

ORIGINAL ARTICLE

From a diagnostic and particular approach to a person-centred approach: a development project

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Aims and objectives. To investigate changes over time in an interdisciplinary group that was engaged in development work regarding pain and pain assessment.

Background. The outcomes of nursing research do not always find their way to the daily care of patients. This is evident within, for instance, physical rehabilitation, where relieving patients' pain is a major challenge. To gain new understanding, develop and change, registered nurses have a great part in engaging their staff.

Design. A qualitative study using a participatory action research approach was used, and a hermeneutic analysis was conducted.

Methods. A group of three registered nurses, two assistant nurses and a physiotherapist took part in focus group sessions. This group was followed with seven repeated sessions during a period of five months from January 2010 until June 2010. A hermeneutic analysis was used.

Results. The participants changed their attitudes towards the patient in pain, their own caring role and the team's role towards a more person-centred care.

Conclusions. Participation and reflection were key aspects as means to transfer knowledge into action and establish change. The participants came to the sessions, shared actively their experiences and expressed pride in the work they accomplished. This can be seen as an expression of a need to share and a joy to be working together in a person-oriented development area. In addition, the approach seemed to contribute to increased job satisfaction.

Relevance to clinical practice. The participants expressed that their work resulted in a changed approach to pain and pain assessment in their daily practice at the ward. The participants were actively engaged in enhancing their work with pain and pain assessment in their own daily practice and in implementing research-based knowledge.

Key words: development care, focus groups, hermeneutics, pain, participatory action research, person-centred, teamwork

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Introduction

The outcomes of nursing research do not always find their way to the daily care of patients. This is evident within, for

instance, physical rehabilitation, where relieving patients' pain is a major challenge to medical staff (Dysvik & Furnes 2012). Research studies show that patients in severe pain experience lower levels of physical independence, stay

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What does this paper contribute to the wider global clinical community?

- The study shows an example of how to engage professionals in a person-oriented development area and how to reduce the gap between research findings and the daily practice.
- Participation and reflection were key aspects.
- The study shows that the participants were actively engaged to enhance their work in their own daily practice to implement research-based knowledge.

longer in hospitals and have a poorer quality of life (Herrick *et al.* 2004).

Despite new scientifically proven methods for relieving and plan for pain management, many patients do not get their pain relieved accordingly. This indicates that the gap between research findings and the daily practice of health-care staff is unnecessarily large. Research findings emphasise the importance of employing a person-centred approach (McCormack *et al.* 2010) as well as working strategically preventively across the different disciplines involved in caring, all working towards the common goal of providing the best possible care to the patient. One important reason why research findings regarding pain fail to find their way into daily care is likely that the primary focus of researchers lie in producing research studies rather than in spreading and implementing them on a larger scale (Clarke & Wilcockson 2002, McCaughan *et al.* 2002, Chang *et al.* 2005, Duffield *et al.* 2008).

Background

The Swedish health care is working continuously with improving quality of care and to increase knowledge among health professionals. One example is quality development where the goal is to create a person-centred care designed to improve staff understanding of the person with the disease and not just focus on the condition or the diagnosis (Rycroft-Malone *et al.* 2002, Ahgren 2003, Mills *et al.* 2003, Ahgren & Axelsson 2011). Ahgren (2003) stresses the challenge to pay attention to patients' individual experiences and not view patients simply as objects for quality improvement. Studies show that this is not always the case; the focus is instead often placed at an organisational and/or management level (Ahgren 2003) despite the fact that Swedish law clearly puts the patient in the centre (SFS 2010:659).

The health care has tried different ways to translate research into practice, and to secure and enhance the quality of care for patients (Mills *et al.* 2003, Ahgren & Axelsson 2011). Success factors for such a development are identified as having clear expectations about what should be achieved for employees and management and that the expectations are anchored in the daily practice (Kyrkjebo & Hanestad 2003, Mills *et al.* 2003). According to Balfour and Clarke (2001) are projects too often anchored only at the management level, resulting in closed-down projects due to lack of time, resources, knowledge or support among employees. On the other hand, success factors in the development of care are said to be commitment, creativity and participation (Balfour & Clarke 2001, Clarke & Wilcockson 2002, Apker *et al.* 2006).

Learning methodology could be seen as a possible strategy to get staff to use research-based knowledge and to become more person centred in their work regarding patient pain. It is only when knowledge is related to previous knowledge or experience that thought and action can change (Ellström 2010). To gain new understanding, develop and change, Ekebergh (2007) points out that reflection needs to be regarded as a central phenomenon in health care. This can be facilitated, by engaging the staff in participatory action research, where reflection is central (Stringer & Genat 2004, Carr 2006, Glasson *et al.* 2008, Petersson *et al.* 2009, Li *et al.* 2010). One important area to implement new research is in the work with pain. This participatory action research study aimed to investigate changes over time in an interdisciplinary group that was engaged in development work regarding pain and pain assessment within the rehabilitation area.

Methods

Design

A qualitative study with a participatory action research approach was used, and a hermeneutic analysis was conducted. The study was conducted in a rehabilitation ward, specialising in orthopaedics, rheumatology and multitrauma care. The team of staff at the ward was composed of a range of professions, including registered nurses, assistant nurses, physiotherapists, occupational therapists, speech therapists, counsellors and physicians.

A group of professionals from the ward, consisting of three registered nurses, two assistant nurses and a physiotherapist, took part in focus group sessions using a participatory action research approach to deal with the issue of pain and pain assessment. The group was interdisciplinary to guarantee a variation in relation to the subject of the study. This group was followed with seven repeated sessions during a period of five months from January 2010 until June 2010. As a part of the study, all sessions were conducted during the development work.

Data collection

The researchers led all sessions by asking questions and by urging the group to reflect. In the first two sessions open questions were used: How do you meet patients in pain? How do you act? Sessions 3 to 5 focused on issues related to treating patients in pain. During these, the participants made a plan for the work and made a decision to use a pain assessment form and began the development work.

During the two final sessions, the participants evaluated the pain assessment form and further developed their work related to pain. All sessions started with a feedback given by the researcher from the previous session, and the participants decided together on a way forward. The focus group sessions lasted between 60–90 minutes. The issues that were dealt with in the sessions over the course of the study, the professionals’ process and the researchers’ parallel process are presented in Fig. 1. All focus group sessions were

recorded and transcribed. The focus group was kept intact for the duration of the development work, and all participants, with one single exception, took part in all sessions.

Analysis

A hermeneutic analysis based on the transcribed material from the focus groups was considered appropriate to achieve the goal of this qualitative study (Nyström 2003,

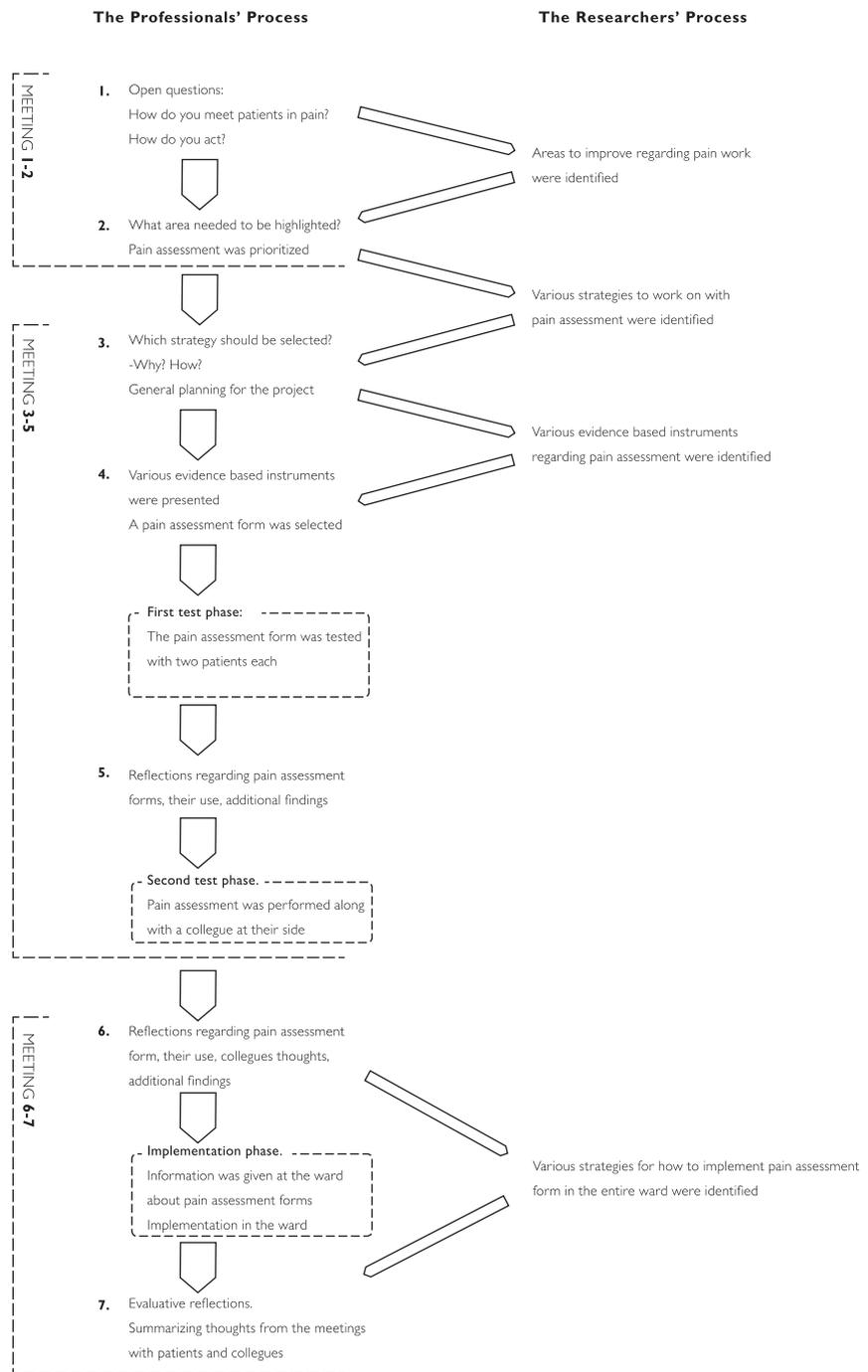


Figure 1 The professionals’ and the researchers’ process.

Gadamer *et al.* 2004, Polit & Beck 2006). We hoped that the development work would lead to change towards a more person-centred care. Our preunderstanding may thus have, without that being an explicit intention, favoured reactions from participants when reflecting on the patients' experiences and consequently affecting the outcome. In this study, we exerted ourselves not to be coloured by the preunderstanding in the analysis, although a hermeneutic horizon of understanding emphasises that preunderstanding should be considered an unavoidable fact and be used as an asset. This was done by continually comparing the interpretations with our preunderstanding. The approach used in the analysis of the transcribed interviews was inspired by Nyström (2003) and Nyström *et al.* (2003). Initially, the transcribed material was read through as a whole a several times to gain an understanding of what happened during the interviews. In the subsequent analysis of the material, three key topics were considered important enough to further study in order to gain a deeper understanding. The three topics were how the participants talked about: (1) the patient, (2) their view of their own caring role and (3) the colleagues/team. While reading, a sense appeared that the participants' way of talking about these topics changed over the course of the study. Therefore, the material has been divided into three sections. Within each section, the analysis focused on the participants' discussions about the patient, their view of their own caring role and the colleagues/team. Meaning units were identified in the text, and a tentative interpretation was made. Finally, the analysis focused on the changes in the conversations over time. A main interpretation was conducted when the tentative interpretation was decided to have reached a conclusion. Repeated re-readings of the tentative text were made to test the viability of interpretations.

Ethical considerations

The study was based on voluntary participation. The participants were allowed to end their participation at any time during the study. Each focus group session began with a question of consent and information about how their participation was voluntary. The study was approved by an ethics seminar at Kristianstad University, Sweden (approval No. IEG-2009-PEL-06).

Results

The findings have been divided into three thematic categories: *from patient to person*; *a clearer professional/caring role*; and *the team spirit amplified*. Each theme presentation

begins with a description of how the participants talked about subjects related to that theme in each of the three sections. A tentative interpretation is used as a tool for understanding how the discussions in the sessions developed over time. The chapter ends with a main interpretation of the findings and a discussion. Quotes from the sessions are used throughout the text to exemplify and illustrate the contents.

From patient to person

How patients were talked about in sessions 1 and 2

During the first two sessions, the participants presented a general picture of patients as being persistent and reluctant to receiving the help offered. A recurring description was that patients were hesitant to take painkillers. One of the participants gave an example of a common reaction from patients when being offered medication:

-Well, it has to do with how stubborn the patients' are. "- don't come dragging with those pills again", or "- No, I'm not in pain right now, I don't need them". (1)

The discussions also dealt with the types of patients the participants treated. The patients were often spoken about in terms of diagnosis:

-It is hips. Those in worst pain are the hip fractures, and the pelvis fractures too. Yes, but we've had a lot of hip fractures recently. Those with plastic repair get going much easier, yes they do. (6)

During discussions, the participants also described how they, as staff, schedule the patients' day and give analgesic medicines based on their planning:

-We have these training sessions scheduled, and you medicate a while before it's time to go training. Yes, it is already being arranged during morning activities that they will be training in two hours. (3)

How patients were talked about in sessions 3 to 5

During sessions 3 to 5, the participants discussed the observation that patients often not tell staff how much pain they are in unless explicitly being asked to. The following quote is from one participant who believed that the patient would tell her when she was in pain. It was only when she used the pain assessment form that she understood that the patient did not take initiative to talk about her pain:

-It was her choice not to tell me. I suppose I believed her to be the kind of patient who would tell, but she wasn't, so these things we believe... (4)

The participants discussed how they could be more explicit in conversations with patients about pain. They also

talked about how there might be underlying reasons for patients to behave the way they do. The following reflection was made by a participant when they were discussing a patient who did not talk about his pain:

-It may carry a meaning, that he tries not to show that he is in pain. (2)

How patients were talked about in sessions 6 and 7

During sessions 6 and 7, when the participants had asked more patients to assess their pain, the participants mentioned that they had become aware that patients often want to share their view of their situation:

-It is his experience, and that is what it's about. (4)

The participants expressed how they previously had taken too much for granted. They gave examples of how they used to believe that they understood the patients' pain and assumed that patients knew about different types of pain relief available. They came to the conclusion that it is important to ask patients to give their own view of their pain. They also talk about how important it is to inform about a range of available pain relief methods to give the patients the opportunity to take part in the decision of what suits them best:

-They don't know what's available, so they have no clue what to ask for. (2)

One way of understanding these conversations

The tentative interpretation is that the participants' view of their patients gradually moved from an outside perspective with focus on details and diagnoses to later on seeing the patient more as a whole individual. Initially, without much reflection, the staff did not involve the patients in the decisions made regarding their pain management. Gradually, they began seeing patients as persons with their own thoughts, desires and abilities. The view on the patient transformed from being based on generalisations about how patients are to an attempt to familiarise themselves with, and understand, the one particular patient they are treating. The participants went from observing how patients were to reflect on why patients react in a certain way.

A clearer professional/caring role

How the professional/caring role was talked about during sessions 1 and 2

In the initial sessions, the participants talked about situations when patients were in pain and how pain was eased.

In the discussions, the pain relief was described in medical terms and in dialogue with physicians. The participants described their own contribution to pain management as 'zapping things':

-Well, we try using heat and cold, yes, those types of things. (2)

The participants described how they are paying attention to pain but that one cannot visually see it and stresses the physician's role in pain relief:

-Yes we pay attention to pain, but that is probably not apparent. Yes, you tell the doctor that this doesn't really seem to be working, and they increase the dosage or make some adjustment and things turn out really well. (1)

How the professional/caring role was talked about during sessions 3 to 5

During the second round of interviews, the participants discussed how the physicians' prescription of analgesic medicine only is *one* part of the patients' pain management. The participants talked about their ability to provide alternative and complementary pain relief methods and that they could be better at telling patients about these options. One participant expressed the following reasoning:

-I've been thinking a lot about this "medical" but more on alternative treatments. I was actually discussing that with a patient; that there are alternatives, such as heat/cold treatment that kind of alternatives and I thought that one should be more open about that. They should know that there are alternatives. (5)

In these sessions, the participants expressed an awareness that many patients do not talk openly about their pain. The participants also talked about their own shortcomings in assessing the patients' pain:

-Last time, there were a few forms in which patients are in pain but don't tell, I reacted strongly to that, I just felt, "oh, we have failed in this". I have failed here, why don't they tell? (1)

The participants described how they had realised that the actions they do relieve the patients' pain were important to the patient. In the discussions, the participants also talked about how more patients that they had noticed want to ease the pain using nonanalgesic methods:

-One patient I talked to used heat for her shoulder, and it helped tremendously. You should know that there are other options. Her neighbor asked, "those things seem good, can I have one too?" We had none left at that time. (4)

During the fourth session, the participants discussed their own behaviour in relation to the patient, especially when

asking questions to the patient. In the discussions, one theme that came up was the importance of taking time to listen to the patients' response when a question was asked. The participants stressed the importance of taking your time to really listen to the answer in order to understand the patients' needs. The participants described how they always had not taken that time:

-If you feel that you have enough time to actually listen to the answer. If you say "good" and they say "I'm in so much pain". You ask the questions before you know that you have enough time to listen to the answer. (6)

The participants also began to question their own competence regarding pain, pain planning and pain management. That might be that the easiest and fastest solution is to deliver analgesic medicine when the patient is in pain:

-Well, I was thinking we have the knowledge? Do we have enough time to process? We are really good at handing out pills, but then what. What's your opinion? (2)

How the professional/caring role was talked about during sessions 6 and 7

In the final sessions, participants discussed the importance of encouraging patients to talk openly about their pain. They gave examples of how they engage actively aiming to explore how patients experience their pain and whether the relief given has had any effect:

-I feel that I've become much better at following up and really thinking about not letting two hours pass until I ask the patient or waiting until I see him in the corridor, but instead walk straight in and ask him in a completely different manner. (1)

The current treatment guidelines regarding pain were now questioned by the participants as they had tried to work systematically with pain assessment. Instead of routinely using analgesic medicine, they talked about the importance of offering talks, massage and heat/cold and see those treatments as important complements to analgesic medicines:

-I think that it is positive in many ways that we as staff also are more aware that there are more things we can use against the pain than this "when as-needed medication". There are other options. (4)

In the final sessions, the participants described how their way of thinking about pain and pain management had changed since they began using pain assessment methods:

-We have discussed that we are more attentive about that now when we treating patients. . . a thinking process has begun. (3)

One way of understanding these conversations

The tentative interpretation is that the participants have gone from not seeing their own role in the patients' pain management to actively taking responsibility to identify pain and measure and assess pain. The participants' awareness of the importance of their own engagement in the patients' pain management improved from initially underestimating their own contribution. Although the participants already performed pain management before this study, they have now become much more aware of their own methodology and use it in a more systematic manner. They have created work routines that help to communicate with patients who experience pain. As a result, their attitudes towards their roles as professionals have become clearer in working with patients' pain.

The team spirit amplified

How the colleagues/the team were talked about in sessions 1 and 2

In the first two sessions, participants were discussing the rounds in the hospital ward when all professionals in the team had discussed patients' pain. One of the participants described how she was not trusted in what she was telling about the patients' pain:

-I felt at that time, that I had seen the patient in that state and I wasn't trusted. (1)

The participants also discussed a feeling of powerlessness when they received very little response from the team despite them perceiving and telling the team that patients had an inadequate ease for their pain:

-You feel that you see how much pain the patient is in and that you really want to. No, this doesn't work, they need better pain relief but you don't really get any feedback, of course one does feel powerless in that situation, it's not a good feeling. (1)

How often analgesic medicine should be given was discussed at one point. The participants realised that they have received various guidelines and that their views of the appropriate frequency differed. They became aware that they had put each other in difficult situations as they had given analgesic medicine with different range to the same patient. One participant said that she gave analgesic medicine to patients when she believed that they needed the relief. There was also a notion within the group that some physicians think that analgesic medicine is given too frequently and that nursing staff should be held accountable also for the actions of their colleagues:

-I medicate the patient when they need it, but when it becomes too frequent the one working at that time is the one who gets the hit.

How the colleagues/the team were talked about in sessions 3 to 5

The participants gradually started talking about how they aimed to help each other. They described to be more consistent in their approach to patients with pain and a wish to develop a common approach:

-It is important to receive clear directions regarding how to act and so on, and that they apply to all, that we've come up with them together. (2)

The participants discussed how they wanted to implement changes in their work routine regarding pain assessment, among the other colleagues at the ward. They wanted the changed routines to be perceived as effortless and stressed the importance of implementing the changes to the daily work in a good manner. The participants talked about the importance of feeling support from the manager of the hospital ward:

-The ward manager is really positive to this she asks us how we are doing. (4)

How the colleagues/the team were talked about in sessions 6 and 7

A single patient was discussed at one point. The group agreed that they wanted to change the pain management for the patient. The conversation ended in a decision to use the pain assessment form that the patient had filled in as a way to clarify the assessment during discussions with the physician:

-I'll show this to the doctor on Monday, yes I will, I'd like to show it to the doctor today. (6)

In the last two sessions, the participants expressed a desire to involve more colleagues at the ward in developing and improving the work with pain. Pain assessments were made by the participants with a colleague at their side. The aim was to implement and spread the use of pain assessment forms within their ward unit as a basic tool used in the daily practice:

-I believe it would be a good thing if we involved more people, then we could get more people who are positive to this and feel like they are part of process. (4)

In the last sessions, the participants discussed the time and effort they had put into this development work. They talked about the importance of getting together like this

and work with other areas of development and a desire to keep working as a group:

-I feel that being alone in this huge field, that there just is no limit, and that it's important that we are more people. I hope we can meet here more times. (1)

The participants concluded that they had come up with a renewed work routine together as a group, and they had involved their colleagues/team within the ward. One participant expressed the notion that it is vital to be allowed to feel proud when you have made an attempt to make a change. This statement was generally agreed upon within the group, and it was also pointed out that they had done this together as a group:

-I think we should be proud of this work because we have come to this point. (4)

One way of understanding these conversations

The tentative interpretation is that participants were amplified in their team spirit. The participants went from an individualistic approach to a more collective reasoning with a common approach while keeping the goal of finding the best possible pain treatment. Another way of describing the change is to say that they went from a reasoning based on 'I will perform my best', saying we are implementing changes together as a team. The awareness within the group of the importance of each role in the team regarding pain management also became clearer. The initial feelings, described by the group, of being powerless, alone and feeling vulnerable changed during the study. In the final two sessions, it was evident that these feelings had changed into a proudness of their development work. They felt confirmed in their own work and the commitment they had put into it; they also acknowledged the efforts and achievements made by others in the group. The participants managed to transfer and implement a renewed approach among other colleagues not involved in the study, and as a positive side effect, the participants' team spirit was strengthened.

Discussion and main interpretation

An overall interpretation of the outcome is that the participants through the focus group sessions changed their attitudes towards the patient and their situation. The patients were initially reduced to a symptom, body part or surgical procedure, for example a fracture, a knee or a hip plastic repair. In the later sessions, patients were considered more as a whole person. A pain assessment form served as a tool for the participants and helped to improve their understanding

of patients' experiences of pain and their requests for pain relief. The patients' individual needs became increasingly clear to the participants over the course of the study. Based on these findings, one can argue that the participants went from a diagnostic and particular approach to a more person-centred and holistic approach. The person-centred pain care focuses on the whole person not just hurting body parts, disorders, symptoms or diagnosis. Person-centred care is also about building a foundation for making the patient actively take part in their own care, and not just be passive recipients of professional care. The expressed needs of the patient are equally important to the needs and treatments observed and prescribed by the staff (McCormack *et al.* 2010).

A change in the participants' attitudes of their own professional role was evident. In the initial sessions, participants emphasised the physicians' competence in easing the patient's pain. As the study progressed, the participants increasingly turned to discussing the value of the care that they themselves could provide and how they can and do take active responsibility in the patient's pain management. One interpretation of these findings is that the participants see more clearly their own professional identity concerning the patient's pain relief. As person-centred care is based on a general approach towards patients, when implementing this approach at a ward or within an organisation, one cannot only rely on a strict methodology or a simple set of routines. Instead, this work requires a main focus on building a common set of values among the staff (McCormack *et al.* 2010). It is thus a development work based more upon reflection than upon prescription.

Another interpretation is that there has been a change in the group over time. During the sessions, the participants changed their attitudes of the patient, their own caring role and the team's role in working with pain. In the early stages of the process, the participants described how patients *were*, how personnel acted and what the physician's task was. They provided care according to routines that they usually followed without further reflection. During the middle sessions there was a change. An uncertainty regarding their own competence arose, and their response to previously familiar situations tasks was now being questioned. Towards the end of the process, the participants showed increased confidence. This transformation can be understood according to Meleis (2010) transition theory. Before the transition everything is familiar, and most things are done as they always have been. A transition takes place in the gap between what was and what will be. A transition process involves a change of relationships and roles. New knowledge is integrated, and ingrained patterns and roles change (Meleis 2010).

Methodological considerations

This study aimed to investigate changes over time in a group that participated in development work regarding pain and pain assessment. Stringer and Genat (2004) point out the importance of prolonged engagement in a participatory action research project as this enables the researchers to establish a trustful relationship with participants. The group was followed by the same persons during five months, which is an argument for the study's credibility (Rolfe 2006). As all of the sessions started with a feedback from the previous session, it was possible for the participants to review the raw data, which also establishes credibility in a study with a participatory action research approach (Stringer & Genat 2004). A long time span was also necessary to make it possible to see what changes occurred in the participants' attitudes towards their own professional role and towards their patients. Continuing the work for time period allowed for repeated sessions of interaction and reflection, which Ekebergh (2007) means is crucial for any lasting change to occur. Participation and involvement are two key aspects in participatory action research as means to transfer knowledge into action and establish change (Stringer & Genat 2004). Petersson *et al.* (2009) highlight the importance of involvement and believe that a group can make a difference if the atmosphere is open to change. The participants came to the sessions and were actively involved in the discussion; this can be seen as indications that a participatory work atmosphere was created.

To verify the interpretations, the possibility of clearly following every step of the approach is required (Rolfe 2006). In the current study, the sessions with the group are first described and quotations are used to illustrate the session outcomes. Thereafter, the researchers' tentative interpretation is presented. With this procedure, the reader is given the possibility of determining whether the interpretation can be considered reliable or not. In addition, to minimise the risk of basing interpretation on preunderstandings, both researchers took part in the analysis and the interpretations were discussed with other researchers as well.

A prerequisite for transferability (Rolfe 2006) is that the study gives a clear description of the context and implementation. To help the reader understand what was required to achieve a person-centred approach, a detailed design and data collection description is provided. The description shows how the study was based on sessions with a group where interaction had significant impact. Provided that another study is built up in a similar way, this study's findings are probably possible to transfer to other

units and other areas in need of development. Another aspect that is supported by Ekebergh (2007) is that the change is to be expected as the approach was based on interaction and reflection.

Conclusions

Participation and reflection are key aspects as means to transfer knowledge into action and establish change. The participants came to the sessions, shared actively their experiences and expressed pride in the work they accomplished. This can be seen as an expression of a need to share and a joy to be working together in a development area concerning pain and person-centred care. In addition, the approach could be seen as contributing to teamwork and increased job satisfaction.

Relevance to clinical practice

In the present study, participants expressed that their work resulted in a changed attitude to persons in pain and pain assessment in their daily practice at the ward. The participants were actively engaged in enhancing their work with pain and pain assessment in their own daily practice and in implementing research-based knowledge. The pain assessment form became a way for the staff to initiate a conversation with the patient, and a tool for understanding the

patient's experience of the pain, that is, to work in a person-centred manner.

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Disclosure

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_1author.html), as follows: (1) substantial contributions to conception and design of, or acquisition of, data or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content and (3) final approval of the version to be published.

Conflict of interest

The study was supported by the Kristianstad University, and no conflict of interest exists for any of the authors.

References

- Ahgren B (2003) Chain of care development in Sweden: results of a national study. *International Journal of Integrated Care* 3.
- Ahgren B & Axelsson R (2011) A decade of integration and collaboration: the development of integrated health care in Sweden 2000–2010. *International Journal of Integrated Care* 11 Spec Ed.
- Apker J, Propp KM, Zabava Ford WS & Hofmeister N (2006) Collaboration, credibility, compassion, and coordination: professional nurse communication skill sets in health care team interactions. *Journal of Professional Nursing* 22, 180–189.
- Balfour M & Clarke C (2001) Searching for sustainable change. *Journal of Clinical Nursing* 10, 44–50.
- Carr W (2006) Philosophy, methodology and action research. *Journal of Philosophy of Education* 40, 421–435.
- Chang EM, Hancock KM, Johnson A, Daly J & Jackson D (2005) Role stress in nurses: review of related factors and strategies for moving forward. *Nursing & Health Sciences* 7, 57–65.
- Clarke CL & Wilcockson J (2002) Seeing need and developing care: exploring knowledge for and from practice. *International Journal of Nursing Studies* 39, 397–406.
- Duffield C, Gardner G & Catling-Paull C (2008) Nursing work and the use of nursing time. *Journal of Clinical Nursing* 17, 3269–3274.
- Dysvik E & Furnes B (2012) Nursing leadership in a chronic pain management group approach. *Journal of Nursing Management* 20, 187–195.
- Ekebergh M (2007) Lifeworld-based reflection and learning: a contribution to the reflective practice in nursing and nursing education. *Reflective Practice* 8, 331–343.
- Ellström PE (2010) Practice-based innovation: a learning perspective. *Journal of Workplace Learning* 22, 27–40.
- Gadamer H-G, Weinsheimer J & Marshall DG (2004) *Truth and Method [Elektronisk Resurs]*. Continuum International Publishing Group, London.
- Glasson JB, Chang EM & Bidewell JW (2008) The value of participatory action research in clinical nursing practice. *International Journal of Nursing Practice* 14, 34–39.
- Herrick C, Steger-May K, Sinacore DR, Brown M, Schechtman KB & Binder EF (2004) Persistent pain in frail older adults after hip fracture repair. *Journal of the American Geriatrics Society* 52, 2062–2068.

- Kyrkjebo JM & Hanestad BR (2003) Personal improvement project in nursing education: learning methods and tools for continuous quality improvement in nursing practice. *Journal of Advanced Nursing* 41, 88–98.
- Li PL, Bashford L, Schwager G, Spain R, Ryan H, Oakman M, Firth J, Lockyer M, Harper D & Higgins I (2010) Clinicians' experiences of participating in an action research study. *Contemporary Nurse* 35, 147–156.
- McCaughan D, Thompson C, Cullum N, Sheldon TA & Thompson DR (2002) Acute care nurses' perceptions of barriers to using research information in clinical decision-making. *Journal of Advanced Nursing* 39, 46–60.
- McCormack B, Dewing J, Breslin L, Coyne-Neavin A, Kennedy K, Manning M, Peelo-Kilroe L, Tobin C & Slater P (2010) Developing person-centred practice: nursing outcomes arising from changes to the care environment in residential settings for older people. *International Journal of Older People Nursing* 5, 93–107.
- Meleis AI (2010) *Transitions Theory: Middle Range and Situation Specific Theories in Nursing Research and Practice*. Springer Pub, New York, NY.
- Mills AE, Rorty MV & Werhane PH (2003) Complexity and the role of ethics in health care. *Emergence* 5, 6–21.
- Nyström M (2003) *Ett liv på egna villkor: vård och omsorg vid psykiska funktionsbinder [A Life on Their Own Conditions]*. Natur och kultur, Stockholm.
- Nyström M, Dahlberg K & Carlsson G (2003) Non-caring encounters at an emergency care unit—a life-world hermeneutic analysis of an efficiency-driven organization. *International Journal of Nursing Studies* 40, 761–769.
- Petersson P, Springett J & Blomqvist K (2009) Telling stories from everyday practice, an opportunity to see a bigger picture: a participatory action research project about developing discharge planning. *Health & Social Care in the Community* 17, 548–556.
- Polit DF & Beck CT (2006) *Essentials of Nursing Research: Methods, Appraisal, and Utilization*. Lippincott, Philadelphia, PA.
- Rolfe G (2006) Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing* 53, 304–310.
- Rycroft-Malone J, Kitson A, Harvey G, McCormack B, Seers K, Titchen A & Estabrooks C (2002) Ingredients for change: revisiting a conceptual framework. *Quality & Safety in Health Care* 11, 174–180.
- SFS (2010:659) *Lag om patientsäkerhet inom svensk hälso- och sjukvård [Law Regulating Patient Safety Within Swedish Health Care]*.
- Stringer ET & Genat WJ (2004) *Action Research in Health*. Merrill Prentice Hall, Upper Saddle River, NJ.

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