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Collaboration between social educators and nurses in institutions for persons with disabilities in french-speaking Switzerland

La collaboration entre éducateurs sociaux et infirmiers dans les institutions du handicap en Suisse romande

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Résumés

English Français
The ageing of people with disabilities and the evolution of their situation imply an increased need for support and care. In institutions for persons with disabilities, social education and health professionals are increasingly called upon to work together within socio-educational teams. This article investigates collaboration between social educators and nurses working in residential social care institutions for persons with disabilities in French-speaking Switzerland. Thirty-six semi-structured interviews were conducted with employers, social educators and nurses regarding recruitment practices, the division of labour and collaboration among professionals. Our study pointed out two modalities of division of labour in the participating institutions and the issues they raise: “formal distinction” that involves a difference between social educators and nurses and “no formal distinction” that makes no differences at a formal level between these professional groups. Results also highlight the positive collaboration between social educators and nurses, areas of tension and influences on interprofessional collaboration.

Le vieillissement des personnes en situation de handicap et l’évolution de leurs problématiques impliquent des besoins accrus en matière d’accompagnement et de soins. Dans les institutions du handicap, les professionnels du social et de la santé sont de plus en plus amenés à travailler

ensemble au sein d'équipes socio-éducatives. Cet article explore la collaboration entre des éducateurs sociaux et des infirmiers travaillant dans des structures résidentielles du domaine du handicap en Suisse romande. Trente-six entretiens semi-directifs ont été menés avec des directions, des éducateurs sociaux et des infirmiers en vue d'appréhender les pratiques de recrutement, la division du travail entre éducateurs sociaux et infirmiers et leur collaboration. Notre étude a mis en évidence deux modalités institutionnelles de division du travail ainsi que les enjeux qu'elles soulèvent: la première implique une distinction sur le plan formel entre éducateurs sociaux et infirmiers, alors que la seconde consiste en l'absence d'une distinction formelle entre les deux groupes professionnels. Les résultats ont mis également en exergue une bonne collaboration entre les deux professions, les champs de tension qui apparaissent ainsi que les éléments qui l'influencent.

Entrées d'index

Mots-clés : éducateurs sociaux, infirmiers, handicap, collaboration, division du travail, recherche qualitative
Keywords: Social Educators, Nurses, Disability, Collaboration, Division of Labour, Qualitative Research

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Texte intégral

1. Introduction

1 In Switzerland, approximately 1.8 million people are considered disabled according to the federal law on equality for persons with disabilities (LHand in French) (Federal Statistical Office, 2019). Historically, people with disabilities had a shorter life expectancy, but in recent decades their life expectancy has increased (Azéma & Martinez, 2005; CCDMA, 2013a, 2013b; Delporte, 2015; Rothkegel, 2012). Despite the lack of reliable national statistics, this evolution is widely observed by professionals and employers in institutions for persons with disabilities, the associations representing them (Infri, 2016; Insieme, 2017; INSOS, 2011), as well as by some studies conducted at regional scale (CCDMA, 2013a; Creux & Korpès, 2012; Gremaud, Charrière & Cappelli, 2009). This new longevity is notably the result of the increasing quality of screening, diagnosis, medical treatment and care of people with disabilities (Azéma & Martinez, 2005; Zribi, 2012). It can also be explained by an improvement in the quality of education, relational networks and living conditions of people with disabilities, as well as by the evolution of health and social policies.

2 Demographic ageing is of concern to various Swiss authorities, which are seeking ways to respond to the major challenge represented by this new longevity. National and cantonal policies support keeping ageing persons with disabilities in their living environment (for example, at home or in an institution) for as long as possible, by adapting the provision of services to their specific needs, rather than transferring them to a nursing home for the elderly (CCDMA, 2013a; DSAS, 2017). Moreover, ageing is part of a singular life course, and everyone's needs and expectations are different.

Whether people with disabilities live at home or in residential social care institutions, the ageing and the evolution of their situation imply an increased need for support and for daily and medical care (CCDMA, 2013a, 2013b; Creux & Korpès, 2012; Delporte, 2015). However, they often have difficulty expressing their needs and expectations, which makes the development of technical aids (communication aids, pain scales, etc.) necessary. Furthermore, some persons with disabilities are not able to express formal complaints because of their disability, but the signs of these may appear through other expressions (agitation, shouting, mutism, etc.). A major challenge is therefore to identify the needs of ageing people with disabilities: it is essential that professionals and families set up a differential observation of the signs of ageing, as well as an individual assessment of the person's needs in terms of support for daily living, social and medical care (CNSA, 2010).

3 In Switzerland, 25 000 persons with disabilities live in residential social care institutions: an independent life at home no longer seems possible for them or at least very difficult (Federal Statistical Office, 2019). Among these, 35% are aged 45 years or over and 6.6% are aged 65 years or over. Our research takes place in this context, investigating the collaboration between social educators and nurses who accompany ageing persons with disabilities in residential social care institutions[1] in French-speaking Switzerland.

4 In residential social care institutions for persons with disabilities, the ageing of residents and the ensuing increased need for support and care require reflection and appropriate adjustments (CCDMA, 2013a, 2013b; Creux & Korpès, 2012; Delporte, 2015; Infri, 2016). At a structural level, these adaptations involve the creation of new structures or the reorganisation of existing ones (particularly architectural spaces), the provision of auxiliary aids and the configuration of living units or educational groups (CCDMA, 2013a; CNSA, 2010; Delporte, 2015). At a daily care level of persons with disabilities, adjustments to residents' personal projects, specific measures to support them (e.g., balance between individual and group activities), as well as the reorganisation of daily activities (e.g., adaptation of schedules and tasks related to work and leisure activities) need to be put in place (Azéma & Martinez, 2005; CCDMA, 2013a; CNSA, 2010; Scholder, 2012). The organisation of medical and health services (e.g., access to prevention and specialised care) may also be necessary. In this context, the presence of health professionals, alongside social education staff, appears to be essential because "it makes it possible to accompany the increase of basic care and to keep residents in their environment until the end of life" (Scholder, 2012: 92).

5 An increased need for support and care for persons with disabilities requires the cross-fertilisation of social education and health professionals' skills, implying rethinking the composition of teams, particularly in terms of the diversity of professional profiles (CCDMA, 2013a; Canton de Vaud, 2017; CNSA, 2010). In institutions for people with disabilities, social education and health professionals are called upon more and more to work together within socio-educational teams, which is a challenge in terms of professional practice, relationship, work organisation and institutional structuring (INSOS, 2011; Vujica, 2016). How is this collaboration developing in the institutions concerned? What challenges does it raise?

6 The co-presence in socio-educational teams of social education and health professionals questions and challenges employers and professionals concerning the professionalisation of the field of disability, the building of professional identities, the specificities, boundaries and possible overlaps between these professions, as well as the relationships between the professionals. While there is no empirical research on the implications of the collaboration between social education and health professionals in institutions for persons with disabilities in French-speaking Switzerland, previous

studies revealed that collaboration between social workers and health professionals is influenced by reciprocal representations of missions and skills, representation of each professional group within institutions, and work organisation (e.g., institutional projects, charts, areas of interventions, etc.) (Fondeville & Santiago-Sanz, 2016; Glaser & Suter, 2016; Mizrahi & Abramson, 2000). These studies also highlighted the need to integrate social and health sectors in terms of practices, skills and training, to promote collaboration between professionals and improve the comprehensive care of users. Some studies on collaboration between several professional groups in the field of disability (e.g., social educators, teachers, mental health and rehabilitation professionals) have pointed out both the richness of professional cultures and practices, as well as the barriers to diversity, in accompanying children with special educational needs (Emery, 2011; Oedegard, 2006; Pelletier, Tétreault & Vincent, 2005; Thylefors, 2012; Wirz & Emery, 2015).

7 In order to meet the needs institutions have for better knowledge on this subject and to address the lack of empirical research, we carried out a study on the collaboration between social educators and nurses working in Swiss residential social care institutions for persons with disabilities in French-speaking Switzerland and the issues it raises (Perriard, Gulfi & Rossier, 2020). In particular, we focussed on the discourses used by employers and professionals concerning their representations and experiences of collaboration between social educators and nurses who work together in socio-educational teams. The aims of the study were: (1) to explore the macro-social context in which collaboration between social educators and nurses takes place in institutions for people with disabilities (prescriptive frameworks; social work and nursing education systems); (2) to identify the organisational logics of collaboration between social educators and nurses which are developing in these institutions (recruitment and team composition; modalities and trends with division of labour; specificities and overlaps between professional groups; institutional tools and resources); as well as (3) to investigate the interpersonal relations between social educators and nurses working within socio-educational teams (respective representations, relationships, dynamics of teams).

2. Theoretical framework

8 From a theoretical point of view, our study draws on two approaches: the French sociology of professional groups and works on interprofessional collaboration.

2.1. Two professional groups: social educators and nurses

9 According to the French sociology of professional groups, social educators and nurses are considered as two professional groups, that is to say, “sets of workers involved in an activity with the same name, and who therefore have a social visibility, enjoying both identification and recognition, occupying a differentiated position in the division of labour, and characterized by symbolic legitimacy” (Demazière & Gadéa, 2009: 20). Following the interactionist approach and the idea of social construction, professional groups are perceived as interactive and dynamic processes, “whose future, never acquired, is played out in tension between internal and external forces” (Bercot, Divay & Gadéa, 2012: 2). Works in the field of the sociology of professional groups analyse their dynamics, particularly the processes of emergence, differentiation, transformation or

disappearance of professional activities (Bercot, Divay & Gadéa, 2012; Demazière & Gadéa, 2009; Dubar, Tripier & Boussard, 2011). This theoretical approach is relevant to our study in understanding how the territories, practices and logics of social intervention are redefined through collaboration between social educators and nurses working in institutions for persons with disabilities. Our study investigated the re-composition mechanisms of the division of labour between the two professional groups, as well as the changes in the attribution of responsibilities, activities, skills, roles and professional specialties. We also explored the relationships between social educators and nurses, as well as the regulations developed by professionals to control or extend their area of intervention.

2.2. Interprofessional collaboration from an ecosystem perspective

10 To explore the collaboration between social educators and nurses more specifically, our study used works on interprofessional collaboration (D'Amour et al., 2005; D'Amour & Oandasan, 2005; San Martin-Rodriguez et al., 2005). Interprofessional collaboration is defined as an interactive and dynamic process by which social educators and nurses work together to positively impact user's care and well-being (D'Amour et al., 2005; Emery, 2015). This model focuses on user-centred practice, which can take different forms depending on elements linked to the user, such as its specific situation, support and care needs, or life project (Aiguier, Poirette & Pélissier, 2016; Oandasan & Reeves, 2005). Interprofessional collaboration also depends on interpersonal relationships between professionals (e.g., perceptions and previous experiences of interprofessional collaboration, sharing common visions and user-centred objectives), on factors related to the work context (e.g., institutional philosophy and management, attribution of responsibility and activities, institutional resources, coordination and communication mechanisms), as well as on factors external to the institution (e.g., subsidisation, disabilities policies, social work and health training curricula).

11 Based on the abovementioned study, the present article highlights and discusses the following questions: what are the practices for recruitment and composing teams between social education and health staff in institutions for persons with disabilities? How is the division of labour between social educators and nurses addressed in these institutions? How do professionals position themselves in relation to the modalities of division of labour observed? How do social educators and nurses collaborate?

3. Method

12 A mixed-methods approach (Creswell, 2014) was chosen, combining a literature review, a questionnaire survey and semi-structural interviews. The present article focuses on the interview data collection phase.

3.1. Recruitment and participants

13 A two-stage purposive sampling procedure was used. Firstly, a written questionnaire was sent to all residential social care institutions for adults with disabilities (intellectual, physical, psychic and/or multiple disabilities) (n=63) in two cantons of French-speaking Switzerland (Fribourg and Vaud), in order to identify those with socio-

educational teams composed of both social educators and nurses.[2] Of the 41 institutions that completed the questionnaire (response rate of 65%), 17 (41%) mentioned having "mixed" teams. Finally, 12 institutions[3] agreed to participate in the second stage of the study, in which the professionals involved[4] and their employers were invited to take part in an individual interview. A total of 36 face-to-face semi-structured interviews were conducted with employers, social educators and nurses (12 interviews per group). The research team fully informed all participants regarding the background, aims and risks of the study, both verbally and in writing, prior to the beginning of the interviews. All participants signed a corresponding consent form.

14 In line with the feminisation of the social education and nursing professions, more women (n=23) than men (n=14) participated in the study. The participants' mean age was 44 years (range: 25-61 years) and most (n=24) were Swiss nationals.

3.2. Data collection

15 In line with the study's aims, two semi-structured interview guides were developed by the research team for professionals and for employers; the themes explored were identical in both guides, but some questions were adapted. Five different themes were discussed: (a) professional context and team composition (e.g., What is the distribution between social educators and nurses within your institution? Who decides on this distribution and on what basis? What motivated your institution to set up teams composed of social educators and nurses?); (b) the responsibilities and activities of social educators and nurses, as well as the competencies they mobilise to perform them (e.g., What are your daily activities as a social educator? What does a nurse do? What skills do social educators and nurses need to carry out these activities, in terms of knowledge, know-how and soft skills?); (c) the assignment of responsibilities and activities to social educators and nurses, as well as different aspects of the prescriptive framework (e.g., How are activities and responsibilities allocated to social educators and nurses? What wage class are social educators and nurses in?); (d) the collaboration between social educators and nurses (e.g., In your experience, how do social educators and nurses work together? What are the strengths, but also the possible limits, of collaboration between social educators and nurses?); and (e) perspectives on the future of social educators, nurses and their collaboration (e.g., What are your expectations concerning collaboration between social educators and nurses? How do you see the future of these professions in your institution and in a general way?). Interviews lasted about 75 minutes and were audio-recorded with the participants' permission. Interviews were pseudonymized and transcribed verbatim for analysis.

3.3. Data analysis

16 The collected data were subjected to a thematic analysis (Miles, Huberman & Saldaña, 2014). Firstly, the analysis involved a process of familiarisation with the data: the transcripts were read and re-read and emerging themes and patterns noted. Secondly, an initial list of codes and themes was drawn up by researchers, based on the study's objectives. The process of theme generation was reviewed and refined by going back and forth between the themes and the codes, as well as between the themes and the transcripts, until the final themes were defined. Both inductive and deductive coding were employed to arrive at the final themes. Thirdly, the transcripts of each interview were read through, and the responses identified, then coded manually in

accordance with the identified themes. Fourthly, data were sorted and grouped together under patterns considered accurate, complete and generalizable. As patterns of meaning surfaced, similarities and differences were identified. Finally, data were summarized and synthesized, retaining the language of the participants as far as possible. An intra-site analysis focusing on individual interviews has been done in order to verify that the three actors interviewed agreed on the existence of the same modality of division of labour in their institution. Then, an inter-site analysis comparing responses across the participating institutions and the three categories of respondents was carried out. Each research team member independently reviewed and explored interview transcripts and analysed data. Regular revisions and discussions occurred between team members at each step of the data analysis process in order to agree upon the data segments to be coded, the categories used, how data segments were placed into categories, analyses, findings, and the interpretations drawn from the findings.

4. Results and discussion

4.1. Practices for recruitment and composition of professional teams

17 According to the participants, almost all institutions consulted had set up teams composed of social education and health professionals "*for several years*," but their presence was not always systematic or formalised. The recruitment of health caregivers and the creation of mixed teams can be explained mainly by the "*increased need for support and care*" for residents, linked to their "*ageing*" as well as the "*growing complexity of disabilities*," that requires the cross-fertilisation of social education and health professionals' knowledges, skills and expertises. From the employers' perspective, the creation of mixed teams had brought about two major changes in their institution: firstly, the care of residents had become more comprehensive, and secondly, the presence of nurses within teams provided "*support*" for social educators in caring for residents. Several participants underlined that it was not easy for health professionals to find their place in this socio-educational context, even if their arrival contributed to a better "*acceptance of the medical professions*" in institutions for people with disabilities. These findings highlight that social work in the field of disability is situated at the intersection of socio-educational and health practices (Kuehni & Bovey, 2017). Indeed, teams composed of both social education and health professionals were historical in most of the institutions consulted, linked to the ageing of people with disabilities and the increased need for support and care. These findings are in line with national (Loi fédérale sur les institutions destinées à promouvoir l'intégration des personnes invalides, 2017) and inter-cantonal (CDAS, 2019) guidelines that require residential institutions for people with disabilities to have infrastructures, services and multidisciplinary qualified staff adapted to the care and support needs of residents. Mixed teams make it possible to keep residents "at home" for as long as possible (Scholder, 2012) and to avoid transferring them to sociomedical establishments.[5]

18 With reference to the participants' discourses, social education professionals are more strongly represented than health caregivers (70-75% versus 25-30%) in most of the institutions consulted, which appears consistent with cantonal recommendations (CCDMA, 2013a; Conseil d'État du canton de Fribourg, 2010; DSAS & SPAS, 2010)

concerning staffing in socio-educational institutions, which involve hiring more social education professionals than health caregivers, in contrast to sociomedical establishments.

19 Finally, most participants indicated that this distribution is likely to evolve towards a greater presence of health professionals, due to the evolution of the residents' problems and their care. This trend raises questions for employers and professionals about the potential development of greater medical intervention within institutions for persons with disabilities and calls into question the socio-educational nature of resident care, as the cantons have pointed out (Conseil d'État du canton de Fribourg, 2010; DSAS & SPAS, 2010).

4.2. Institutional modalities of division of labour between social educators and nurses

20 Two modalities of division of labour were observed in the participating institutions. The first one, which concerns three-quarters of the structures investigated, involves a distinction at a formal level between social educators and nurses who are both employed with a specific job description. However, the participants pointed out that their job descriptions include lots of common responsibilities and activities. Indeed, both social educators and nurses are involved in the daily care of residents and assume the responsibility of acting as reference persons for residents. The formal distinction mostly concerns the responsibilities and activities linked to medical care, which are exclusively assigned to nurses.

> [...] The educators have six main responsibilities whereas the nurses have seven, one of which is specific to medical care. (Employer, female, 42 years old)

21 The second modality of division of labour consists of no formal distinction between social educators and nurses who are both employed as social educators and have the same job description, including identical responsibilities and activities.

> In our institution, all the job specifications are the same. Whether the person is trained as a nurse or an educator, it doesn't change, they are all hired as educators. (Employer, female, 53 years old)

22 This modality implies that both professional groups are equally in charge of daily care of residents and act as reference persons for residents. Indeed, even if nurses have the necessary training, they cannot provide medical care for residents who require follow up from medical services, whether internal or external to the institution. However, the two professional groups are assigned to provide a different perspective (i.e., observations, analyses, interventions) on the residents' needs and situations. On the one hand, social educators have to promote the "*autonomy*" of the residents, the development of their "*resources*" as well as the intervention "*with the person*," on the other hand, nurses are primarily concerned with the "*health*" and the "*safety*" of the residents and are more focused on analysing the care problems of the residents. Nurses are also called upon to build bridges with medical services and to accompany residents to medical appointments.

23 It should be noted that the modalities of the division of labour have evolved in recent years: several participating institutions are characterised by a recent shift from a "no formal" to a "formal" distinction between social educators and nurses.

In all the participating institutions, the daily care of residents involves, for both social educators and nurses, "*basic care*"[6] (e.g., "*waking*" and "*putting to bed*" residents,

"*giving them food or drink*," helping them "*shower*") as well as simple delegated medical acts (e.g., "*giving medication to residents*," "*changing simple bandages*," "*taking temperatures*"). Daily care also implies relational and educational activities (e.g., "*meeting diverse resident's needs*," "*talking with them about the day*"), the organisation and support of "*stewardship*" and "*household*" tasks (e.g., "*making a meal*," "*washing up*," "*guiding residents*"), as well as the organisation of resident-driven recreational activities (e.g., "*going for a walk*," "*going out for a drink*").

25 Both social educators and nurses also assume a role as reference (or co-reference) person, meaning they are (co-)responsible for the resident's situation. The responsibilities and activities linked to this role include: elaborating, planning, following up and evaluating the resident's "*personal project*" (including analysing support needs, defining, implementing and monitoring aims and the means to be put in place to achieve them), managing the resident's situation on an administrative and financial level, as well as elaborating assessments and summaries of the project. Acting as reference person also involves networking activities with residents relatives, healthcare professionals or with other professional groups.

26 Social educators and nurses also share specific responsibilities and activities related to the functioning of the socio-educative group or of the institution (e.g., distribution of working hours, entertainment, "*accountancy*"). Finally, they are engaged in collaborative and communicative activities with a team of professionals, whether within the socio-educative team, the institution or external professional networks.

27 According to the participants, these common responsibilities and activities require undifferentiated skills from both social educators and nurses, which are linked to providing daily care to residents: being able to develop a relationship with the residents (e.g. "*empathy*," "*listening*," "*communication*") and to manage the educational group, as well as having knowledge and experience in the field of intervention, disabilities and basic care. They also imply skills in acting as a reference person for residents, for example, being able to analyse the resident's situation as well as develop, follow-up and evaluate a socio-educational project. Finally, they involve teamwork skills (e.g., being able to collaborate with colleagues, transmit relevant information, respect the team's decisions), as well as transversal skills, such as "*creativity*," "*versatility*," "*openness*."

28 In the institutions which formally differentiate between the two professional groups, only nurses are allowed to assume responsibilities and activities linked to complex delegated medical acts, such as "*blood samples*," "*vaccinations*," "*exchange of probes*." Nurses are also assigned to accompany residents to medical appointments, to collaborate with physicians, as well as to control and manage the institutional pharmacy. Finally, they are also called upon to teach, supervise and evaluate basic care and simple delegated medical acts carried out by the social educators, as well as to transmit their medical expertise to the team.

29 According to the interviewees, nurses need some specific skills to carry out medical responsibilities and activities, including a focus on resident's health, theoretical and practical knowledge concerning basic care and medical acts (simple and complex).

30 These findings highlight that professional boundaries between social educators and nurses are tenuous: both share a number of common areas of intervention. Medical acts and the specific skills it mobilises, characteristic of nurses' work, are the elements of distinction between the two professional groups, in particular in institutions that make a formal distinction. This blurring of boundaries also questions the social educators' and nurses' professional autonomy (Molina, 2017), which is based on specialised knowledge and skills. The results also show that, in institutions for persons with disabilities, social educators are called upon to perform some medical acts usually reserved for nurses and, conversely, nurses carry out socio-educational responsibilities

and activities (accompaniment, reference) normally allocated to socio-educational staff. While the processes of division of labour are ever changing in their boundaries (Hughes, 1996), the redistribution of responsibilities and activities between social educators and nurses can lead to a blurring of professionals' identities. Indeed, the delimitation of intervention areas raises issues for professionals because they can obtain a monopoly on specific responsibilities and activities (Kuehni & Bovey, 2017). On the other hand, social educators are confronted with regressions linked to the ageing of people with disabilities and the foundations of their work are consequently modified. Indeed, social educators have been trained to find the meaning of their missions and practices in the dynamics of progression, empowerment and the acquisition or maintenance of skills and this model is challenged by advancing age, illness and even the death of residents (Chaize, 2015). This requires social educators to change their daily care of residents, given the state of permanent doubt between stimulating and protecting, as well as the ambiguity of the injunction for autonomy.

4.3. Participants' positions in relation to the modalities of division of labour

31 Employers and professionals also positioned themselves in relation to the modality of division of labour they had experienced.

32 On one hand, formal distinction seems to make sense for participants, mainly because it reflects and values the differences between educational backgrounds and the specificities of each profession, in terms of knowledge, skills and expertise.

> I think it is important to differentiate them because you cannot deny the different skills, functions and trainings between nurses and social educators. (Nurse, female, 26 years old)

33 It also presents the advantage of clarifying the roles, responsibilities and activities of social educators and nurses, according to their respective professions.

> The advantage is that everyone has a well-defined job and all professionals know what they should and should not do. (Social educator, female, 43 years old)

34 However, the participants also pointed out some limits to formal distinction, the main one being the risk of specialisation and hierarchisation of activities and professions of social educators and nurses, which could contravene a global and unitary practice of social intervention and eventually lead to a "*split*" between the two professional groups.

35 On the other hand, having commonly attributed responsibilities and activities encourages residents to live "*at home*," as noted by our participants.

> It's because here, for the residents, it's their home. We come to them to help them live their lives, to live as they would at home and not in an hospital. (Employer, female, 53 years old)

36 It also contributes to maintaining unified educational work, including common objectives and a "*global*," "*complementary*" and "*multidisciplinary*" support for the residents, who thus benefit from both socio-educational and medical care, providing "*quality responses*" to their needs. Finally, no formal distinction allows social educators and nurses to "*share*" and acquire mutual professional knowledge, skills and expertise.

37 Nevertheless, some disadvantages of this modality are also highlighted by participants, including the difficulty for both social educators and nurses to "*find their place*" and to get their specific knowledge, skills and expertise recognised and valued, in

a context where all professionals assume the same responsibilities and activities. Participants also mentioned that sharing a common vision and goals for the care of residents is time-consuming.

> It's very slow. We have to discuss together to agree and to upgrade the level of information so that everyone can understand where we're coming from because not everyone has the same background to understand the thinking and why it's important to put it like that and not otherwise in place. That's on both sides. (Educator, female, 45 years old)

38 Our findings highlighted that the strengths of formal division between social educators and nurses – recognition of educational backgrounds and professional specificities, clarification of professional roles, responsibilities and activities – appear to be the weaknesses of no formal distinction. Conversely, the advantages of common responsibilities and activities – encouragement of "living at home," unity of the educational project, sharing of professional knowledge, skills and expertise – are the disadvantages of formal distinction. Both modalities of division of labour raise some issues regarding social intervention and accompaniment for residents, as well as regarding professional identity. Formal distinction suggests a risk of potential reorientation for global and unitary practice of social intervention, towards a specialisation or hierarchisation of social educators' and nurses' activities and professions. While these processes of specialisation are an integral part of the dynamics of professional groups (Demazière & Gadéa, 2009), they raise a major issue in the field of social work, as they seem likely to affect the classical conception of social intervention, which considers the accompaniment of users as comprehensive and unitary (Chopart, 2000). Specialisation would therefore participate in a form of fragmentation of social work and social intervention (Maurel, 2000). On the other hand, non-differentiation underlines the difficulty both social educators and nurses face in finding their place and having their specific knowledge and skills recognised. Nurses claim legitimate control over a domain of work by way of their expertise in the social educators' jurisdiction, while social educators experience a potential challenge to their usual areas of intervention as well as a possible redefinition of their professional responsibilities and activities, as reported by Vezinat (2016). No formal distinction also raises another major issue: that of the possible deskilling of social education professions, which would counter objectives of Swiss social work professional associations favouring the professionalisation of the field (Keller, 2018).

4.4. Collaboration between social educators and nurses

39 While the multiplication of professional groups is generally seen as an element that reinforces competition and tensions between professionals (Aballéa, 2000) or even jurisdictional struggles for control on areas of intervention (Abbott, 1988), the collaboration between social educators and nurses is mainly perceived as "*positive*" by participants, regardless of the modalities of division of labour they have experienced. This includes a good "*understanding*" and "*working atmosphere*," as well as a "*positive experience*," free of major "*conflicts*" and "*problems*." Similarly, collaboration between social educators and nurses is mostly defined in positive terms by participants, such as complementarity, richness, respect, communication and mutual comprehension. These findings underline the importance of mutual respect, of knowledge and mutual understanding of expertise, as well as of open and constructive communication in

establishing good interprofessional collaboration, which appears consistent with previous studies (Aiguier, Poirette & Pélissier, 2016; D'Amour & Oandasan, 2005).

40 However, participants also noted that collaboration between social educators and nurses can be a source of tensions as well as of difficulties, such as "*defensive*" or "*explosive*" interactions, worries and "*power relationships*" between the two professional groups, which is consistent with some previous results (Conq, 2010). According to interviewees, these difficulties are largely due to misapprehensions, misconceptions and misunderstandings related to divergent professional cultures, which includes values, beliefs, attitudes and practices. They are also linked to professionals' attitudes when holding on to their own perceptions and positions. Furthermore, having to manage the ageing of residents and the evolution of their needs seems to increase the possibility of collaboration difficulties among professionals (Aiguier, Poirette & Pélissier, 2016; Oandasan & Reeves, 2005).

41 According to participants, there are some elements related to the institutional context and interprofessional relationships which may promote collaboration between social educators and nurses or, in their absence, hamper it.

42 With regard to institutional elements, staffing allocated to institutions for persons with disabilities firstly appears as an influencing factor. Some participants mentioned a lack of staff to deal with the growing complexity of residents' situations and expressed the need to "*have more staff*" to ensure the continuing quality of accompaniment for residents, even if they consider this perspective "*unrealistic*" for several reasons, including economic and political uncertainties surrounding social institutions in the field of disability, in line with Vulliet (2014).

43 Secondly, a clear definition of the mission and philosophy of the institution, including a positioning that supports and "*advocates*" for interprofessional collaboration through charters, accompanying concepts or regulations, is considered by interviewees to be a key aspect of collaboration, which is consistent with some previous results (Bronstein, 2003; Kosmerelli Asmar, 2011; San Martin-Rodriguez et al., 2005). Conversely, participants pointed out that a lack of clarity regarding institutional identity is damaging to the collaboration between social educators and nurses.

> What could be an obstacle is if management doesn't do this work upstream, clearly announcing the line to follow, with an institutional identity based on a clear concept of the institution and interprofessional collaboration. (Employer, male, 44 years old)

44 The third institutional element that seems to support collaboration is a better, clearer organisation of work between social educators and nurses, in terms of organisational charts, roles, job descriptions, allocation of responsibilities and activities, which is consistent with previous studies (D'Amour & Oandasan, 2005; Kosmerelli Asmar, 2011). Both employers and professionals highlighted the importance of having institutional documents, such as specific job descriptions for social educators and nurses, that clarify the roles of professionals as soon as they are hired, as well as formally allocate them responsibilities, activities and skills (Vilbrod, 2010). Indeed, the clear organization of work allows professionals to know what they can and cannot do, i.e., to define and delimit their areas of intervention. Conversely, participants noted that a too rigid, unbalanced allocation of responsibilities and activities between social educators and nurses also limits how teamwork functions and consequently hampers collaboration. In other words, professionals want to have an institutional framework for the organisation of work, but also to have a degree of flexibility in how they carry out their job.

> [...] if their [professional] opinions are not taken into account, if things are unclear

> as to what's expected of them, if they have no flexibility, that's what puts people off at work. (Employer, male, 44 years old)

45 Finally, according to participants, the availability of time and space for communication and coordination (e.g., working meetings, supervisions, working groups, trainings) facilitates and enhances collaboration between social educators and nurses.

> People have to talk to each other. There have to be spaces for regulation where we can tell each other what we're doing, why we're doing it, how we're doing it and talk about what we're doing. (Employer, male, 44 years old)

46 This is in line with literature in the field (Bronstein, 2003; D'Amour & Oandasan, 2005), which found that the implementation of manageable caseloads and institutional culture, in terms of administrative and financial support, time and space, facilitates and enhances collaboration among professions, as well as maximizing complementarity between professionals.

47 Conversely, a lack of time to exchange knowledge, competencies, expertise and practices, often related to a context of work overload, contributes to difficult working conditions and puts pressure on employees, which is perceived by participants as an obstacle to interprofessional collaboration.

> We need time to exchange, so that we can discuss our practices. It takes time. It takes time to create these links and bridges. If we cut corners on this, professionals are going to gnash their teeth. (Social educator, female, 45 years old)

48 Concerning interpersonal relationships, teamwork is seen as a key factor in interprofessional collaboration for effective resident-centred care. In line with previous studies (Bronstein, 2003; D'Amour & Oandasan, 2005; Oandasan & Reeves, 2005; San Martin-Rodriguez et al., 2005), sharing "*missions*" and "*common goals*" focused on residents, as well as being able to "*communicate*" and "*exchange*" within the team is seen as favourable for interprofessional collaboration by our participants. Conversely, a focus on one's own profession, mutual negative attitudes and the inability to take the other profession into account in teamwork leads to a limited ability to recognize the roles, perspectives and practices of other professionals and is thus perceived as damaging to the collaboration. Participants therefore note the importance of and need for "*trust*," "*understanding*," "*mutual respect*," "*transparency*," "*adaptation*" and "*openness*" towards colleagues from different professional fields, consistent with previous studies (Bronstein, 2003; Oandasan & Reeves, 2005). According to participants, mutual knowledge along with earlier and positive experiences of working in mixed teams also seem to be beneficial for interprofessional collaboration (Bronstein, 2003).

5. Conclusion

49 This article provides an overview of collaboration between social educators and nurses working in institutions for persons with disabilities in French-speaking Switzerland.

50 The co-presence and collaboration between these two professional groups raises issues both for the institution (staffing, work organisation, institutional resources, etc.) and for interpersonal relationships between social educators and nurses (competition, cooperation, complementarity, blurring of professional identity, etc.). The development of new forms of employer and professional participation and mobilisation at an

institutional level and in professional practices would enable social educators and nurses to construct, innovate, transform their practices and find their place in the institution (Fondeville & Santiago-Sanz, 2016). As Mucchielli (2012) has pointed out, cooperation in a work team results from the adherence of all professionals to a common project and from a sense of belonging among the team members, while knowing and accepting their respective roles, competences and professional cultures. This reciprocal knowledge can be greatly facilitated by clear positioning from institutional leaderships.

51 Our findings also highlighted that collaboration between social educators and nurses is both accepted and rejected, supported and debated, endorsed and discouraged. On one hand, interprofessional collaboration is perceived as beneficial for residents (improved support and care for their needs, improved health and well-being, etc.) (D'Amour et al., 2005; Emery, 2015; Kosmerelli Asmar, 2011), professionals (mutual learning and support, improved intervention, etc.) and institutions (comprehensive care for residents, palliative care for ageing people) (D'Amour & Oandasan, 2005; Kosmerelli Asmar, 2011). On the other hand, this collaboration raises questions about the professional identity of social educators and nurses (King & Ross, 2004), as well as the professionalisation of the disability field and the social work field more generally. It also challenges the traditional conception of social intervention (in relation to the specialisation and hierarchisation of activities and professions) and questions the socio-educational nature of care in institutions for persons with disabilities.

52 The long tradition of specialisation and fragmentation of social work and health training in Switzerland also presents obstacles to successful collaborative practice. Indeed, social work and nursing education programmes are conducted in silos (Louis Simonet, 2017): future professionals are not familiar with the values, skills, practices, expertise and vocabulary of the respective professions and they don't learn to work together; as a result, they don't have a clear idea of what the other caregivers could contribute. Consequently, the development and implementation of common courses for social work and nursing students should be encouraged (Fondeville & Santiago Sanz, 2016), in order to increase understanding among the respective disciplines for the benefit of users. The aim would be to make them aware of the respective professional cultures, models, approaches and practices, to promote changes in reciprocal attitudes or perceptions, and to discuss issues of blurred professional identities and boundaries (King & Ross, 2004). Shared training within institutions for persons with disabilities would also be a good opportunity to enable social education and health professionals to face the new challenges they have to deal with. In this way, they could benefit from the plurality and liveliness of the contexts in which they practice to continue building and developing their professional practice (Conq, 2010).

53 Training and research must also consider the evolution of professional practices in more difficult and complex contexts, by analysing the emergence of common social and health fields, which bring new problems to which trainers and researchers must be able to respond (Tschopp, 2014). Indeed, the beneficiaries of social intervention need social and health professionals who work together, keeping a critical eye on competition and corporatism, while remaining attentive to the growing problems of care beneficiaries.

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Notes

1 The term "residential social care institution" is used to describe institutions providing housing, training, work, activities or care for people with disabilities (intellectual, physical, psychic and/or multiple disabilities), in which socio-educational nature of care is central. The residential social care institution refers to the "Foyer de vie" or "Foyer d'hébergement" in France.

2 In this study, we wanted first to contact both social education (socio-educational assistants, social educators) and health (healthcare assistants, auxiliary nurses, nurses) personnel, with different levels of education, working within mixed teams in institutions for people with disabilities. This was regardless of their level of training (respectively, Federal Diploma of Vocational Education and Training, Advanced Federal Diploma of Higher Education, Bachelor's degree). Social educators and nurses were chosen because it was important to us to explore collaboration between two professions with comparable levels of education, responsibilities and activities. However, with a view to a larger project, it would be interesting to extend the scope of the research to other social education and health professionals.

3 All the residential social care institutions that took part in the second phase of the research supported ageing people with disabilities. The majority of the institutions (n=9) provided care for people with multiple disabilities (intellectual, psychic, physical, sensory), while in two institutions the care was reserved primarily for people with intellectual disabilities and in one institution the care was reserved primarily for people with physical disabilities.

4 We selected 12 institutions to ensure a balanced distribution between the cantons of Fribourg and Vaud. Then, we asked each of these institutions to define with us the social educator, the nurse and the member of the management who would participate in an interview: the social educator and the nurse had to work in different mixed socio-educational teams in order to get their point of view on interprofessional collaboration and to avoid an evaluation of the team's functioning.

5 The term “sociomedical institution” is used to describe institutions where, besides other services, people with disabilities receive professional care, in which the medical nature of care is decisive. The sociomedical institution refers to the “Foyer d’accueil médicalisé” in France.

6 Basic care (showering, washing, body care) is an integral part of the social educator’s job, but social educators also carry out medical and technical procedures normally executed by nurses. Some medico-technical care is carried out by delegation from the nursing staff, subject to by means of an authorisation (DSAS, 2012).

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