

Achieving competences in patient-centred care: an evaluation study of a training programme in assisted personal body care for respiratory patients

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Submitted for publication: 23 September 2010

Accepted for publication: 24 January 2011

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LOMBORG K, NIELSEN ES, JENSEN AL & JØRGENSEN LB (2011) *Journal of Nursing and Healthcare of Chronic Illness*

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Aim. To document the efficacy of a training programme in patient-centred care in which the nursing staff was trained to involve chronic obstructive pulmonary patients in assisted personal body care (APBC). The objectives were to describe the programme and uncover the outcomes.

Background. Chronic obstructive pulmonary patients suffer from breathlessness and may need comprehensive assistance with personal body care. The patients' well-being may be improved and their integrity safeguarded if nurses are able to involve the patients in accordance with their illness conditions and personal preferences. In order to achieve such competences in nursing staff, we developed, implemented and evaluated a training programme.

Design. A qualitative outcome analysis was conducted in order to explore the dynamics of the training programme process and the outcome.

Methods. Seven nurses and six nursing assistants from three hospital units were divided into two groups in which training and evaluation took place. The content of the programme was documented. Audio-recorded pre- and postfocus group discussions and oral evaluation within the two groups were analysed using Interpretive Description. Data were collected in 2007–2008.

Results. The competences of the nursing staff to act in a patient-centred manner improved following the training. Staff was able to integrate patient preferences and professional measures, especially the ability to abstain from putting pressure on the

patients to be more active, as was common practice prior to the training. According to the staff, there was no actual change in the patients' level of activity. The training was time-consuming.

Conclusion. A comprehensive training programme can improve nursing competences to action patient-centred and involve severely ill respiratory patients in APBC. Further studies are needed to investigate the efficacy from the patients' perspective.

Relevance to clinical practice. This programme can be adopted in respiratory nursing care and may be adjusted to other groups of patient who suffer from unpleasant symptoms and who need comprehensive assistance.

Key words: chronic obstructive pulmonary disease, education programme, evaluation research, nurse–patient relationship, patient-centred care, respiratory nursing

Introduction

Patient-centred care is recommended in modern healthcare services (Stewart 2001). Finding the right balance and the right way to involve severely ill patients in decision-making and caring activities is however, not straightforward. The Danish National Board of Health has documented a serious gap between ideals and reality in terms of patient participation in acute as well as in long-term care (Jacobsen *et al.* 2008). In a British study, it appears that compared with doctors and physiotherapists, nurses find active and informed self-managing patients particularly challenging citing perceived litigious vulnerability as the cause (Wilson *et al.* 2006). According to a survey of barriers to patient-centred nursing, a lack of time, tools and training are the most reported obstacles. The nurses, however, seem to be more than willing to participate in further training, particularly in social and interpersonal aspects of care (West *et al.* 2005).

We developed a training programme with a particular focus on assisted personal body care (APBC) among hospitalised patients suffering from chronic obstructive pulmonary disease (COPD). In line with qualitative outcome analysis (QOA) (Morse *et al.* 2000), the training programme intended to apply substantial grounded theory into clinical nursing practice. Based on previously published theoretical contributions to understand patient experiences (Lomborg *et al.* 2005) and nurse–patient interactions (Lomborg & Kirkevold 2008), the entire training programme was developed as an exemplar of patient-centred care. In this article we describe the content and documents the outcome of the training programme.

Background

The overall idea of patient-centred healthcare is to empower patients and their families. Patient-centred care is individualised and has a safety dimension and a service dimension (Reynolds 2009). Effective practice includes cultivating good

communication skills, providing the patients with clear and useful information and including the patient in the decision-making process as it concerns the individual health needs (Reynolds 2009). Ideally, these general intentions and practical components should permeate to all healthcare services no matter the patients' conditions and no matter the particular healthcare professions involved.

One of the specific challenges in nursing care is how to assist patients who depend on other people's help to eat, drink, eliminate, wash and dress. These tasks and bodily functions normally take place independently and in private. Assisting patients in these kinds of activities has often, mistakenly, been considered by society as 'basic' and 'taken-for-granted' competences that 'everybody' is supposed to have (Lawler 1991). It may also be challenging to transform the intentions, principles and components of patient-centred care into good clinical practice.

Patients with severe COPD suffer from breathlessness. Daily activity such as personal body care is often a major challenge and during exacerbation, patients may need comprehensive assistance. Nonetheless, these patients perceive personal body care as a significant daily ritual that has to be carried out in order to preserve their integrity and thereby remain empowered (Lomborg *et al.* 2005). For severely ill patients, supportive caring activities should be tailored to individual patients (Ek & Ternstedt 2008), but previous studies have demonstrated several challenges that nurses must address to meet individual patient preferences. Firstly, assisting severely breathless patients with personal body care is a complex task. The main problem is how to keep the patient's breathing under control while optimising comfort and well-being. Therefore, APBC needs to be carefully planned and performed with a purposeful balance of protection from breathlessness and promotion of the patient's present and future functional capacity in order to preserve their integrity (Lomborg & Kirkevold 2005). It has been indicated that the quality of care depends largely on the nurses' ability to achieve therapeutic

clarity in the nurse–patient interaction. The ideal interactions should reach a common understanding of the patient's current conditions and stage of illness trajectory; negotiate a common scope and structure of the body care session; and clarify mutual roles (Lomborg & Kirkevold 2008).

In accordance with these challenges and in close collaboration with the nursing staff in a university hospital, we developed and implemented a patient-centred training programme to improve nursing competences and subsequently evaluated its efficacy. The overall purpose of the training was to develop patient-centred nursing competence to improve respiratory patients' well-being and safeguard their integrity. The training programme was directed towards nursing staff and did not address organisational aspects.

Methods

The study was designed as a QOA (Morse *et al.* 2000). QOA is an inductive research strategy which permits researchers to examine the dynamics of clinical interventions without prescriptive hypotheses. Unlike more traditional forms of evaluation research, QOA addresses issues of both process and outcome in order to enhance programme applicability to complex clinical experiences.

The protocol of the training programme

The aim of the training was that nurses and nursing assistants (from now all referred to as trainees) should develop competences to involve patients in APBC in a patient-centred manner, respecting individual patients' actual illness conditions (breathlessness in particular), needs and preferences, and should safeguard the patients' integrity.

Content and schedule

The training programme consisted of five interrelated components (see Table 1). Each group attended 30 hours of training, spread over 18 weeks. Together the principal investigator and one of the three involved research assistants (from now all called trainers) led all sessions. The trainers had negotiated their individual roles for each session. A psychologist with special expertise in communication took part in the communication training.

The trainees were briefly introduced to the training programme and the study. They were then introduced to a socio-cultural and phenomenological interpretation of APBC. The content of this theoretical introduction was research-based (Lawler 1991, Merleau-Ponty 1994, Lomborg 1995) and subsequently adjusted to the educational level of the trainees with examples from their every day practice.

After the introduction, the trainees were invited to participate in the development of a tool to structure the exchange of information with patients about the APBC sessions. The tool (also referred to as speaking 'the agreement sheet') was pilot tested and adjusted until consensus was reached across the participants in the study. In this tool, all relevant elements of APBC were taken into account (Fig. 1) and the trainees were carefully trained to use it to respectfully involve the patients.

The trainees were also instructed and trained to use the Modified Borg Scale (Kendrick *et al.* 2000) to measure patients' experience of breathlessness in order to take the individual patients' breathing pattern into account.

In addition to the use of the above mentioned tools, trainees were trained to communicate and act according to an adjusted version of The Calgary–Cambridge Framework (Kurtz & Silverman 1996, Kurtz *et al.* 2003) in order to provide structure to the APBC session and build a relationship with the patient. The framework encompassed four consecutive phases of each APBC session: initiation of the session, information exchange, performance of APBC and evaluation (Fig. 2). This element of training formed a significant and comprehensive part of the programme as did the subsequent sessions of supervision, in which competences related to all previous mentioned components were integrated and increased.

The supervision was based on video-recordings of authentic APBC sessions performed by the trainees. Together trainees and trainers watched a video sequence, which was carefully selected by the trainers prior to each training session. First, the focus was on one of the trainee's individual developmental process (trainees were selected in turn). The trainee in focus was supervised by an experienced supervisor (a research assistant). The other trainees played a subordinate role; they were encouraged to observe and, at the end of the supervision, comment on the session. Each session then moved to a second phase in which the video was repeated in full and all participants practised observation and reflection according to the training programme for APBC.

Educational approach

The content of the training programme was carefully aligned with the objectives (Biggs 2003) (see Table 1). The educational framework was inspired by systemic theory with reflective dialogues and a positive attitude as the leading elements to support the trainees' learning process. Together with the trainees, the trainers made an effort to create innovation by: (1) creation of a common language, (2) active and appreciative listening, and (3) 'interruption' of routines and habits (Andersen *et al.* 1991).

Table 1 The 4-component training programme for patient-centred assisted personal body care (APBC)

Content	Subsidiary Learning Goals	Training	Duration
Component 1 Introduction to a socio-cultural and phenomenological interpretation of APBC	<ul style="list-style-type: none"> The trainees has achieved preliminary insight into what takes place between themselves and the patient during APBC 	Oral presentations and hand outs with ensuing discussion	Two hours
Component 2 'Agreement sheet' for structuring the planning, performing and evaluation of the APBC	<ul style="list-style-type: none"> The trainees can use the agreement sheet when organising the APBC with the patient 	The agreement sheet is scrutinised, critically assessed and adjusted according to the trainees' experience with its application. Clipboards are provided for bedside use	One hour
Component 3 The Modified Borg Scale for assessing the patients' breathlessness	<ul style="list-style-type: none"> The trainees can instruct the patient how to assess his breathlessness and its intensity on the Modified Borg Scale The trainees can apply the patient's respiratory assessment when organising the care with the patient 	The Modified Borg Scale is provided in laminated pocket format with the scale on one side and the instructions on the other. Following the patient instruction, its use is trained by role playing and the specific challenges are discussed	One hour
Component 4 Communication based on the APBC-adjusted Calgary-Cambridge framework	<ul style="list-style-type: none"> The trainees can initiate a dialogue with the patient focusing on body care and exchange information and structure the APBC session The trainees can work together with the patients to perform and assess for daily care planning The trainees can relate to their personal competences and closest development zone for the competences in patient-centred APBC 	Special course with external instructor (psychologist with special expertise in communication based on the Calgary-Cambridge framework)	2 × 8 hours
Components 1-4 Supervision meetings	<ul style="list-style-type: none"> The participants can see how the components of patient-centred APBC interact and influence the cooperation with the patients 	Authentic video recordings of the trainees providing APBC. The recordings are used for: <ol style="list-style-type: none"> 1 Personal supervision to support the individual trainee's development from personally selected focus area within the competences to be achieved when providing APBC for COPD patients. This supervision is done using the other trainees as observers 2 Joint observation and reflection on the elements that combined should fulfill the aim of patient-centred APBC. The participants watched video recordings and were encouraged to observe signs of good clinical APBC practice that subsequently provided the starting point for joint discussions 	5 × 2 hours

Data collection

A purposeful sample of seven nurses and six nursing assistants from three separate university hospital units in

Denmark were enrolled by their head nurse to participate in the training programme. Inclusion criteria were: (1) they should be motivated to participate, (2) they should be employed in the unit for the next year, and (3) the selection

Label _____ Date _____ Start _____ Stop _____ Signature _____

Assessment of breathlessness before body care activities (Borg scale) _____ Other remarks about condition _____

Provisions	Procedure	Body care products	Clothing	Aids
<input type="checkbox"/> Time for activity	<input type="checkbox"/> Bedbath	<input type="checkbox"/> Lotion	<input type="checkbox"/> Hospital	<input type="checkbox"/> Glasses
<input type="checkbox"/> Inhalors	<input type="checkbox"/> Sitting, edge of bed	<input type="checkbox"/> Deodorant	<input type="checkbox"/> Private	<input type="checkbox"/> Hearing aid
<input type="checkbox"/> Pauses	<input type="checkbox"/> Sitting at washbasin	<input type="checkbox"/> Shampoo		<input type="checkbox"/> Dentures
<input type="checkbox"/> Extent of body care	<input type="checkbox"/> Shower	<input type="checkbox"/> Other	Toilet visits	<input type="checkbox"/> Nappy
<input type="checkbox"/> Practical sequence	<input type="checkbox"/> Bag Bath	<input type="checkbox"/> Electric shaver	<input type="checkbox"/> Before start	<input type="checkbox"/> Other
<input type="checkbox"/> Oxygen				

	Special needs and desires (sequence in next column)	No.	Help	Partial help	Self-assisted	Evaluation and future agreements
Scheduled pauses						
Undressing						
Dressing						
Washing face						
Washing hands and arms						
Washing chest						
Washing back						
Washing legs and feet						
Washing perineal area						
Teeth and oral health care						
Nail care						
Hair care						
Beard maintenance						
Skin care						
Glasses						
Hearing aid						

Breathlessness underway: 1. When was it worst _____ 2. Score (Borg scale) _____

Figure 1 Agreement sheet for personal body care activities.

of nurses and nursing assistants should be balanced. The only exclusion criterion was previous involvement in similar studies. The participants were divided into two mixed groups of nurses and nursing assistants. In order to create a confident learning milieu, these groups remained unchanged for the duration of training and data collection. The training lasted four months and was finalised in 2008.

Semi-structured focus group discussions were conducted before and after training. They all comprised of the same six

items, which the participants were encouraged to discuss (see Box 1). These items were constructed on the basis of the foundational grounded theories.

Further, the participants were continuously encouraged to reflect upon what they found easy and what they found difficult to practise in terms of APBC to patients suffering from COPD and the training was evaluated after it was finalised. The principal investigator moderated the group discussions, encouraging participants to elaborate their statements and to interact without any intention of reaching consensus. A research assistant observed the individual behaviours of the participants and the group interaction. Field notes were taken and included in the data material for analysis. Recording from all group discussions were verbally transcribed by a secretary

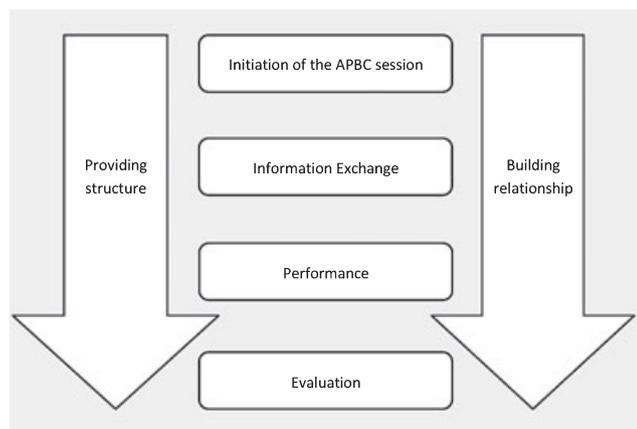


Figure 2 Framework for patient-centred assisted personal body care (inspired by The Calgary–Cambridge Framework by Kurtz *et al.* (2003)).

Box 1 Focus group issues

- Perception of, and attitude towards APBC among severely ill COPD patients
- Assessment of the individual patient’s actual condition and stage of illness trajectory
- Attitude towards patients’ experiences of breathlessness
- Interaction with the individual patient in terms of aim, content and role distribution
- Planning the sequence of APBC, including pauses (due to breathlessness)
- Conduct and atmosphere during APBC

and the transcriptions validated by the principal investigator. The analysis was processed in NVivo 8.

Data analysis

The QOA was a so-called goal-free evaluation (Patton 2002) searching for the actual efficacy of the training programme. The analysis addressed process content and outcome and consisted of an interpretive description (Thorne 2008) of the changes in the trainees' competences. As a starting point data on the trainees' attitudes, thoughts and concerns in each group discussion was roughly categorised into provisional transverse themes of interest. Second, we accumulated the categorised data in pre- and postfocus group pairs according to the provisional themes of interest, and generated an idea of the most prevailing changes in attitude, thoughts and concerns for further analysis. Last, we compared the two pairs of ideas on prevailing changes in order to identify and interpret the overall efficacy of the training programme.

Ethical considerations

The study was registered by the Regional Ethics Committee and was approved by the chief executives of the participating clinics. Informed consent (oral and written) was obtained from voluntary participants. The integrity of all participants was carefully safeguarded throughout the study with particular attention on the use of video.

Findings

All the invited nurses ($n = 7$) and nursing assistants ($n = 6$) accepted to participate. One nurse withdrew before the postfocus discussion due to relocation. One nursing assistant withdrew due to long-term sick leave and did neither finalise the training nor the postfocus group discussion. The participants were happy to be selected, proud of being involved, engaged in the study but, initially reticent about being videoed.

The training programme was time consuming for both the trainees and the trainers. In order to do video-based supervision, recordings had to be arranged and conducted, which took about 40 hours for the recorder and in turn, about one and a half hours for each individual trainee who was video-recorded twice.

Before initiation of the training, the nursing staff expressed caring values and high ideals of doing the very best for the patients. This was a favourable basis from which to develop their competences to act in a patient-centred manner. In the following, we present the most prevailing changes according

to three themes: From pressure to pleasure, Relating and structuring and Being an authentic healthcare professional.

From pressure to pleasure

Before training it appeared that the nursing staff felt a strong obligation to approach the patients in a health-promoting manner. They intended to improve patients' self-care and, on some occasions, even to encourage patients to adapt to a healthier lifestyle. At the same time, the nursing staff felt obliged to make sure patients were assisted with washing and therefore struggled to meet the requirements of the APBC session. Consequently, they tended, more or less openly, to put pressure on the patient to be more active, thereby fulfilling the goals of the nursing staff. When this strategy very often failed, the nursing staff became 'frustrated', 'irritated' and 'annoyed'. They felt inadequate and negative if they thought they had acted paternalistically by taking control and directing a patient more or less against his will. This unpleasant feeling could negatively influence their general view of the COPD patient group. For example nursing staff talked about 'revolving door patients' and 'tiresome old friends' and stated that some COPD patients' had 'a special psyche', 'a psychological superstructure', and could be 'neurotic', 'demanding' and 'unaesthetic' (with all their coughing, sputum and tissues everywhere). The nursing staff were more positive when talking about COPD patients in the end-of-life-stage of their disease. Once patients were considered to be terminal, the nursing staff would stop pressurising the patients and would enjoy taking care of them and do their very best to meet the patients' needs and wishes.

After having undergone the training, the nursing staff had changed their views on COPD patients and encountered them differently. Even though patients could still be considered 'irritating', the nursing staff tended to take a positive stance towards COPD patients:

I don't pressurise my patients now as I used to. We make a sort of deal: What would you prefer? How breathless are you today? What do you need help with? And then perhaps tomorrow, it might just be that ... well, we always hope that they will be better. And then at some point, the patient says: I would like to go to the bathroom now – will you help me? And that's all there is to it. I have given up saying to myself: 'I just have to work harder and do this and that'.

Training made the nursing staff realise that even though health promotion is an important issue in COPD nursing care, the bathing/washing situation may not necessarily be the best time and place to teach and motivate patients towards radical behavioural changes. The nursing staff had thus moved on from the unrealistic idea that everything could

be sorted out and fixed during a session of APBC. In return, they became more aware of the small things that they did accomplish, which previously had been underestimated. By experience they knew that when they planned and worked together with the patient, everything would be easier and better. Thus, the tension in the nurse–patient interaction that had occasionally been troublesome was resolved, resulting in a feeling of satisfaction and pleasure in assisting the patients not only in the terminal phase of their disease, but also when patients were expected to recover from their exacerbation.

Relating and structuring

Before their participation in the training, the nursing staff would encounter each individual patient with the intention: (1) to get to know the patient as a person, (2) to get an idea of patients' awareness of his own disease, (3) to determine his actual condition, and (4) to build up a relationship of trust. This, they said, was the starting point from which they decided of the type of bathing procedure to choose, which elements of bathing/washing were appropriate according to the patient's breathlessness and current situation, and how eagerly they should encourage the patient to do things on his own:

When I am in with a COPD patient, I think first of all: What stage of COPD has he got to? Is this a person who knows how to breathe properly and what help can we give? This is what is in the back of my mind. Nobody can see that I am thinking: I must try and 'read' the patient the first time in. I spend a lot of time doing this and getting them to trust me and then we take it from there.

They did not involve the patient in their considerations that were 'in the back of their minds', with only a few attempts to make sure the individual patient agreed with their decisions. Rather than making the APBC session a common project, it seemed that the nursing staff considered it to be a nursing project. The staff demonstrated full awareness of how to observe the patients, but seemed to have problems dealing with observations and using them when planning and structuring the APBC session together with the patient.

After finishing the training, the nursing staff would still meet the patient as a person, but would simultaneously focus on his breathing and would be aware of how to use the person-specific information about the patients and share their thoughts and concerns regarding the APBC session with them:

You are encountering a person, who more freely tells about how he is coping with his breathlessness at present and you accept this. Perhaps because you know that the breathing issue is the one and all in their situation. I have become more aware of their personal challenges and I take it from there – instead of my own needs.

The project was no longer a nursing project, but a joint venture in which they involved the patients in their clinical assessment of the situation:

I have noticed that I always start by asking the patients how they are and whether they think that their breathlessness is better or worse. I learnt this from the training. I ask first and then I always tell them whether I can see that they are having difficulty breathing.

The nursing staff had learned to focus on APBC rather than inviting the patient to discuss broader health promoting themes, such as exercise training and smoking. Further, they had learned to structure the process of planning, performing and evaluating APBC in a clear and manageable way. They experienced that increased patient involvement had a positive effect on the interaction:

It is our job to encourage the patients to open up by asking them the right questions at the right time. It makes everything just that much easier, when they get to tell us what their priorities are on that particular day. Especially when their reserves are low or ours likewise.

Thus, the training appeared to improve nursing competences to involve patients in accordance with their condition and personal preferences.

Being an authentic healthcare professional (nurse or nursing assistant)

Throughout the training, the nursing staff acquired a more specific and detailed understanding of their professional task to assist severely ill respiratory patients with personal body care. This deeper understanding combined with practical skill training improved their confidence and they felt comfortable about being present and available for the individual patient. The nursing staff increased their awareness and improved their competences to monitor the patients' conditions by carefully observing, listening and even sometimes smelling subtle signs from the patients.

Having undertaken the training the nursing staff realised that the act of listening could be more or less engaged, resulting in a relatively authentic collaboration with the individual patient:

And here's me thinking that I was a good listener, and I have been listening for many years – but only at a superficial level.

In the postfocus group discussion, the nursing staff further demonstrated an awareness of the importance of being present and actually listening. They now considered the patients' experiences to be a valuable contribution:

They are so experienced and we must listen. It makes everything so much easier. When they know that they get breathless if they have to do something or other, we must listen to them, instead of saying: 'It'll be alright, your FEV-1 is OK and your breathing is fine, so you can walk'.

Once the nursing staff had discovered what it meant to the patients to have a say, the nursing staff would also acknowledge the value of their own professional performance:

Even though it may be a little more time-consuming, it is easy to see how well the patients react when they are allowed to make their own decisions, by accepting or declining what they need assistance for – and that we are there to help and support them. It has been an eye opener for me to see just how much it means to them. There isn't much we can do about their condition, but on the other hand this is something we can do.

As apparent in some of the statements, time spent on APBC was a repeated theme in the focus groups. During the training, the nursing staff developed new strategies to manage their perceived lack of time. Instead of avoiding the patient when they had a busy day, they tended more openly to share with the patient the opportunities available and they would tell the patient how long they could be at their disposal:

I think that I am offering the patient some possible options, but I am in fact limiting them for the patient. The patient then chooses from my list of options, which are more or less based on how busy I will be on the day.

Whether job satisfaction correlated to heavy workload was an open question among the nursing staff. When encouraged to discuss the characteristics of successful care, the following dialogue took place:

A: I have a good gut feeling. The setting was right. There were plenty of staff ... and time.

B: Yes, but you can tend to them in less time, and the patients will still have a good experience. I also think that it all boils down to whether I am happy when they convey to me that they are happy too.

The nursing staff were aware of their own improvements and demonstrated a whole new vocabulary to express what they had learned and which elements of the training programme had been productive. In particular, they found the 'agreement sheet' to be a useful tool:

In my mind, I don't find this type of patient very interesting, but I did learn that if you use the agreement sheet and give yourself plenty of time, then it is not half as bad with this rather unfortunate type of patient.

Accordingly, the staff used a richer and more precise terminology related to planning, performing and evaluating

APBC. For example, they mentioned the wording 'common agenda' several times and they were satisfied that creating a common agenda with a patient improved their nursing care and enabled them to get a distinct response from the patient:

I am not certain that it is all about how much time you have. I also feel that whatever the 'assistance' is, it mustn't take too long, because the patients don't have the energy. So it is a good idea to have a common agenda and ask the patient what they would like to do first.

This comment demonstrates the development of professional competences. We also observed signs that the nursing staff developed their personal competences according to their own priorities and needs. For example, one of them chose to work with the antipathy that she had sometimes felt when encountering a breathless patient:

I think the course helped a lot – in particular the bit where you learn to say to yourself: 'you can always find something endearing about these patients'.

Another nurse decided to work on her impatience and inclination to take over for the patient:

I am not really nuts about working with COPD patients. I am a little too hasty and impatient. The training has changed all this...I find them exciting to work with and this has come about because I now meet them in a different way.

Thus, it seems as though the awareness of possible projections in the nursing staff that might be in play when patients 'are irritating' was improved by the training.

Discussion

Our findings demonstrate that changes in the nursing staffs' skills and attitudes occurred after completing the training. In the following we first discuss how our findings relate to the existing knowledge in the area of patient-centered APBC in respiratory patients and other corresponding literature and then address the limitations and strengths of the study.

In accordance with the general concept of patient-centred care (Reynolds 2009), our findings demonstrate that the training programme improved the relational and communicative dimension of the nursing staff competences. The improvements encompass the ability: (1) to engage with the individual patients and include them in all those detailed decisions that have to be taken during APBC and (2) at the same time prevent patients becoming exhausted and severely breathless. The findings also give warrant to believe that the training programme made the nursing staff feel more confident and proud of their professional contribution to ensure patient safety and comfort.

A survey of barriers to act in a patient-centred manner points to lack of time, tools and training to be the most reported barriers among nurses (West *et al.* 2005). The same study reports that nurses are motivated for further training, particularly in social and interpersonal aspects of care. Such motivation was also observed among the nursing staff in our study.

In the statements given by nursing staff, it is clear that the time spent on APBC is mentioned at various intervals and with varying reports. It would be interesting to measure the time spent on APBC and compare the patient-centred approach to care-as-usual in order to find out whether the former is more or less time-consuming.

Our study indicates that clinical tools such as the tool to structure the exchange of information with patients about the APBC sessions (Fig. 2) are useful. The training programme was a comprehensive 'package', developed on the basis of very detailed knowledge in a narrow field. This may be the reason why the programme appeared to be very efficient. On the other hand, the comprehensive programme also made the training rather time-consuming for the trainees as well as the trainers. In our study, it appeared that participation in the comprehensive training programme would develop new nursing competences to integrate patient preferences and professional measures.

To act in a patient-centred manner is a dynamic phenomenon and it may be challenging to accommodate conflicting interests of 'care valued for its own sake' vs. 'care to produce health outcomes' (Perry 2010, Sanders *et al.* 2010). Patient-centeredness means congruence between 'desired' and 'allowed' participation, and congruence is neither synonymous with promoting patients participation nor with doing as the patients' want (Schoot *et al.* 2005). For severely ill respiratory patients, the desire to and benefit of being involved should carefully be considered. Sometimes it may be better for the patient – at least for a while – to hand his body over to the nurse. Involvement and handing over may be a delicate balancing act. Our training programme addressed the problems with reluctant patients and eager nurses that have hitherto flawed clinical COPD nursing care (Lomborg & Kirkevold 2008). To our knowledge, our study is the first to offer, with empirical evidence, an answer to the delicate matter of motivating vs. putting pressure on severely ill respiratory patients who are supposed to recover to some level of self-care. Interestingly, according to the nursing staff involved in our study, the dissolution of tension in the interaction with patients did not necessarily influence patients' actual level of activity. It seems that especially the nursing staffs' ability to share their thoughts and concerns with the patients' contributed to achieve the valued therapeutic clarity (Lomborg & Kirkevold 2008). The

development of such competences to engage in a personal relationship and simultaneously to reveal to the patient a professional interpretation of his or her actual illness conditions may also be of benefit in APBC in other hospitalised patients who struggle with dyspnoea, pain or other unpleasant symptoms.

With the patient-centred approach, the nursing staff learned to work together with the patient in a manner that – from the professional perspective – was more pleasant for both the patients and the nurses themselves, as they no longer felt obliged to stress the patients to be more active than was reasonable. The nursing staff had learned to build patient relationships and offer a convenient structure by planning, doing and evaluating the APBC with the patients. This significant change, in turn, made the nursing staff feel more competent and proud of their professional nursing performance.

Study limitations and strengths

In general, the intention of patient-centred healthcare is to empower patients and their families (Reynolds 2009). Our study specifically addressed the nursing staff's competences in patient-centred APBC and was therefore exclusively concerned to develop, implement and evaluate a training programme that would improve their competences interacting with the patients. Although we have documented positive comments from the nursing staff that the patients' were actually empowered, we have no warrant to conclude on the patient outcomes. In return, our study provides evidence to the efficacy of the training programme from the viewpoint of the nursing staff.

The QOA included a formative and a summative evaluation of the training programme in patient-centred APBC. In line with QOA recommendations, there was no prescriptive hypothesis against which outcomes could be measured. Consequently, the evaluation was not supposed to be replicable as more traditional forms of evaluation research could have been. Rather, our study was supposed to offer a rich description of the components of the training programme together with a broad interpretive description of the most prevailing patterns of changes observed in the study. As an important part of the study, we believe our description has documented the process and content of the training fairly well and thereby given readers the best possible information about the programme. The summative evaluation is based on a comparison of two pretraining and two post-training focus group discussions. We cannot exclude the possibility that local conditions may have influenced our data material and we cannot contend that our interpretation is the one and only way to interpret data. However, we made an effort to conceptualise, comprehend and convey the quality of the

training programme with particular focus on the changes in the nursing staffs' attitudes, thought and concerns. Further, the study carefully complies with the criteria of validity offered by the method Interpretive Description. We therefore believe our study is a sound contribution to knowledge in the area of patient-centred COPD nursing care and provides evidence of the efficacy of the training programme.

Relevance to clinical practice

This programme can be adopted in respiratory nursing care. We further suggest that our findings may – possibly with slight modifications – be applicable to nursing care in other patient groups with different unpleasant symptoms such as nausea and pain.

Conclusion

A comprehensive training programme can improve nursing competences to act in a patient-centred manner and thereby involve severely ill patients in APBC. Further studies are needed to investigate whether patient-centred APBC is more time consuming than care-as-usual and to document the effectiveness from the patients' perspective.

Acknowledgements

We are grateful to the participant for generously sharing their experiences. We thank Janet Mikkelsen for translating the quotes into English and Lisbeth Rune Schultz for leading the communication training. Grants were received from The Aarhus University Foundation and The Aarhus University Hospital.

Contributions

Study design: KL; data collection: KL, ESN, LBJ; data analysis: KL, ESN, ALJ and manuscript preparation: KL, ESN, ALJ, LBJ.

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