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Nutzerbeteiligung in der perioperativen Krankenhausversorgung

methodisches Rahmenkonzept für ein Forschungsprogramm

Uhrenfeldt, Lisbeth; Søndergård, Susanne Friis; Ingstad, Kari; Kymre, Ingjerd Gåre; Pedersen, Preben Ulrich

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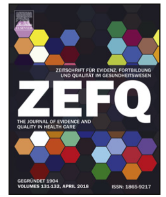
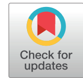


Beteiligung von Patientinnen und Patienten / Patient Participation

User participation in perioperative hospital care research: a methodological framework for a research program



Nutzerbeteiligung in der perioperativen Krankenhausversorgung: methodisches Rahmenkonzept für ein Forschungsprogramm

Lisbeth Uhrenfeldt[a,*], Susanne F. Sondergaard[b], Kari Ingstad[c], Ingjerd Gåre Kymre[a], Preben U. Pedersen[d]

[a] *Faculty of Nursing and Health Sciences, Nord University, Bodø, Norway*
[b] *Center for Research in Clinical Nursing, Central Region Hospital Viborg, Denmark & VIA University College, Nursing Education, Viborg & Department of Health, Aarhus University, Aarhus, Denmark*
[c] *Faculty of Nursing and Health Sciences, Nord University, Levanger, Norway*
[d] *Center for Clinical Guidelines, Department of Clinical Medicine, Aalborg University, Aalborg, Denmark*

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ABSTRACT

It is important to study the well-being of patients and their relatives after receiving hospital treatment, as both the healthcare professional and the political attention towards user participation is constantly increasing. In this study, user participation is understood as a way to manage user rights, opportunity for choices and human rights through relationships and with their well-being as a common goal. Therefore, the health professionals' understanding of this must be increased, evidence must increasingly form the basis for the chosen actions and the professional management must support a person-oriented clinical practice.

The research program's theoretical perspective for perioperative nursing is presented in this article, and it is based on answering person-oriented Fundamental of Care questions and as a methodological challenge to have user involvement as a constant activity. This theoretical and methodological choice guides the continued development of the research program. Perioperative nursing starts when the patient meets the nurse at the time of admission and ends at the time of discharge after the elective surgical treatment is completed. To our knowledge no studies regarding the outcome of FoC for the perioperative patient have been conducted.

We address healthcare providers' actions, starting from when a nurse admits a patient until the day of discharge after treatment is complete, and nursing care related to elective surgical procedures in Norwegian and Danish non-university hospitals. The research program seeks insight into the experiences of current and former patients and relatives as well as the healthcare professionals who perform the treatment in Norwegian and Danish non-university hospitals.

Based on results from this research program, we expect to be able to increase the healthcare professionals' competencies in Fundamental Care and to increase their openness regarding user involvement, options and human rights for the benefit of surgical patients well-being.

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ZUSAMMENFASSUNG

Untersuchungen zum Wohlergehen von Patienten und ihren Angehörigen im Anschluss an eine Krankenhausbehandlung sind wichtig, da die Nutzerbeteiligung sowohl vonseiten der Leistungserbringer als auch vonseiten der Politik zunehmend Beachtung erfährt. In dieser Studie verstehen wir Nutzerbeteiligung als eine Möglichkeit zur Wahrnehmung von Nutzerrechten, Entscheidungsfreiheit und Menschenrechten durch Gestaltung der Beziehungen zwischen Gesundheitsfachkräften und Patienten und deren Wohlergehen als einem gemeinsamen Ziel. Aus diesem Grund muss das Verständnis dafür aufseiten der Gesundheitsfachkräfte erhöht, über die gewählten Vorgehensweisen zunehmend auf der Grundlage von

* Corresponding author. Prof. Lisbeth Uhrenfeldt. Faculty of Nursing and Health Sciences, Nord University, 8026 Bodø, Norway.
E-mail: lisbeth.uhrenfeldt@nord.no (L. Uhrenfeldt).

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Evidenz entschieden und von der Krankenhausleitung ein personenorientierter Ansatz im Klinikalltag gefördert werden.
In diesem Beitrag stellen wir den theoretischen Rahmen des Forschungsprogramms zur perioperativen Pflege vor, basierend auf der Beantwortung personenorientierter Fragen zu den Grundlagen pflegerischen Handelns (Fundamental of Care, FoC) und, als methodische Herausforderung, der Einbeziehung von Nutzern (Patienten) als einem festen Bestandteil pflegerischer Tätigkeit. An dieser theoretischen und methodischen Entscheidung richtet sich die kontinuierliche Fortentwicklung des Forschungsprogramms aus. Perioperative Pflege beginnt mit dem ersten Kontakt zwischen Patient und Pflegekraft zum Zeitpunkt der stationären Aufnahme bis zum Zeitpunkt der Entlassung nach Abschluss der elektiven chirurgischen Behandlung. Unseres Wissens wurden bislang keine Studien durchgeführt, in denen das FoC-Outcome im Hinblick auf den perioperativen Patienten untersucht wurde.
Gegenstand der Untersuchung sind die Tätigkeiten von Gesundheitsfachkräften, angefangen bei der Aufnahme des Patienten durch die Pflegekraft bis zum Tag seiner Entlassung nach abgeschlossener Behandlung, sowie die pflegerische Versorgung im Zusammenhang mit elektiven chirurgischen Eingriffen in norwegischen und dänischen außeruniversitären Krankenhäusern. Mit diesem Forschungsprogramm sollen Erkenntnisse über die Erfahrungen gegenwärtiger und früherer Patienten und ihrer Angehörigen sowie der Gesundheitsfachkräfte gewonnen werden, welche in norwegischen und dänischen außeruniversitären Krankenhäusern Behandlungsleistungen erbringen.
Wir gehen davon aus, dass uns die Ergebnisse des Forschungsprogramms in die Lage versetzen werden, die Kompetenzen von Gesundheitsfachkräften in den Grundlagen der pflegerischen Versorgung (FoC) zu verbessern und ihre Offenheit gegenüber Nutzerbeteiligung, Entscheidungsfreiheit und Menschenrechten zum Wohle der chirurgischen Patienten zu steigern.

Introduction

This paper aims to present the theoretical and methodological foundation for a research program titled: *Specialized Healthcare: users and providers perspectives*. The authors are all engaged in this program which relies upon a standpoint of nursing care that has an ontological influence from a publicly-funded free healthcare, which in turn affects the patient-nurse relationship [1]. The program was primarily developed to raise awareness of user participation in research and to meet the need for evidence based teaching in specialist nurse education. This paper it is not a common method paper but a paper that shows the basis of a research program. It offers a Scandinavian perspective on user participation as a methodology including an epistemological and ontological approach informed by the Fundamentals of Care (FoC) framework [2], and within perioperative care in non-university hospitals in rural areas of Norway and Denmark. Worldwide, it is a challenge to involve patients in the development of their treatment and care, in this study the focus is fundamental care.

The overall study intends to contribute to knowledge of fundamental care needs in non-university hospitals and is organized into three main parts with different aims and sub-studies.

The first part, aims to establish a baseline description of adult elective surgical patients' assessment of their experiences and the importance of the perioperative nursing care already offered and/or received. In addition, healthcare providers (HCPs) are asked to comment on elective surgical patients' assessment in focus groups.

The second part, aims on developing and prioritizing the evidence-based skills and clinical interventions of the HCPs involved, disseminating knowledge based on ontological and epistemological sources, and preparing interventions. The required skills, knowledge base and selected interventions are to be identified and chosen in workshops as well as in dialogue with users and HCPs. Further, to encourage user participation in these initiatives in similar hospital departments in both countries we follow a stepwise dialogue and decision-making process between users and HCPs.

The third part, aims to introduce and activate the plan needed for further user participation through reference groups and collaboration with HCPs. In addition, the study strives to disseminate knowledge, implement interventions in the teaching, planning and practice of perioperative nursing care and to evaluate how patients and users perceive the extent to which their expectations surrounding health and care needs are being met.

The relationships between the patients and the nurses

Being a patient in specialized healthcare, entails diverse quality and safety issues [2]. The FoC framework for nursing care complements existing conceptualizations around patient-centered care [2]. In developing and defining FoC, the challenge was to create and describe a common classification system. The challenge seemed to concern both the essential meaning and understanding of fundamental aspects of human existence, the ontological tangle, and the ability to develop and provide systematic processes in FoC, which is the epistemological component [2]. The development of the FoC framework as a knowledge base is published to identify and collaborate on research questions, to ensure that relational dimensions are maintained, and to guarantee the application of new knowledge in nursing practice [2]. The FoC framework is meant to inform nurses about working collaboratively with patients in building relationships to generate, test and implement meaningful ways of capturing nursing care practice around fundamental care issue, as well as to ensure more integrated, holistic patient care in nursing practice. The relationships between patients and nurses lie at the core of FoC [1,2].

Such relationships are built through dialogue that aim to establish safe, confidential cooperation for planning and evaluation of nursing care. The FoC framework rests upon nurses' ability to connect with patients and, through that bond to meet or help patients meet their fundamental care needs. The focus is on enabling patients and nurses to assess, design, and implement and evaluate care around fundamental care needs confidently and competently. Clinical conditions affect the performance of care, and the contribution of nursing to a patient's achievement of well-being facilitating the effective fulfilment of basic needs in a way that is competent, respectful, personal and empathetic [2]. This is critical for effective nursing care and is attained through the conscious alignment of three core elements: establishing a relationship; being able to integrate the patient's care needs; and ensuring that the HCP, system or context is committed and responsive to these core tasks. This

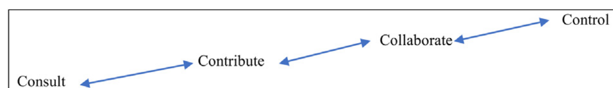

Figure 1. HCPs building partnerships with users moving from low influence to most influence or reverse (inspired by Morrow et al., 2012).

approach is already described as part of the Scandinavian person-oriented approach to nursing care [1].

Around the world, international healthcare organizations emphasize together with the World Health Organization, that there is a need for nationwide focus more explicitly on individual patients‘ wellbeing and needs [2]. This paper portrays user participation as a methodological element using the ‘Look-Think-Act’ framework [3] to explore and measure perioperative elective patients’ experiences, participation and outcomes within FoC framework and in a specific context. The chosen perspectives and methodology are described below.

To increase experiences of perioperative care and to focus on well-being

The three perspectives of perioperative care chosen to answer the patient-oriented FoC questions are: user participants, HCPs in Norwegian-Danish non-university hospitals perioperative settings and reference groups.

User participation

All over healthcare systems patient satisfaction audits/surveys and quality development projects are conducted frequently in order to monitor and develop improved quality [4,5]. Thus, further user participation can lead to important advancement in healthcare services and has its roots in the tradition of democratic rights. According to Slomic *et al.* (2016), individual user participation aims to strengthen each individuals rights and range of choices [5]. In a narrative review and synthesis by Kitson and colleagues patient-centred care is defined as patients‘ involvement in establishing a patient–nurse relationship, with a focus on the context of care delivery [2]. They point at an ongoing recognition and acceptance of the need to embrace patient-centred care approaches in healthcare systems. In addition, international literature stresses on the significance of offering services that meet the needs and wishes of patients and their relatives. Patients have a right to be involved in and to control their own treatment and nursing care. This perspective is seen as part of a larger view in public management discourse where patients and relatives are increasingly seen as consumers with the right to determine the value of services and to choose from among them [4,6]. Based on Morrow *et al.* [7] we understand building partnerships through four levels with users: our consultations, their contribution, mutual collaboration, and finally their control of a project (Figure 1). In this study we plan for the first three steps of collaboration. However, the stepwise development will depend on our participants physical and mental endurance, and to what extent they wish to be included.

Healthcare providers in perioperative care

Perioperative healthcare has a long history of practice traditions and routines [8]. Further, perioperative nurseṕractice goal and role providing patient care that yields positive safe patient outcomes based on a supportive care environment and nursesṕroficiency [8]. Perioperative care is carried out as nursing care in anaesthesia, intensive care, and in recovery department and often in the surgical departments via pre- and postoperative care. In sum, perioperative care is given before, during, and after surgery; it takes place in hospitals, in surgical centre’s attached to hospitals, in freestanding surgical centres, or at HCP’ offices. The perioperative period is used to prepare the patient both physically and mentally for the surgical procedure and after surgery. Over the past decade improvement in perioperative nursing care has relied on scientific literature about different topics such as hygiene, or the time-limited encounter between a HCP and a patient [8]. Nevertheless, there is a lack of nursing professionals research effort in perioperative nursing [8], as well as a focus on certain diagnosis or procedures in the perioperative settings. This means that measuring nursing care in perioperative setting has been broken down into smaller perspectives revealing a dearth of coherence in knowledge, and moreover gaps in perioperative nursing research on adult surgical patient. In this study program, we address HCP actions from when a nurse admits the patient until the day of discharge after treatment is completed and nursing care related to elective surgical procedures. To our knowledge no studies regarding the outcome of FoC for the perioperative patient have been conducted.

Reference groups

Patients benefit from advances in healthcare research yet face risks due to HCPs failure to translate new knowledge into daily practice [9]. This is relevant in identifying how, when and under what circumstances specific knowledge is pertinent to an actual context; and raises questions dealing with a time-consuming skill-intensive process such as building credibility or being a messenger for the transfer of research knowledge [9]. In addition, interventions that are effective in some settings and for a certain patient might only have a modest impact when it comes to the care of others and be completely wrong for a third patient. Hence, evaluating the process as part of quality improvement interventions is a well-known activity. Planned reference groups have HCP as members representing each hospital and invite users who have participated earlier in a study or who are recruited newly for new investigations. Reference groups comment on the outcome of a baseline investigation and how it relates to the evidence for each topic selected.

Stakeholders, frameworks, and methods

From a methodological angle, we search for the best way to meet people’s needs in the role as patients participating before, during, and after elective surgical treatment. The cooperation involves two partners: the patient, (perhaps together with a relative or significant other), and the healthcare provider (perhaps together with leaders). The two partners share experiences, expertise and a vision, and jointly explore opportunities for well-being [10]. Thus, the main methodology entails qualitatively exploring human experiences [11,12]. The Scandinavian healthcare system is built for these kinds of joint efforts; it is publicly financed, free for all citizens, and within reach of most people [1]. The relevance of rural hospitals are equivalent to the rural spread education and workforce activity in the two countries. In this study program, we revisit the Look-Think-Act framework [3,13] initiated by a baseline questionnaire, and followed by focus group interviews, adding knowledge implementation to the perioperative hospital setting. Then, based on evidence, we carry out a second questionnaire to determine how the FoC has progressed as experienced by users, and include dialogues with reference groups established with HCPs and users.

The user: A significant stakeholder in user participation in healthcare

Ideas of increased user participation in healthcare have been a priority in many European countries over the past two decades. The literature often distinguishes between three different discourses on

Table 1
The user perspective in combination with our interpretation of the Look, Think, Act framework and methods.

Step	User participation	Research method	Argument
LOOK	Consult	Baseline test	Gather information from the user perspective
THINK	Collaborate	Select work packages /designated fields	Gather evidence and review from the users, HCP and contextual perspectives
ACT	Contribute	Prepare and implement actions	Evidence implementation, setting mutual goals (users, HCP and leaders)

user participation; -democratic or rights-oriented (voice); - consumer oriented (choice); and co-production (human right).

Democratic or rights-oriented user participation is tied to individual citizenship, and the individuals rights and duties in society. This concept includes the individual's right to economic security and prosperity and to live in accordance with the prevailing standards of society [14]. Consumer oriented user participation perceives individual users as consumers of services. This discourse is based on a view of users as competent, rational actors with the right to choose service providers within a service market [14]. Choice was introduced as part of several NPM-inspired reforms in the 1990s. The core notion was to use quasi markets in healthcare to make HCPs more responsive to users. In recent years, user participation has included a co-production discourse, and users are seen as equal partners, citizens with the right to influence their services, and with resources and competencies that can improve services. At the same time, responsibility in one's role as a participating citizen is emphasized. Users and HCPs have complementary competences, by entering relationships that promote co-production; -users (at least theoretically) receive both qualitatively better and more democratic services.

The literature is developing quickly regarding different methods of involvement [7]. However, the core of user participation means including people who receive healthcare services; it can occur in various capacities, structures, and remits. [15,16]. Healthcare organizations worldwide are challenged by the fact that more services are required based on limited resources. Involving a user reduce FoC issues and increases quality; for example, in terms of post-operative malnutrition [17], constipation, enhancing one's health status, increasing patients' adherence to pre-operative oral hygiene recommendations and reducing costs [18]. Hence, involving users in their own care seems like a strategy worth pursuing as the approach combines ethical and democratic rights with an effective method for achieving better healthcare outcomes at lower cost [17].

Our study program relies on the concept of user participation in terms of the ability to build a relationship between the patient and the nurse as well as having a person-oriented care perspective but we also focus on the patient involvement process and developing relationships in certain contexts [7].

By constructing partnerships over a series of four steps it is possible for a user to move from a low, middle, or high level of involvement up to the highest level of participation, described with the words: consult, contribute, collaborate and control (see Figure 1). In the initial step of participation, users can be consulted on specific issues of value for HCPs. They may contribute to designated fields, such as recruitment or education. As collaborators, they may receive payment for their expertise and time, and at the highest level of influence they might control particular projects. The method is linked to primary nursing and person-oriented care [1].

The Look-Think-Act framework

This study program is a longitudinal intervention with a pre-and post-test design and three main parts based on the; "Look - Think – Act's" theoretical framework of action research which frame the research process [3,19,20].

For the first part, we initiate an inquiry process based on a cross-sectional study: – the 'Look' phase. The questionnaire is designed to consult and measure elective surgical patients' experiences and values of FoC aspects of perioperative care. This baseline description is followed by focus group interviews in the HCPs.

For the second part, we establish a reference group with user participation, HCPs and other relevant stakeholders to collaborate as reference groups, thus forming the 'Think' phase. We delve into the results from the cross-sectional study and prioritize areas for intervention. We search the literature and present suggestions for interventions, to the reference group. The reference group prioritizes the recommended interventions.

For the third part, we introduce and activate the intervention plan, and carry out a cross-sectional post-test; for example six months after the implementation is completed. We ask the reference group to contribute to designated areas and additional actions (see Table 1).

Baseline questionnaire: the first part and method

The first part, the "Look", phase, begins with a cross-sectional study that provide a baseline of the users' perspective. A questionnaire is developed and is being validated for this study. The Peri Operative User Perspective (POUP) questionnaire is based on both experiences and value-based assessments of the users experiences of quality. There are two sections for each of the 71 items besides the seven demographic questions: Section A: Report on how the surgical patients has experienced the specific item during admission and Section B: Report on how the surgical patients values the specific item. The POUP-questionnaire has been validated on item level using face and content validity approaches. In the validation participated 69 patients and eight experts with expertise in perioperative nursing care. The patients report their values and experiences within the four domains in the FoC framework (relational, psychosocial, physical and system level). The relevance of the questions was, by the patients, reported to be between 82-93% in the respective domains. On a five-point scale (from 1-5, 1 is lowest) the clinical experts' mean scores for relevance were from 4.62-4.71 depending on the domain. The internal consistency of the domains was reported to be 0.64-0.92 for reporting of patients values and 0.58 – 0.81 for patients experience of care (Cronbach's alpha). Thus, the POUP-questionnaire can provide insight in surgical patients' experience of perioperative nursing care offered, and show individuals perceived reality and subjective importance in perioperative nursing care during admittance to hospital.

Baseline data will be analysed using descriptive statistics with focus on the discrepancies between patients values and preferences on care and the actual care delivered. Gaps between these answers will determine the final specific outcomes.

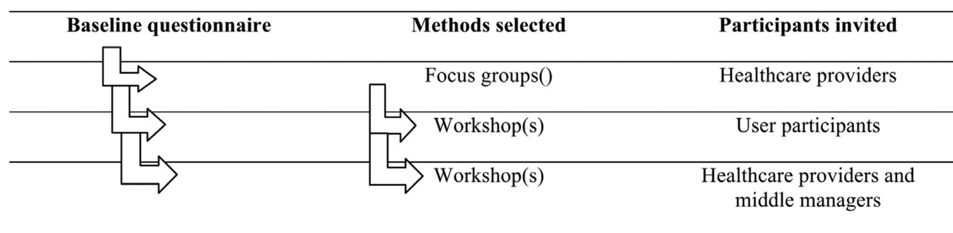

Figure 2. Ending the Look phase, interpretation and prioritization of results before initiating the Think phase.

Focus groups and workshops: The first part and the second methods

The baseline questionnaire is followed by the focus groups and workshops. This is the second step of the "Look" phase and is followed by the "Think" and "Act" phases. The data collection in the focus groups is grounded in the outcome from the questionnaire and formulated into a semi-structured interview guide [2,21]. Furthermore, the outcome needs is negotiated with users involved through invited workshops.

Focus groups participants represents perioperative nurses from perioperative departments in Norwegian non-university hospitals and similar Danish hospitals. In addition, users are invited to participate as observers. Workshop participants are former surgical patients who accepted to be contacted when they answered the questionnaire. Other participants such as relatives, partners or significant others may also be invited (see Figure 2).

The data from the focus groups and the workshop will be audiotaped. We then analyze the content of the data with descriptive content analysis and publish it, in order to frame the search for evidence and the later implementation of evidence.

Selecting interventions at the hospital or ward level: The second part

The second part, the "Think" phase, begins with a presentation of the results from the "Look" phase. At each participating hospital we invite user participants, HCPs, and hospital leaders, and show results from the first part. We ask for their collaboration in prioritizing further research and future implementation. This leads to the creation of argued work packages within the FoC framework. Based on the previous questionnaire and focus group findings, the second part involves a literature search for new interventions in perioperative care. This leads to choosing one of two steps: a) the implementation of evidence for existing knowledge in perioperative care practice at the non-university hospitals involved, or b) the systematic production of evidence through comprehensive literature searches.

Planning the act: The third part

The third part in terms of the "Act" phase, entails introducing and implementing evidence based on literature searches and work package results. The evidence-based nursing care to be carried out within the FoC framework, is based on a selection process supported by user participants and HCPs in reference groups. Focuses for implementation depend on all three phases. The implementation differs across departments and hospitals depending on the local context. Upon ending the third part, a second questionnaire study is planned for, on a year after evidence is implemented into perioperative nursing care practice. The evaluation may restart a new stepwise process of user involvement as presented above. Evidence-based practice (EBP) is both an attitude and a process. The process ties in to HCPs use of research and scientific results in combination with patients' or relatives' perceived reality, subjective importance, preferences, needs and/or other experiences [21].

Competencies for the nursing profession when performing person-centered care

According to Martinsen (2005) and Uhrenfeldt et al. (2018), there has been discussion in Scandinavian society of nursing according to what kind of knowledge the nursing profession must acquire to perform person-centred care. This epistemological debate has also addressed the pros and cons related to evidence-based nursing practice [1,22]. To practice EBP healthcare providers need to be skilled and have access to specialists when required. EBP is furthermore correlated with organizational and economic knowledge and perspectives. Thus, HCPs conceptualize user participation as a potentially beneficial process being dynamic, rather than a static feature of clinical practice, as a patient's experiential knowledge is valued because it may improve care delivery [23]. Therefore, research must consider including HCP's expertise and patients and their relatives personal and experiential knowledge.

In Norway, in recent decades, "user participation" has evolved from a marginal phenomenon to a well-established concept in public welfare policies [24]. The concept is recognized as a policy objective, and the politics imply a social-citizen discourse; it was temporarily replaced by a discussion of individual safety, and a weak consumer discourse [24]. Currently, user participation has shifted toward co-production. Norwegian public documents in the welfare realm are influenced by a co-production discourse where individuals 'rights' to influence their lives as citizens are connected with individual responsibility for their own welfare, as well as for the community they are part of [14,24]. Further, user participation in treatment decisions is key to Norwegian healthcare policy and enshrined in legislation [14]. User participation in Denmark as a strategy, was developed over the past two decades. Despite this, it has been almost absent as a concept for coherence in everyday practice in hospitals [25]. However, since founding "The National Knowledge Centre for User participation" within the healthcare organization in 2011, the concept has slowly gained acceptance in the Danish healthcare system.

Brett *et al.* point out that active user participation in research can lead to research of greater quality and relevance due to the perspective users bring to actual research [4]. Moreover, researchers have been encouraged to develop systems and processes to involve patients and the public in research projects [4,14]. Even though there is an increasing international interest in user participation in research, there is little robust evidence about its impact on health and social care research [4]. In addition, including a user participation approach in healthcare as well as in research has been an important driver of increased transparency throughout several activities in healthcare [26]. User participation and patient-centred care are described as a shift away from authoritarian provider care towards care based on patient autonomy [5].

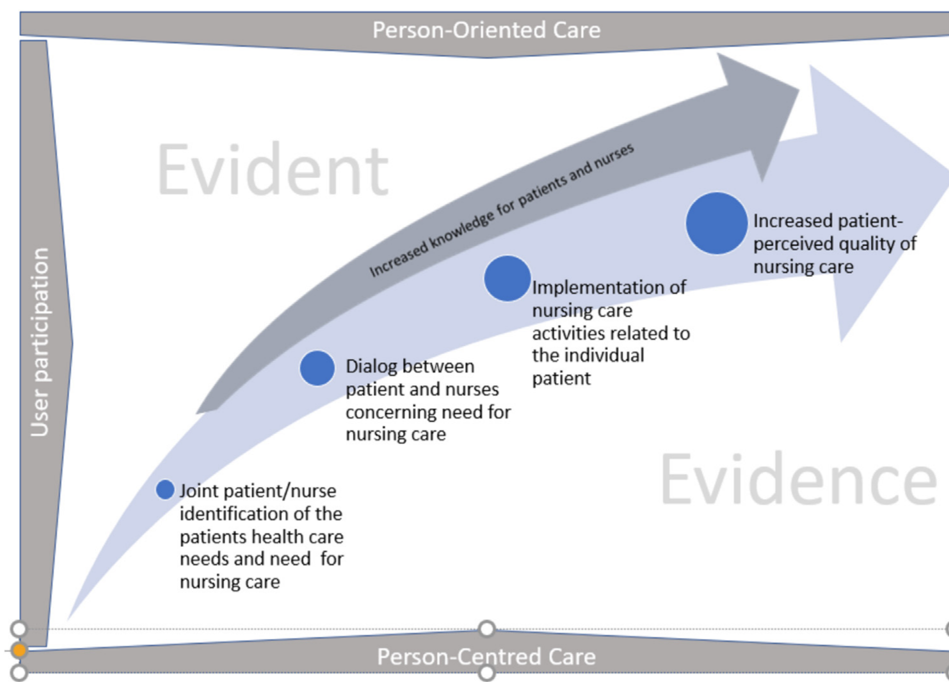

Figure 3. The user participation influence the HCPs person-oriented and person-centred care.

Competences that the nursing profession must acquire to perform person-oriented care

Uhrenfeldt et al. (2018), adds another discussion to nursing about the kind of knowledge the nursing profession must acquire to perform person-oriented care. This ontological debate has addressed how to deal with peoples experiences in an innovative way [1]. From the patient's perspective, person-oriented care strives for a deeper understanding of what or how a person (-being a patient for the time being, or as a previous patient), offers us as plausible insight [2]. This insight represents this persons lifeworld, it is told through the language and spoken words familiar to her/him. When patients share such experiences, some are collected through stories from other patients and some are personal. Together, they form the background for any present dialogue with a patient in person-oriented care. This background contains what is described as an ontological difference; the difference between what there is and the being of what there is, the difference between beings and being- on one side all that exists, on the other the very existence of what exists" [27].

Figure 3 illustrates the coherence between the person-centered and person-oriented approach as described here and in the previous paragraph.

The figure shows two aspects of care and treatment, the evidential and the evidence-based knowledge and that we strive to move towards person-oriented care rather than person-centred care. The figure is a further elaboration of an earlier description of the relationship between person-oriented care and person-centred care [1]. In Figure 3, the user perspective is highlighted as a strengthening of the balance between the person-oriented and the person-centred care provided in favour of the person in need of care.

Evident is the obvious - a self-evident insight that comes to you in the encounter with another human being, the other's distress, need, suffering, goodness or inadequacy is immediately understandable without other detours and it is possible to act on this. It is a patient-oriented care, the patient has the full right of definition of the problem.

Evidence is the scientific insight, it may have been taken from research or repeated development work, it lies behind the HCPs' right to provide care and treatment independently.

The arrow (reads from left to right) illustrates steps needed for staff in the developmental process towards achieving a clinical practice that deliver person-oriented care. The arrow gets wider along the way, it shows that the collaboration is becoming more comprehensive that is, more extensive without us knowing whether the width is retrieved from the obvious or the evidence-based area. The speed of this development process is characterized by the degree of user involvement as shown in the x-axis of the figure. When the cooperation is successful, both the patient and the HCP contribute and learn from each other in the specific situation.

It is all about how we the people, the HCP and patients understand the world and our own world and if we can reach out to each other and have a dialogue based on this understanding aiming for a specific patient's wellbeing (see Figure 3).

Discussion

Our reflections are connected to the study's three parts:

For the first part, we collect the users perspective through a baseline study to describe a patient-oriented, ontological understanding of fundamental care in the perioperative setting in non-university hospitals in two Scandinavian countries.

To capture the essence of FoC we develop, validate, and pilot test a two-dimensional questionnaire (POUP) grounded in selected areas of the FoC framework. This framework points out requirements, characteristics, and consequences of fundamentals care. Additionally, it illustrates the complex domains of FoC. The items in the questionnaire are generated to reveal the essence of the concepts characteristics. The starting point for interventions is established by adding the views of HCPs to the users stance. The starting point might be different in some areas or alike across wards. Efforts to develop core competencies are recommended to

be grounded on systematic assessment in order to choose the intervention that is most likely to improve the outcome of a set of efforts [28]. Further, the results of the baseline study used as a priority setting in local working groups. High-priority outcomes could be aligned with intervention strategies and offer insight as to which strategies offer the best chances of achieving the intended changes. Interventions to increase the use of evidence and to deepen competencies have been documented to be effective in healthcare settings [13,29].

For the second part, we present the outcome of the baseline at a workshop with users, aiming for a mutual priority of the most important fields of nursing to be further developed. The priority leads to epistemologically based systematic research to identify evidence relevant for quality improvement; and to plan for the implementation of a systematized evidence in specific areas pertinent for each department [30]. In this part of the study, scientific evidence, as well as users and HCPs expertise and experiences, guide the process of finding solutions and spheres suitable for quality enhancements. A reference group is established to forward suggestions for actions to be carried out in clinical practice. Reference groups are formed in each hospital, to a larger extend they capture local cultural and organizational differences. The members invited are users, relatives, HCPs and nurse leaders. Interventions are identified, presented, and discussed from both a person-centred and person-oriented perspective followed by establishing dialogues with healthcare middle managers to seek active support for planned nursing care activities.

For the third part, evaluations of the process, are used to aid the implementation of continuous evidence. Before interventions are launched, power calculations are performed for each organization to ensure that the evaluation is supported by the required power. We use the POUP questionnaire as outcomes measure for the upcoming interventions in a pre- and post-test design, which is relevant for an implementation study. The control patients could overhear information given as a part of the intervention or could share information. Further, it is not possible to allocate organizational changes to one group of patients. Nurses need to change their behavior whether their nursing care is based on intervention or counter intervention.

Conclusions

Fundamental care is described as poorly covered and executed in healthcare. This work respond to the challenge of systematically including users perspectives in developing evidence-based healthcare practice. The methodological foundation for the described research program implements user participation as a valuable ontological source when reaching out for perioperative nursing care concerning FoC. The POUP questionnaire explores both objective and subjective assessments of the users experiences of the received quality of care and the value it has for each user. Through this methodological approach we find it possible and highly relevant to illustrate how FoC in perioperative care fits with other policy agendas such as user participation informing the research process and enhancing the quality of care and outcomes, taking the users and healthcare premises into account. Finally, this approach is the first-time that user participation has been combined with the FoC and the Look-, Think-, Act frameworks to ensure genuine user participation within the perioperative hospital care. Hence, we plan a final evaluation to ensure the extent and substance of the user involvement and in this process as a whole. This evaluation is expected to point at future recommendations on users participation and the look-think-act framework as methodological guidance in both research and clinical development.

Ethical approval

We carried out this work according to ethical guidelines and the baseline study registered at the Norwegian Center for Research Data (with reference no. 61358).

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Conflict of interest

All authors declare that there are no conflict of interests.

CRediT author statement

Lisbeth Uhrenfeldt and Preben U. Pedersen: Conceptualization, Methodology. All authors with Lisbeth Uhrenfeldt as lead: Writing-Original draft. Lisbeth Uhrenfeldt and Preben U. Pedersen: Visualization, Investigation. Supervision. Lisbeth Uhrenfeldt and Susanne F. Sondergaard: Software, Validation. All authors with Uhrenfeldt as lead: Writing- Reviewing and Editing.

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