Nurses’ learning capabilities using action research

A change from a medical to a person-centered approach

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ABSTRACT
The assumption of our study was that when nurses’ existing capabilities are deeply rooted in routines, action research is suitable to change practice as it involves and engages the nurses. The objective was to explore supportive and obstructive factors for the nurses’ learning capabilities in a cardiology health care setting using action research when changing from a primarily medical-centered to a person-centered nursing approach. An action research design was used. Data was generated through qualitative methods.
Systematic text condensation was used for data analysis. Eight specialized cardiac nurses and three researchers participated. The results showed that the process was complex and challenging for the nurses. Four main points were developed: 1) A major obstacle to jeopardize customary practice – but it can be overcome, 2) The culture was challenged by the nurses’ participation in democratic processes, 3) Mirroring own practice strengthen nurses’ self-perception, 4) Learning capabilities require a sustained effort. It is concluded that nurses working and participating in a democratic way in their practice contributed to develop the nurses with continued learning capabilities, which significantly supported the change. The result is a strengthening of nurses’ self-perception, motivation, professional identity and capacity to work jointly, critically and with commitment to create meaningful and renewable change and cohesiveness in the organizational context. It was important for the process that nurses as insider action researchers managed to be aware of organizational possibilities and obstacles.

Keywords
Action research, learning, nursing, person-centred nursing, qualitative method

BACKGROUND
Traditional scientific results do not always fit the uniqueness of patient-related situations in clinical nursing practice where practitioners rely on their intuition and experience (1). Nurses’ institutionalized ways of acting are often rooted in routines, which makes it difficult for nurses to verbalize, develop, discuss and document their nursing (2). Thus, existing capabilities are deeply rooted in routines, culture and frameworks of the organisation (3).

Institutions consist of cognitive, normative and regulative structures and activities providing stability and meaning to social behavior (4). There is a tendency to uphold stable
routines and a reluctance to give up old habits (5). Thus, changing clinical practice in public health care organizations by translating and implementing research findings into routine practice is challenging. Cultural and concrete organizational conditions are significant for the process of implementation (6) when health care systems need to improve quality in illness management, which is a central goal of nursing care and treatment (5).

Action research is a potentially appropriate method for changing clinical practice by involving practitioners in the process of change (1,3,7). The success of action research can often be viewed in relation to what has been learnt from the experiences the work undertaken (1, 8). In this way action research is a dynamic process where the situation changes because of deliberate actions. Learning capabilities must, however, be developed to secure deliberate actions (3). According to Fraser and Greenhalgh (9), competence is the individual’s degree of knowledge, skills and attitudes. Capability extends to individuals able to adapt to change, generate new knowledge and continuously improve performance (9).

Health care services for patients with cardiac disease are often based on international and national clinical guidelines as well as local policies and standards. These programs include information to and education of patients. Health care professionals seek to convey standardized academic knowledge to the patients routinely. According to Ekman et al. (10) the dissemination of information is largely controlled by the agenda of health care professionals. Health care systems are in no way neutral but are subject to norms, which health care professionals are not always conscious of; these are, however, vital for patients’ possibilities to manage life with illness. When health care professionals are pressed by e.g. limited time and scope, they often prioritize medical rather than interpersonal tasks (2,11,12).

A BOTTOM UP INITIATIVE

Due to experiences with and concerns about the dilemma between empowering patients to manage life with chronic heart disease and institutionalized, primarily medically-oriented ways of acting by health care professionals, two nurses from two different out-patient clinics of a cardiology department in a university hospital had a common interest in improving and developing their nursing capabilities. The two out-patient clinics treat persons with heart failure and congenital heart disease. The two nurses contacted the clinical nursing researchers in their department and a collaborative process using action research was initiated. The intention was to secure a systematic, individualized way for nurses to meet the patients in a nursing-led consultation to professionally support patients to improve management of their life with a chronic cardiac disease. An action research study in the two out-patient clinics was planned to develop and implement a person-centered care (PCC) intervention inspired by the University of Gothenburg Centre for Person-Centered Care (GPCC) (12,13).

THE PERSON-CENTERED CARE INTERVENTION

The PCC intervention involved complementing a medical science-oriented objectifying observation language with a phenomenological life-world perspective based on the human experience of the lived body and how our lives are intertwined with the world (14). It is
important for the nurse to know the patient as a human being with motives, will, feelings and needs to be an active partner in his/her care (12).

PCC starts with establishing a partnership with the patient through the patient’s narrative (15). The narrative describes the patient’s personal perception of illness, symptoms and the impact of these on life. Through the narratives, focus shifts from the disease as a fragmented part of a person to a person with an illness. The nurse supports the patient’s narrative by listening and asking relevant questions; in this way a mutual understanding of the illness is created. Together with clinical signs of the disease, it provides the nurse with a good basis for discussing and planning individual care and treatment together with the patient. The partnership includes exchange of information, shared deliberation and shared decision-making. The partnership must be safeguarded by documenting the patient’s perspective, involvement in care and decision-making in the electronic patient record (EPR) (15).

In our study, organizations are understood as social constructions created by human beings conditioned by human minds and actions. They are guided by cultural rules and values, roles and interactions and create meaning. Everyday life is often taken for granted where unconsciousness as social defence may prevent changes (16). The assumption of our study was that when nurses’ existing learning capabilities are deeply rooted in routines, culture and frameworks of the organization (3,16), action research is suitable to change practice from a primarily medical to a PCC approach, as it involves and engages the nurses and makes them actors in the change of dominating organizational structures.

AIM AND RESEARCH QUESTIONS
The aim of this study was to explore supportive and obstructive factors for the nurses’ learning capabilities in a cardiological health care setting using action research when changing from a primarily medical-centered to a person-centered nursing approach.

DESIGN AND METHODS
The study was inspired by Meyer (1) and Coghlan and Brannick (16). It consisted of four iterative phases: 1) constructing actions, 2) planning actions, 3) taking action and 4) evaluating actions (Table 1).
Table 1 Research process

<table>
<thead>
<tr>
<th>Phase 1 Constructing actions</th>
<th>Phase 2 Planning actions</th>
<th>Phase 3 Taking actions</th>
<th>Phase 4 Evaluating actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intention: To develop a preliminary well-founded intervention for patients with congenital heart disease and heart failure, respectively to be used in nursing consultations</td>
<td>Intention: To prepare implementation of the preliminary intervention in both clinics. A pilot-test was first planned and completed to improve the described intervention.</td>
<td>Intention: To implement the pilot-tested and improved intervention in the two clinics and prepare the final evaluation.</td>
<td>Intention: To generate the last data, to finalize the overall analyses of the implementation process as an action research process, to convey the results, validated by the participants and to maintain the intervention</td>
</tr>
<tr>
<td>Data-generation: - Observation from learning lessons - Meeting summaries</td>
<td>Data-generation: - Audio recording of dialogues - Log-books - EPR documentation - Meeting summaries</td>
<td>Data-generation: - Focus-group interviews with patients before and after participating in PCC consultation - Audio recording of dialogues - Log-books - EPR documentation - Meeting summaries</td>
<td>Data-generation: - Telephone interviews with patients</td>
</tr>
</tbody>
</table>

This study reflects primarily the third phase as a part of the whole study.

This study was qualitative and the process cyclic and experimental until the intervention worked. According to Coghlan and Brannick (16), three elements are typically part of action research: 1) a participatory element, which means that participants perceive the need to change and are invited to play an active and committed role in the research and change process; 2) a democratic element, which implies that the researchers work as facilitators of change, consulting participants not only during the action process but also on how it should be evaluated. Moreover, insights are continuously communicated back to participants for validation and to inform decisions concerning the next step of the study. Finally, 3) a two-fold element aims to bridge the gap between research and practice. The strength of action research is its ability to influence practice while simultaneously creating findings which can be shared with a wider audience (16).
Action research in one’s own organization involves managing three interlocking challenges when developing new learning capabilities and securing deliberate actions: Pre-understanding, referring to participants’ need to build on the closeness they have with their setting and at the same time create a distance to be able to see things critically. Dual roles, referring to participants having an organizational role and a role as action researchers, as well as the ambiguities and conflicts between these that may arise. Organizational politics, referring to participants’ management of organization politics and balancing requirements of their future career plans with requirements for the success and quality of their action research (16).

SETTING
The study was carried out between 1 January 2013 and 28 February 2015 as an action research process.

The out-patient clinics for persons with congenital heart disease and heart failure are parts of a large out-patient clinic led by a nurse manager and a head consultant with 37,500 consultations in 2014. The out-patient clinic for persons with congenital heart disease sees patients when they are diagnosed and visit the clinic for routine follow-up typically once a year. A total of 4,580 patients visited the clinic in 2014. Three nurses are daily affiliated to the clinic of whom one is responsible and a specialist in congenital heart disease. Traditionally, the consultation includes the patient being seen by a cardiologist; the nurse primarily has an assisting role.

The out-patient clinic for persons with heart failure sees newly diagnosed patients and patients with progression of disease. A total of 2,501 patients visited the clinic in 2014. Five nurses are daily affiliated to the clinic of whom one is responsible and a specialist in heart failure. Consultations are typically separated into physician and nurse consultations. An important task for the nurse is to help the patient to get the optimal benefit of the prescribed medicine.

ORGANIZATION OF THE STUDY
The organization of the study was planned with a project-manager in close collaboration with the persons responsible for clinical nursing practice and research. The practice groups were nurses working with the concrete changes in practice in close collaboration with the project group. A steering group involved the leading nurses and physicians from the two out-patient clinics to ensure the management focus in the organization. Finally, an advisory professor from the university supported the study with the perspective from an outsider (Table 2):
Table 2 Project organization

<table>
<thead>
<tr>
<th>Organizational unit</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project manager</td>
<td>Researcher from the department</td>
</tr>
<tr>
<td>Project Group:</td>
<td></td>
</tr>
<tr>
<td>Practice responsible</td>
<td>Two specialist nurses in the clinic for patients with congenital heart disease and heart failure, respectively the project manager and two researchers from the department</td>
</tr>
<tr>
<td>Research responsible</td>
<td></td>
</tr>
<tr>
<td>Practice group(s)</td>
<td>The specialist nurse and two nurses from the clinic for patients with congenital heart disease The specialist nurse and four nurses from the clinic for patients with heart failure</td>
</tr>
<tr>
<td>Steering Group:</td>
<td>Head nurse, nurse manager of the department, head consultant, specialist consultant in the clinic for patients with congenital heart disease, clinical physician in the clinic for patients with heart failure</td>
</tr>
<tr>
<td>Advisory person:</td>
<td>Professor in nursing science from the University</td>
</tr>
</tbody>
</table>

The two specialist nurses in the two clinics were assigned 9 ¼ and 18 ½ hours per week in 2013 and 2014, respectively to participate in the project group and to ensure the practical implementation of the project.

ACTIONS AND CONTEXT

According to Coghlan and Brannick (16), experiencing, understanding, judging and taking action should characterise learning in the action process during the action research cycles. To support this learning towards development and implementation of the PCC intervention, the actions described in Table 3 were completed.

Table 3 Actions to support the learning in action process

<table>
<thead>
<tr>
<th>Action</th>
<th>Description of the action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic learning sessions</td>
<td>For the two project nurses in phase 1: 10 academic learning sessions (10 days, 7 hours a day) with nurses engaged in other nursing projects in the department. Purpose: To acquire academic skills in the area of nursing. At each learning session the two project nurses were committed to make either a presentation of their project or parts of it for discussion or to bring up problems to be discussed. They also had to enter into discussions about the other nursing projects.</td>
</tr>
<tr>
<td>PCC learning sessions</td>
<td>Sessions were completed by the project manager in phase 1 for the two project nurses and in phase 3 for all involved nurses (8)</td>
</tr>
<tr>
<td>Narrative dialogue learning lessons</td>
<td>All involved nurses. An external consultant completed 11 lessons. The nurses were taught narrative dialogue and they got verbal and written constructive response on their audio recorded PCC dialogues from the consultant.</td>
</tr>
<tr>
<td>Study visit to the University of Gothenburg Centre for Person-Centred Care</td>
<td>For the two project nurses and two of the involved researchers. The visit made it possible to learn more details about PCC and how they practised the intervention. The input was used to put own experiences and expectations into play.</td>
</tr>
</tbody>
</table>
For each phase, a meeting schedule was made. In addition to dialogue meetings and workshops, meetings with the steering group were planned. During the process the project was discussed with the advisory professor from the university to get the perspective of a person unrelated to the organization.

**DATA GENERATION**

Typically, action research draws on qualitative methods when collecting data (1). Due to the research questions, data primarily originated from the third phase concerning supportive and obstructive factors for the nurses’ learning capabilities. Relevant data generation methods are shown in Table 4. Focus group interviews were, however, not included as this data would not be relevant for this study but complement studies concerning PCC from the perspective of persons with congenital heart disease and heart failure.

### Table 4 Data generation methods

<table>
<thead>
<tr>
<th>Data generation methods</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audio recordings</td>
<td>Were carried out in both clinics from the PCC nursing consultation focusing the dialogue between the patient and the nurse. In total, 32 audio recordings were carried out. The patients received written and verbal information about the project and gave their informed consent before the recording. Each of the nurses used an USB key to store her recordings.</td>
</tr>
<tr>
<td>Logs</td>
<td>Were written in connection to the narrative dialogue learning lessons initiating the implementation process and afterwards when audio recordings were conducted. In total, 25 logs were written. Each of the nurses had a small notebook with notes. The nurses were asked to write about their immediate thoughts, considerations and reflections concerning the dialogue. What had been easy or difficult for them and what had supported or prevented the PCC dialogue?</td>
</tr>
<tr>
<td>EPR documentation in relation to the audio recorded dialogues between the patient and the nurse</td>
<td>Were written by the nurses in connection with the narrative dialogue with each patient as part of securing the partnership. In total, 32 documentations were made.</td>
</tr>
<tr>
<td>Meeting summaries</td>
<td>Concerning decisions and supportive or preventive elements from all dialogue and steering-group meetings were made by the two project nurses. In total, 14 meeting summaries were made.</td>
</tr>
</tbody>
</table>

Abbreviations: EPR; Electronic patient records; PCC; Person-Centered Care
DATA ANALYSES

Data was analyzed focusing on apparently supportive and obstructing factors for the nurses in the process of changing the nursing approach.

Data from the audio recordings, the log-books, the EPRs and summaries from meetings from phase 3 constituted the primary data. Systematic text condensation according to Malterud (17) is a descriptive and explorative method for thematic cross-case analysis of different types of qualitative data, which was considered appropriate for this analysis. Data was content coded and analyzed through systematic text condensation and consisted of the following steps: 1) overall impression – from chaos to themes; 2) identifying and sorting of meaning units – from themes to codes; 3) condensation – from code to meaning and 4) synthesizing – from condensation to descriptions and concepts (ibid). An example of the analysis of the summaries is shown in Table 5. To optimize the credibility of the analysis, at least two researchers participated. The two specialist nurses from the out-patient clinics analyzed the summaries in accordance with steps 1–3 supported by the three researchers. Two of the researchers analyzed the audio recordings, log-books and EPRs as a whole during step 1 to 3 supported by the third researcher. Step 4, the synthesizing process, was conducted for both sets of data by the third researcher in close collaboration with two other researchers and the advisory professor. The research questions constituted the foundation for discussing and organizing the meanings according to participatory, democratic and dynamic practice/research aspects of the action research process. The data triangulation supported the analysis process and contributed to ensure validity. The analysis process was complex, and it was a puzzle to create consensus about the final syntheses. The end results were discussed and validated together with the nurses in the out-patient clinics and the nurse manager.
**Table 5** An example of the analysis

<table>
<thead>
<tr>
<th>From chaos to theme</th>
<th>Meaning units</th>
<th>Condensation</th>
<th>Synthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>New practices are challenging</td>
<td>“The patient’s assessment of own situation seems so big that you could think that it is the whole life-situation. But it is about small and big narratives. What is it that the patient is preoccupied with? – also small things”</td>
<td>A challenge using narratives and documentation in a PCC spirit – but reflections and suggestions to meet the challenges are made</td>
<td></td>
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<tr>
<td></td>
<td>“Documentation is a challenge. It is quite a “handful”. It takes a long time and it is important that it is written briefly and without mistakes. One must be aware that other professions can read it”</td>
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</tr>
<tr>
<td>Concrete problems</td>
<td>“It is not always documented what is planned for the next consultation”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“The documentation does not always reflect the narrative of the patient”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“The documentation does not always precisely reflect, which information is given to the patient”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivating factors</td>
<td>“Nursing has become more clear in the documentation – this is supporting”</td>
<td>Nursing has become clearer which is experienced as supportive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“This is really good nursing”</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>“X (a chief consultant) is positive to the project and says that he often experiences that the patients do not tell the physicians everything”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“The physicians’ attitude to the project is generally positive”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“The physicians have become aware that the nurses are able to make constructive dialogues with patients who have problems”</td>
<td></td>
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</table>

**ETHICAL CONSIDERATIONS**

Action research involves authentic relationships between the action researcher and members of the client system. Therefore, ethical considerations on how action researchers work with the members of the organization are important (16).

The study complied with the principles of the Declaration of Helsinki (18) and ethical guidelines for nursing research in the Nordic countries (19). Complying with these guidelines, the integrity and anonymity of the participants in the study were secured. Approval was granted by the Danish Data Protection Agency (Journal number 1-16-02-328-14).
RESULTS
The results will be presented as four main points – syntheses: 1) A major obstacle to jeopardize customary practice – but it can be overcome, 2) The culture was challenged by the nurses’ participation in democratic processes, 3) Mirroring own practice strengthens nurses’ self-perception and 4) Learning capabilities require a sustained effort.

A major obstacle to jeopardize customary practice – but it can be overcome
When the practice of the nurses was already meaningful to them, it was a major obstacle for them to see their customized practice jeopardized. However, it strengthened their motivation and created even more meaning and sense of coherence when they took ownership of the new intervention, acted at the organizational level and received organizational, management and interdisciplinary support and recognition.

Thus, nurses’ traditional practice was already meaningful to them; especially in the clinic for persons with heart failure where they had nurse-led consultations. As one of the nurses expressed initially, “PCC is almost what we usually practice”. But having learned about the narrative dialogue and being more deliberately reflected and critical she said: “I have learned to listen to the patient – now I am no longer afraid of the silence”. The nurses experienced that by really listening to the patient’s narrative they became aware of the extent to which patients were preoccupied with their prognosis. Meaningfulness was created in both clinics when the nurses acknowledged that using narratives did not mean that the nurse should be concerned about the whole life situation of the patient; it was more about “what is important for the patient right now in relation to his illness”. Even “small things” were important and made sense. The nurses learned from the patients and nursing became much more focused on the patient’s individual needs and resources.

It was very important to the nurses’ motivation when the nurse manager and head nurse recognized the innovative approach expecting this to be developed and implemented also in other parts of the department. The nurse manager expressed directly that the change was a “major boost for the competence level among the nurses”. The nurse manager met the nurses’ needs for organizational and management support. Also, the physicians showed an interest in the change and found the innovative approach meaningful, e.g. when a patient did not realize the connection between his symptoms, medication and disease status.

Nurses felt particularly challenged in relation to safeguarding the partnership by documenting the patient’s perspective, involvement in care and treatment decision-making in the EPR. The nurse wished to do this part alone when the patient had left the consultation. One nurse from the clinic for persons with congenital heart disease expressed that when she made her notes in the EPR, she was in her mind addressing the physicians. Therefore, she used a medically-oriented language and found it difficult to document in a way that matched the partnership she had established with the patient. She was aware of this and wished to discuss what to do.

Proactively, a lot of practical tasks had to be made jointly and in consensus to secure coherence between administrative elements and the practicing of PCC, such as improvement of tools to ask useful questions to support the narrative dialogue and develop additional information material for patients. Moreover, organizational issues such as the
The patient-booking system had to be changed to secure sufficient time for each PCC consultation. The most problematic organizational challenge was, however, the EPR structure.

The culture was challenged by the nurses’ participation in democratic processes

Traditionally, the nurses tended to isolate themselves in their own busy practice with sparse exchange of uncertainties, thoughts and considerations. By being more active in a democratic process, they became aware of the existing culture and their roles as authorities.

It was a recurring feature among all nurses that in the beginning of the action research process they were not used to be observed and assessed by colleagues or researchers. They expressed feeling “uncomfortable” and they noticed that they were reluctant to expose their professionalism to each other. However, they recognized that this feeling was tied to the culture in the out-patient clinics. Engagement in democratic processes necessitated that the nurses were willing to look at their own practice and become more conscious of their role. An important focus was to discuss with other colleagues when witnessing specific PCC dialogues, listening to each other’s audio recordings of PCC dialogues and discussing how the dialogue was documented. The nurses expressed that they had become aware that it was not a question of evaluating each other but of being curious and inquisitive in an honest and open atmosphere.

In both clinics, clinical guidelines were used as a kind of agenda on how to be an authority and on what was best for the patient. Especially in the clinic for persons with heart failure, the nurses saw themselves as authorities in relation to the patients because of their expert knowledge in heart failure. One of the nurses said about her authority and shift in roles: “I could be so annoyed when the patient did not take his medicine as I had told him to. Now it is important for me that the patient understands his medical situation and we have a dialogue about it. But what he decides to do regarding his medicine is his responsibility – not mine. I feel completely calm”.

It was not easy for the nurses to summarize the most important points for the patient at the end of the PCC dialogue. Their traditional authority constituted a risk for focusing on what the nurse found most important. The nurses reflected together on this problem and suggested to ask the patient to list the three most important issues in the dialogue. Opposite the traditional and often very implicitly agreed way of starting a consultation, the nurses all realized that to get a successful dialogue, a good introduction was important with a clear framework to balance expectations between the partners.

Mirroring own practice strengthens nurses’ self-perception

The nurses feared not to perform well enough. Individual feedback and research based on data from the nurses’ own practice, made it possible for the nurses to mirror their own practice. It strengthened their courage to act and their individual identity as nurses as well as create a mutual self-perception in relation to nursing.

Especially in the clinic for persons with congenital heart disease the nurses felt professionally insecure when they differed from their traditional way of acting professionally. For all nurses it was inspiring to learn about the theoretical perspectives on PCC and narrative
dialogues. But what really changed their understanding was the individual feedback in the lessons on narrative dialogue. Afterwards in each out-patient clinic they were presented with the systematic results of the data analysis on how PCC was conducted. Initially, the nurses were silent, seemed a little tense and did not know what to expect. During the presentation and when discussing the results, they felt proud of their professionalism which became clear to them in the presentation. All the nurses had more than 10 years of experience in cardiology. One of the nurses in the clinic for persons with heart failure expressed that it was “the first time” she ever saw her work mirrored. In this way she learned about what she actually did and how professional nursing was performed. It made the research constructive to support the nurses’ professional identity but also to notice elements that needed to be changed to improve practice. The nurses were assured that what they felt was difficult was often similar to what was experienced as difficult by their colleagues. Uncertainties and doubts thus became a common concern. It was obvious that this process created a feeling of obligated ownership of the intervention.

Learning capabilities require a sustained effort

Even when the innovative approach seemed to be integrated in daily practice, the nurses still felt that their learning capabilities might fade, and everyday life routines would go back to the traditional way of acting. The nurses became highly aware of this risk and planned how to prevent this from happening.

Especially in periods when many were on summer holiday, the nurses in the clinics were extremely pressed and busy. In busy periods the nurses opted out of the PCC and returned to their old practice. There was a tendency that after periods with audio-recording of the dialogues, the nurses “put a distance” to PCC interventions. This problem was noticed and discussed, and it was decided what should be done to maintain the focus on PCC and their new roles. In both clinics the nurses were enthusiastic, had the will to fight and the spirit that “PCC has come to stay”. They experienced that PCC worked. They found it important that the structural frame was well organized and clear to everybody involved. The nurses e.g. decided that the patients should only have two contact nurses to ensure continuity of care.

In each of the two clinics the nurses had started to use peer mentoring and appreciated this. In one of the summaries it said:

We have been listening to our own sound recordings, to each others’ attended each others’ conversations, read each others’ documentation and discussed it. There has been an honest and open dialogue, which has further qualified the dialogues with the patients and the documentation process.

It continues:

In the clinic for persons with congenital heart disease the nurses now have a much more relaxed attitude to exhibiting their own practice for each other. This has improved how we analyze the dialogues together. We also have the courage to talk about things even if they are not perfect.
An important part of maintaining the efforts is the establishment of scheduled journal clubs and nursing conferences in the two clinics once or twice a month together with one of the participating researchers discussing patient cases, documentation, articles and other relevant issues.

DISCUSSION

The overall impression of this part of the study was that the action research process strengthened nurses’ learning capabilities. As these learning capabilities were made conscious, continued and strengthened they became a significant driving force to support the process of action research implementing PCC.

The findings demonstrated that the nurses’ learning capabilities in an action research process are complex and challenged by the pre-understanding embedded in their customary practice, traditional decision-making and fear of not performing well enough. The findings also demonstrated that these challenges can be overcome when meaningfulness, democratic actions and the nurses’ self-perception and professional identity were strengthened. Finally, it was important to maintain the nurses with continued learning capabilities to sustain the change process.

When it was a major obstacle for the nurses to see their usual practice jeopardized it may refer to the nurses’ traditional pre-understanding in the beginning of the process. Changes may represent a situation of imbalance and are considered a threat (20). Thus, the nurses may have defended their traditional tasks and skills because it was close and familiar. However, it is important to create a distance to what is close and familiar to explore what is taken for granted (3). Examples of aspects taken for granted by the nurses in the beginning were the language they used to document their practice, their normative approach to the patients, the traditional cohesiveness and way of collaborating. As pointed out by Coghlan & Shani (3), participants need to balance the closeness they have to their setting and at the same time create distance to it to see things critically when deliberately changing their practice. During individual feedback, dialogue meetings and workshops, the practice of the nurses was mirrored through theory/philosophy and results from analyzed data from the nurses’ own practice. It probably supported a distanced reflection on their practice and the way they perceived the situation and thus their view on nursing.

When practitioners according to Schön (21) become aware of their definitions and that they are part of those definitions, they at the same time become aware that there are other ways of defining reality.

To participate in democratic decision-making challenged the nurses’ traditional role, which primarily was to act as authorities according to a medical agenda and in a sort of isolated and often standardized way. All participating nurses were insider action researchers, which means that they were all full members of the organization; this provides a unique perspective on systems, precisely because it is seen from the inside (3). The concept of dual roles in insider action research refers to participants having an organizational member role and a role as an action researcher and the following ambiguities and conflicts between these that may arise (ibid). To be involved in radical changes involves high hassle and high vulnerability (22). According to Bell (23), it requires a combination of self-reflection as well
as vulnerability, realistic expectations, tolerance, humility, self-containment and ability to learn. Therefore, the traditional organizational member role, which implies security and predictability, may be strong as seen in this part of the study by the nurses’ tendency in the beginning of the process to isolate themselves in their own busy practice. The insider action researchers managed to work in several small groups. A small group can be powerful for promoting capability, as social interaction between members stimulates learning, raises individuals’ confidence and increases motivation (9). A communicative culture and the feeling of belonging to a community have a favorable effect on readiness for change (24). To be involved as actors changed the nurses’ roles to be conscious and committed. Commitment and involvement are crucial elements to secure change (25) and capability building takes place when individuals engage in uncertain and unfamiliar situations in a meaningful way (9).

Kjerholt et al. have shown that without managerial support, it is difficult to involve nurses as participating actors in the process of action research (26). In our study the changing process was characterized by a significant organizational, management and interdisciplinary support. This support probably contributed to the development of the insider action researchers’ acting politically and authentically which, according to Coghlan & Shani (3), is important when the action research project must contribute to organisational learning. By participating in contribution of knowledge concerning the real meaning of practicing PCC, the insider action researchers actually created knowledge about their own organization. In this way they also became aware of the risk that nurses with learning capabilities would fade and everyday life would return to the old and less reflected way of practicing. They became aware that learning capabilities require a sustained effort. According to Gustavsen (27), sustained change is best realized through network-based and participative dialogues. In this way action research can help to create recognition and learning, also about deep structures.

STRENGTHS AND LIMITATIONS IN THE STUDY

The strength in this study was that all the participants were insider action researchers, which made understanding and interactions easy. The different types of primarily practice or research participation, succeeded in complementing each other and also to take the necessary critical distance to study the complexity of the nursing practice. The risk was that because we were all insider action researchers, a part of our assumptions and pre-understanding was hidden and unexplored. The authors of this article might have been too positive in the interpretation of data concerning the development of the nurses with continued learning capabilities because we have an interest in showing the project as a success. However, the validation process was strengthened through communicative validation (28) as the nurses took an active part in this process.

The epistemology of action research is practically oriented and connected to local contexts (29). Therefore, the results of this project cannot be generalized into a natural science understanding. However, the challenges concerning the nurses with continued learning capabilities are now discussed in the light of existing literature; this has provided a deeper understanding of changing professional practices in general.
It must be understood as socially robust knowledge instead of reliable knowledge (ibid). It has made great sense to use action research in developing and implementing PPC as a new approach in the department. However, there is a great overlap between elements of participation and democratic principles as parts of action research and the philosophy in PPC. Therefore, there might be some uncertainty between using action research and developing nurses with continued learning capabilities. Practicing PPC has been significant also to develop nurses with continued learning capabilities.

CONCLUSION

To change nursing practice from a primarily medical-centered to a person-centered care approach by using action research is complex and challenging.

Nurses working and participating in a democratic way in their practice contributed to develop the nurses with continued learning capabilities, which significantly supported the change. The result is a strengthening of nurses’ self-perception, motivation, professional identity and capacity to work jointly, critically and with commitment to create meaningful and renewable change and cohesiveness in the organizational context. It was important for the process that nurses as insider action researchers managed to be aware of organizational possibilities and obstacles.

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