehensive understanding of interpersonal dynamics, thoughtful leadership and a culture of mutual support. By addressing these dimensions healthcare can take meaningful steps toward improving collaboration and sustaining a healthy and effective work environment.

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Appendix 1: information sheet and consent form

Hej!
Information om intervju för masterstudie/examensarbete

Du tillfrågas härmed om deltagande i denna undersökning.

Syftet med studien är att undersöka hur goda arbetsrelationer och effektiv kommunikation kan stödjas i rehabteamet (inom primärvården). Utifrån en medarbetare och chef perspektiv.

Jag efterfrågar dig som arbetar inom den regionala hälso- sjukvården inom ett rehabteam samt som chefsavdelning för intervju. Intervjun kommer att ta ca 45- 60. Det kommer även att vara möjligt att ta del av resultatet för denna studien efter att uppsatsen har skrivits färdigt.

Deltagande är frivilligt och uppgifterna kommer att behandlas konfidentiellt. Respondenten kan avbryta sitt deltagande när som helst under studiens gång. Informationen kommer att lagras och skyddas och efteråt kommer all material från intervjuer att makuleras.

Denna masteruppsats kan på så sätt bidra till att synliggöra på vilket arbetsmiljöområdet inom primärvården inom primärvården svarar mot chefer och och medarbetare inom rehabteamen. Detta resultat kan även bidra till utveckling av arbetsmiljöarbetet inom rehab teamen.

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Appendix 2: questions for rehab team

Rehabpersonal:

intro frågor:

1. Hur mår du idag?
2. Berätta lite om din profession?
3. Hur länge har du arbetat som FT/AT?
4. Hur ser en vanlig arbetsdag ut för dig?

Main part:

1. Beskriv lite om hur din upplevelse har varit att arbeta regionalt, hur upplever du atmosfären och organisationskulturen?
2. Hur upplever du kommunikationen mellan rehabmearbetarna på din avdelning? - Kan du beskriva din relation med dina kollegor?
   - Hur har sammanhållningen sett ut mellan rehabteamet?
   - Finns det några regler/normer som era rehabteam följer/skapat?
3. Har du upplevt några konflikter inom rehabteamet, i så fall hur hanteras de av cheferna?
   - Hur ofta kommunicerar du med din chef ? Hur ofta är hen tillgänglig? - Hur hanteras de av resterande personal i rehabteamet?
   - Tycker du om hur arbetsfördelningen ser ut mellan rehab personalen?
4. Hur förhåller du dig till att hantera meningsskiljaktigheter eller konflikter mellan teammedlemmar inom rehabteamet?
   - Varför tror att det ser ut som de gör i organisationen?
5. Har du behövt övertyga ditt team om att göra någon större förändring? - Har någon större förändring på organisationsnivå, kan du exempel på vad de hade kunnat vara?
   - Har du upplevt något motstånd från dina rehabkollegor till förändringen?

6. Hur försäkrar ni/du att alla är informerade och engagerade i diskussionerna inom rehabteamet ?

- Har ni eller använder några metoder/metoder?

7. Upplever du avsätter tid till att skapa sammanhållning i rehabteamet? 8. Vad anser du cheferna kan förbättra när de kommer till den sociala relationerna för att rehabteamet ska arbeta mer effektivt? ge exempel.

9. Vad anser du att cheferna kan förbättra när det kommer till arbetsmiljön för att rehabteamet ska vara mer sammanhållna?

- Hur hanterar du personella förändringar i arbetsmiljön?
- Har ni i ert rehabteam tidigare diskuterat vad i arbetsmiljön som skulle kunna förbättras för att få en mer sammanhållning i teamet?
- Har de diskuterats med chefer?

<u>HR initiativ:</u>

10. Skulle du som rehabpersonal vilja ha direkt kontakt med HR? Om ja, varför? 11. Vilken roll spelar HR i ditt perspektiv för att främja samarbetskultur och öppen kommunikation inom rehabteamet?

12. Vad tror du HR-initiativ kan göra för att uppmuntra och förbättra samarbetet och sammanhållning bland rehabteamet?

Avslut frågor:

13. Om du skulle få chansen att förbättra två saker i rehabteamet, vad skulle det vara då ?

14. Med erfarenhet av att jobba med ditt rehabteam, hur har det påverkat dina sociala relationer och ditt arbetssätt?

15. Vad tycker du generellt behöver förbättras i det regional arbetet idag?

Appendix 3: questions for Managers

Avdelningschef:

Intro frågor:

1. Hur mår du idag?
2. Berätta lite om vad du brukar göra en vanlig dag som chef på avdelningen?
3. Hur lång erfarenhet har du med att arbeta som avdelningschef ?

Main part experience:

1. Hur ser du på samarbetet och kommunikationen i rehab teamen? (den senaste tiden)

- Vad kan du se är positivt i deras samarbete?
- Vad behöver förbättras?

2. På vilket sätt kan du som chef kan arbeta för att främja positiva arbetsrelationer inom rehab teamen på din avdelning?
    - Vilket stöd får du/finns det i organisationen för arbetet för arbetsmiljön
3. Tror du att rehabteamet hade haft en mer sammanhållen relation om arbetsmiljön hade sett ut på ett annat sätt?
    - I så fall vad skulle kunna göra för att miljön skulle kunna se bättre ut?
4. Från ditt perspektiv, hur kan du som chef uppmuntra samarbete och sammanhållning bland professionerna i rehabteamet?
5. Enligt dina erfarenheter, vilka är några effektiva strategier/metoder som en chef kan implementera för att förbättra kommunikationen mellan team medlemmarna i rehabteamet?
    - Har du tidigare arbetat med strategier eller metoder som är ägnade åt rehab personalen?
6. Har du stött på konflikter inom rehabteamet och i så fall hur hanterades det?
7. Finns det några specifika konfliktlösning tekniker eller interventioner som du tror chefer kan implementera som inte redan finns för att

förbättra och effektivisera kommunikationen mellan rehabteamen men ännu inte gjorts?

8. Hur kan du som chef bidra eller uppmuntra till en öppen organisationskultur samt främja förtroende och stöd inom rehabteamet för ett bättre lagarbete?

HR initiativ:

9. Hur ser din relation ut till HR i er verksamhet?

- Hur ofta har ni kontakt?

- Kring vilka frågor har ni kontakt?

- Hur lätt/svårt skulle du säga det är att få tag på HR

10. Upplever du/ ni du att du/ni som chefer behöver mer stöd på avdelningen är i behov av mer stöd av HR? Om ja, på vilket vis skulle ni önska att ni fick stöd? ge exempel 11. Kan du ge exempel på initiativ som leds av HR/chefer som framgångsrikt har främjat positiva arbetsrelationer eller positiv arbetsmiljö för rehab personalen?

Avslutande frågor:

12. Om du fick chansen, vad skulle du som chef vilja förbättra främst för rehab teamen?

13. Upplever du att chefskapet behöver få en större inblick i rehabteamet generellt?

14. Hur upplever du arbetet som chef regionalt?

Managers in healthcare sections:

1. What help has HR contributed to the rehab team in your department? What resources are available for the rehab team

2. the rehab team knows what resources are available

3. What methods and strategies have been used to manage conflicts to promote cooperation and cohesion?

4. How do you approach managing disagreements or conflicts between team members within the rehab team?