

ORIGINAL ARTICLE

Prerequisites for person-centered care – As described by community care nurses

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Abstract

Aim: The aim of this study was to describe nurses' experiences of person-centered care within an integrated care chain.

Method: The study included four data sets: Two focus group interviews with a total of 22 nurses; an open questionnaire answered by 17 nurses; and individual follow-up interviews with 4 volunteers from among the 17 nurses. In total, 39 informants were included in this study. Qualitative content analysis was carried out to identify the latent content of the focus group and interview data, and the manifest content of the questionnaire data.

Results: The results showed that learning about, from and with each other were prerequisites for achieving person-centered care. The ability to provide person-centered care was influenced by factors that could be related to both the organization and to the individual nurse. Important factors were organizational transparency and structure, leadership and collaboration between healthcare centers, partnership, sole caregiver attitudes and skills.

Conclusion: In order to develop person-centered care, it is crucial that an integrated care chain feature a joint documentation system; efficient use of the resources allocated to the needs of the various healthcare centers; and a change of focus from the professional to the person seeking care.

Key Words: Integrated health chain, Knowledge, Nurse, Person-centered care, Power

1 Introduction

Swedish healthcare underlines the importance of providing person-centered care characterized by partnership between patient and nurse. The term “person centeredness” is used to avoid focusing on the medical aspects of a person's relation to the healthcare.^[1] Person-centered care implies offering patients a sense of continuity and participation^[1] and requires that the healthcare organization's structures allow for such care. In the spring of 2010, a region in southwestern Sweden started a change process to develop a more in-

tegrated care chain, meaning care provided across the continuum of care especially with a focus on multi-ill elderly. In the course of each patient contact, nurses were expected to offer the patient the appropriate care level and to use the collective healthcare resources efficiently. Nurses in various services were offered to participate in two university courses aimed to provide opportunities for learning from each other and for increasing the skills needed to provide person-centered care. During the courses a study was carried out to explore the training that enabled nurses to feel confident about providing person-centered care in an inte-

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grated care chain.^[2]

Result from an international study of patients from eleven European countries found that Swedish patients feel the least involved by physicians in decisions concerning their health when compared with patients from other countries.^[3] Swedish healthcare is still primarily organized based on administrative requirements rather than on patients' or caregivers' needs,^[4] which presents a barrier against integrated care.^[5] As a result of this top-down system cooperation within and between healthcare organizations and the actual provision of care is hampered, and it becomes difficult to create integrated care processes.^[6]

In order to develop an integrated care chain, and to provide care at the right level, healthcare based on the health needs of those seeking care is desirable. Patient care that is planned and implemented in consultation with the patient could then be an integral part of the care and treatment. In respect for the patient's individual needs, preferences and value involves taking a holistic approach to patients as persons with both medical and non-medical needs. The holistic approach includes involving family and relatives in the care in accordance with the care-seeking person's wishes.^[1,7]

1.1 Theoretical framework - Person-centered care

Person-centered care is an internationally acknowledged concept. Already in 1987 the Picker Institute started its work to develop person-centered care. The institute's person-centered care principles have influenced the efforts of other organizations and agencies to develop healthcare quality. The World Health Organization's European Observatory on Health Systems and Policies has adopted the United States Government's definition of person-centered care: "an approach to healthcare that consciously assumes the patient's perspective". The perspective can be described in terms of "respect for patients' values, preferences, and expressed needs in relation to coordination and integration of care, and continuity".^[8]

In 2006, the Organization for Economic Co-operation and Development published a framework for assessing the quality of member countries' healthcare organizations.^[9] Person centeredness was chosen as one of three dimensions (together with efficiency and safety) used to assess a healthcare organization's quality. In Sweden, the term "patient focused" was used, and was later defined as "patient-focused healthcare based on respect for the equal worth of all individuals and on the dignity, autonomy and integrity of all humans".^[10] According to Leplege, Gzil, Cammelli, Lefevre, Pachoud and Ville,^[11] a person is not defined based on their illness but on their status as a person with feelings, knowledge, values, self-will, social life, and a desire to be involved in their treatment. The provision of person-centered care places new demands on both healthcare professionals and politicians.^[12]

In Sweden, a national patient survey regularly examines patients' perceptions of healthcare quality. Among other issues, the questions deal with the opportunity for participation and influence, trust and information. Swedish studies show that care organized around the care seeking person has the potential to improve clinical outcomes and satisfaction with care.^[13,14] Similar results emerge in international studies.^[15,16] Person centeredness also reduces healthcare costs, although some studies show that person centeredness increases caregivers' short-term costs.^[17]

Harré^[18] described how a person shows himself to others. He distinguished between the person and the self, where the concept of person is the overarching basis. In the person of self the narrative identity is based on the autobiographical memory, as expressed by the patient's story. Person-centered care is of benefit to older people, as it promotes feelings of well-being and offers a greater sense of autonomy and independence.^[19,20] As person-centered care has been found to nurture the "personhood" of patients, several studies have concluded that it is the best model for improving older people's quality of life.^[12,19,20]

However, although the concept "person-centered care" has become very popular, Fagerberg and Bullington^[21] fear that it risks being used in just as inaccurate and eroded a manner as "holistic care"; that it is "on the way to becoming the same kind of buzz word as holistic care",^[21] which in itself justifies this study of how nurses perceive the prerequisites for person-centered care. The person's knowledge and understanding are prerequisites for participation and influence over their health, care and treatment.^[1,7]

The fact that knowledge is linked to power was described by the British philosopher Francis Bacon already four hundred years ago.^[22] Foucault^[23] highlighted the complex relationship between power and knowledge, and stated that it is very difficult to separate them from each other, as power strives to gain knowledge, which is needed for the sake of retaining power. In order to achieve the required power shift from patriarchal caring to the care seeking person's participation both professional attitudes and organizational structures need to be changed.^[24,25] According to Liedman^[26] there are five relationships between power and knowledge: 1) Knowledge-based power over things; 2) Knowledge-based power over people; 3) Power hindering knowledge; 4) Power encouraging and promoting some knowledge; and 5) Knowledge revealing power. Within healthcare institutions power is mainly about knowledge-based power over things and people, and to a lesser degree about power hindering knowledge or promoting some knowledge.

1.2 Aim

The aim of this study was to describe nurses' experiences of person-centered care within an integrated care chain.

2 Methods

To be able to identify as yet unknown or inadequately described phenomena the interview is an appropriate data collection method.^[27] To obtain a description of the nurses' experiences of person-centered care within an integrated care chain, the nurses were encouraged to freely share their experiences. Consequently, the study was exploratory, striving to gather as much information as possible within the specific area.

Focus groups make it possible to partake of the experiences of several people in the course of one interview session. The interaction between focus group members makes it possible to study attitudes, priorities, language and insights that do not always emerge in individual interviews. Focus groups also allow gaining access to the experiences of informants who would not have participated in an individual interview.^[28] By answering an open-ended questionnaire informants can describe their experiences without providing their name, which is an advantage when studying potentially sensitive subjects.^[29] Individual interviews provide opportunities for follow-up questions, which in turn promotes deeper understanding of the studied subject.

2.1 Sample and setting

The study's empirical data consisted of four data sets: two focus group interviews with a total of 22 nurses (11 nurses in each group); an open-ended questionnaire answered by 17 nurses (not from the focus groups); and individual follow-up interviews with 4 volunteers from among the 17 nurses. The informants were encouraged to describe their experiences of person-centered care within an integrated care chain. In total, 39 informants were included in this study.

In connection with an ongoing change process aiming at broadening and deepening experienced nurses' skills, a 15-point higher education credits (HEC) contract education program, comprising two courses, was carried out in 2010-2013 by University West.

All the nurses, with one exception, who completed the contract education program at University West in the fall of 2012 participated in the focus group interviews. The 22 informants who participated in the focus group interviews included the following professional categories: ambulance nurses (8), home care nurses (13) and emergency room nurse (1). Of the 22 informants, 18 were women and 4 were men. Their ages ranged from 31 to 59. The average age was 46 (46 for women, 45 for men). Years in profession ranged from 5 to 31 and the average years were 15.4.

The 17 informants who answered the questionnaire completed the contract education program in the spring of 2013 and included two professional categories: Ambulance nurses (3) and home care nurses (14). Of the 17 informants, 16 were female and 1 was male. Their ages ranged from 26

to 54. The average age was 42 years. Years in profession ranged from 1 to 25 and the average years were 11.5.

The individual follow-up interviews were made with 4 volunteers from among the 17 informants who responded to the questionnaire. The 4 informants included in the individual follow-up interviews were all home care nurses. They were all women and their ages ranged from 30 to 36. The average age was 32.5 years. Years in profession ranged from 3 to 10 and the average years in profession were 6.5.

2.2 Data collection

The two focus group interviews with nurses following the contract education program at University West in the spring of 2012 were carried out by three researchers (EDL, MSN and SP). The informants were invited to answer questions about their skills and experiences from collaborating with other professional groups. The nurses in the focus groups were encouraged to focus on the conditions prevailing in their individual job setting. Questions were asked about the care-seekers' and their relatives' needs and perspectives, about the conditions and possibilities for collaboration, and about the nurses' needs in terms of skills. Both of the focus group interviews lasted about 60 minutes.

The questionnaire was developed by two researchers (EDL and SP) and contained open-ended questions focusing on the following issues: workload, person-centered care, inter-professional learning, skills development needs, collaboration between professional groups, documentation systems between healthcare centers, and interaction between healthcare activities. The informants were nurses participating in the contract education program at University West in the fall of 2012. The individual open-ended follow-up interviews with volunteer nurses from among those answering the questionnaire were carried out by two researchers (EDL and SP). The individual follow-up interviews lasted 30 to 60 minutes.

The focus group interviews and the individual interviews were audio-taped and transcribed. To ensure the quality of the transcription it was checked and corrected by the researchers. The open-ended questionnaire (see Table 1) was compiled by the researchers.

2.3 Analysis

The texts from the focus group interviews and the individual follow-up interviews were analyzed using qualitative content analysis^[27] to identify the latent meaning. The entire text was read through several times to identify what was prominent in the statements with respect to the study's aim. Relevant meaningful units in the form of sentences, phrases and/or words were highlighted. The meaningful units were sorted and condensed in order to shorten the text, while carefully preserving their meaning. The condensed meaningful units were assigned a code describing their content at a

slightly more abstract level than the condensate. The coded meaningful units were grouped according to their underlying meaning. In order to develop relationships and structures, which may not immediately appear in the text, between and within the meaning units, interpretations were continuously made throughout the analysis phase. This analysis process of reading and interpretation, going back and forth between the text, the study's aim, the questions, the encoded and grouped answers, resulted in themes describing the interviews' latent meaning.

Table 1: The open-ended questionnaire

<p>Background information Age Current job title Years in profession</p> <p>Work load – Do you think the project will entail any changes in terms of work load? If yes, in what way? – What are the opportunities/obstacles for handling the work load?</p> <p>Person-centered care – How do you define the patient group included in the project? – What are the opportunities/obstacles for patient/relative participation at present?</p> <p>Interprofessional learning – What have you learned from other professional groups so far in the training? – What are your expectations in terms of your learning process?</p> <p>Skills development needs – Do you think further skills development is needed? If yes, of what kind? – What are the opportunities/obstacles for skills development?</p> <p>Interaction between professional groups – What are your expectations and thoughts in terms of how the interaction between professional groups should work? – What are the opportunities/obstacles for successful interaction?</p> <p>Documentation system between care activities – Do you think the project will entail any changes in terms of documentation systems? If yes, in what way? – What are the opportunities/obstacles for successful documentation?</p> <p>Interaction between care activities – Do you think the project will contribute to change in terms of the collaboration between various health care activities? If yes, in what way? – Can you give examples of economic effects of the project?</p> <p>Is there anything else you would like to add?</p>
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The informants' answers to the questionnaire's open-ended questions were analyzed using qualitative content analysis^[27] to identify the manifest meaning. The following process was applied: Individually, the researchers read through the informants' responses and compiled the content relating to each issue covered by the questionnaire to identify patterns, which in turn were divided into categories. Throughout the process, the researchers carefully compared the patterns and categories found to achieve a coherent categorization. These categories represent the manifest content.

The data from the focus group interviews, the open-ended questionnaire answers, and the individual follow-up interviews were analyzed separately by all three researchers and were subsequently discussed among them to draw conclusions.

2.4 Ethical considerations

The informants were provided with written and verbal information about the study's purpose, its voluntary nature, and the fact that they could at any time cancel their participation. The informants also signed an informed consent form and they were assured that all data would remain confidential. The taped material and the questionnaire answers were handled confidentially and the participants' data managed in accordance with the provisions of the Swedish Personal Data Act.^[30] The study complies with the World Medical Association's Declaration of Helsinki^[31] regarding the ethical aspects of research involving humans.

3 Results

Prerequisites for person-centered care are to learn about, from and with each other and the results showed that the ability to conduct person-centered care was influenced by both the organization and the individual nurse. The identified themes were organizational structure, insufficient documentation system, professional development, cooperation for learning and value the patient as a person.

3.1 Organizational structure

In terms of developing the quality of care, the informants stated a need for improved interaction between the home-care service, the healthcare information center and the local healthcare center. The informants described flawed and unclear decision-making and responsibility systems, and inadequate communication between local politicians and the various healthcare centers. Municipal healthcare centers worked differently because they had different principles, leading to *“many obstacles especially as regards information technology and medical record documentation”* (Focus group).

Management could either facilitate or hamper interaction between healthcare centers. *“The organization's structure*

affects the nursing work, with the risk that the patient's needs are not satisfied" (Focus group).

The sheer size of the healthcare organization hampered the opportunity for interaction, participation, information sharing, and knowledge development. "Separate budgets and different powers within the healthcare centers are creating obstacles to collaboration and damage continuity and integration" (Focus group).

More meetings between the various healthcare centers enabled cross-border interaction. "Today there are quite a number of watertight bulkheads" (Focus group) between the different care levels in the counties, primary care centers and municipalities. Collaboration between health professionals and healthcare centers could create opportunities to provide person-centered care. An example of the positive possibilities of increased interaction between home care, ambulance and hospital was that it can reduce the number of patients seeking help in the emergency room. This entailed "a reduced workload for the emergency room, reduced use of ambulance transport, and better use of community resources" (Questionnaire answer). The organizational structure, with its numerous unclear work procedures and regulatory documents, threatened to "prevent staff development" (Focus group).

The informants also expressed a risk of excessive demands on home care nurses from top management in the healthcare organization. "Home care nurses are expected to work more actively with clinical assessments and decisions, for example to avoid transporting a patient to the county health center unnecessarily, but sometimes the nurses cannot make accurate assessments because of lacking knowledge" (Individual interview).

The informants believed that one could increase patients' involvement in their own healthcare by increasing public information about the healthcare information and medical advice telephone number 1177. "Thus the patient can be focused and receive treatment at home, thus avoiding unnecessary admissions to hospital" (Questionnaire answer). An example of this was that one of the home care nurses was called by the healthcare information and medical advice service in order to make an assessment of an elderly woman's state of health. "Family members had called and knew about 1,177 from reading about it in the paper. Patients find it helpful to avoid having to go in to hospital; instead we were able to come home and make a judgment" (Individual interview).

3.2 Lack of sufficient documentation system

The informants stated that the lack of a cohesive documentation system could affect person-centered care negatively. They emphasized the importance of all healthcare professionals and healthcare operations using a common documentation system. The absence of a "common documen-

tation system for primary, inpatient and municipality care" was seen as a major problem and was a "barrier to person-centered care" (Individual interview). In order to provide good care the informants believed that "the documentation should follow the patient throughout the continuum of care, which may lead to new work practices and procedures that facilitate person-centered care" (Questionnaire answer).

The various documentation systems created boundaries and barriers between healthcare centers. "There are healthcare centers that do not have access to some documentation systems needed to be able to share information and knowledge about the patient" (Focus group). The lack of a common documentation system could also endanger patient safety and lead to legal discussions and liability cases. "Records are faxed to and fro; there is not one master patient record" (Individual interview). Borders and barriers existed due to the fact of having different documentation systems. Ambulance nurses did not usually have access to patient hospital or home care records, which forced them to work with limited information about the patient and made it difficult for them to adapt their work to that of previous caregivers.

3.3 Professional development

The informants stated that providing person-centered care, particularly to elderly, was difficult. "It takes a lot of knowledge to feel safe and know what one should do" (Individual interview). The informants stressed their need for further training. "Our work requires both further education (in emergency care) and a lot of experience; only a few nurses have received additional training after completing their basic nurse training" (Individual interview).

Lacking skills among staff was considered an obstacle to the provision of person-centered care. For instance, nurses in home care could suffer a lack of knowledge in emergency care, which hampered the appropriate provision of home care. That certain functions in the care provision required specialized skills was described during the interviews. "For example, being a registering nurse at a medical ward for elderly requires a lot of experience as assessments are also made over the telephone" (Individual interview).

Training to develop their personal knowledge was requested. Training was seen as "essential for strengthening the professional role in an organization where knowledge is changing and evolving at an increasing rate" (Focus group). The informants wanted to be able to "practically apply the knowledge obtained during their education". They also expressed a desire to receive a more comprehensive education, for instance advanced clinical nurse education (Individual interview).

3.4 Cooperation for learning

Learning from each other ensured security in the meeting with the patient and provided an opportunity to have a holis-

tic view of the patient. Learning about, from and with each other was considered to be important *“for one’s own knowledge development but also for providing colleagues with valuable knowledge about the patient, thus making it easier to provide person-centered care”* (Focus group). The informants felt a need to *“call and consult with colleagues from other health centers in order to get different perspectives on the health problems”* (Individual interview).

Increased personal skills development could be achieved by learning how healthcare professionals from other healthcare centers assess patients. The possibility of sharing experiences with other professionals was considered to *“offer new ways of thinking, a more open mind, and thereby deepen and broaden the understanding of patients’ problems with ill-health, their needs and resources”* (Questionnaire answer).

The informants believed that cooperation should be based on the different professions contributing their specific skills based on an understanding of the patient’s ill health. Several of the informants had met each other at various residences, such as nursing homes and short-term residences, and felt that *“being able to meet is important and increases the opportunities for person-centered care”* (Individual interview).

Nurses in home care and physicians should organize cooperation with each other. *“A partnership that could make it possible to provide some treatments already in the home, and thereby prevent the patient’s condition from getting worse”* (Individual interview). The goal would be to create a professional team based on respect and trust for each other’s knowledge. Such cooperation would also *“improve the understanding of each other’s professions, which is important for the professional provision of care”* (Focus group). The informants considered cooperation between nurses and physicians to be an important prerequisite for safeguarding the patient’s needs and interests.

Nurses in different healthcare centers could learn from each other and obtain advice in assessing different care situations. There were opportunities to learn about, from and with each other, in an exchange of knowledge. *“We have different skills and different patient cases, we should share that experience”* (Focus group).

3.5 Value the patient as a person

Depending on their organizational belonging, the informants used different terminology for the care seekers: patient, user, or customer. According to the informants, the term “user” covered a person with a disability and was not directly related to healthcare; the term “customer” covered a person seeking a service, but using the term entailed the danger that the ability of nurses to practice professionally based on policy documents and guidelines could be questioned. The term “customer” was related also to a beneficial interest in the healthcare activity (Focus group).

The achievement of person-centered care strengthened the nurse’s professional responsibility. A caring relationship was necessary for the patient to receive appropriate treatment, and for the nurses to have the opportunity to perform their work professionally.

Ability to create understanding and insight about the patients’ situation was emphasized. A caring relationship was seen as important in person-centered care, but this required that health professionals had enough time to sit down and talk with the patient. Making home visits, instead of sending the patient to the emergency room, increased the patient’s participation. *“The nursing staff should be able to perform their work professionally, that is by having the patient and family in mind and have a charitable contact, to meet the patient based on their needs, to have a holistic approach and be able to talk to the patient at their level”* (Focus group). Continuity in the patient’s care, as well as their involvement in the care, were important factors for and part of the development of person-centered care.

The informants stressed the importance of respecting the patients as unique and whole persons, and not just as patients, with different resources, needs, and suffering. Awareness of the importance of having “good values” was emphasized (Focus group).

4 Discussion

The results show that themes relating to both the individual health care professionals and to the organization are important in terms of how an integrated care chain can successfully provide person-centered care. According to the informants, there are opportunities to improve healthcare quality. Greater interaction of care efforts can enable person-centered care and increase the patient’s involvement. This result underlines the impact of unequal power distributions between professionals and patients, and between the organization and professionals. Below we relate this to Liedmans’^[26] five relationships between power and knowledge.

4.1 Knowledge-based power over things

When it comes to knowledge-based power over things, this can be exemplified by the fact that technologies in the various documentation systems are not compliant with the practical needs of users. Municipal healthcare units work differently from emergency response services. For instance, they have different managers and suffer from many operational bottlenecks, especially in the fields of information technology and journal documentation. The lack of a joint documentation system for primary, inpatient and municipal care is a major problem and a barrier to person-centered care. The presence of different documentation systems affects patient safety negatively, creates boundaries and barriers between activities, and makes it difficult to have a holistic view of the individual patient. The various organizations are diffi-

cult to grasp, especially because of the watertight bulkheads between the various care levels in the counties and municipalities, which complicates the nurses' everyday work. According to Ekman, *et al.*,^[11] organizational flexibility is a key factor for person-centered care. The results of this study do not indicate a high degree of organizational flexibility. On the contrary, the informants stated that they sometimes did not have access to vital information about patients and that this hampered the taking of fast and accurate decisions.

Management can either facilitate or hamper the ability of healthcare centers to interact with each other. The technical problems with electronic health records prevent optimal use of the electronic records needed by healthcare personnel to coordinate their efforts and ensure continuity of patient care. The informants expected that decisions based on increased coordination would also entail changes in the record-keeping systems so that there would be one record following the patient throughout the continuum of care. This can lead to new ways of working and fewer barriers between different activities. According to Andreasson, *et al.*^[32] existing information systems do not promote co-operation between social services and healthcare. Because there are different electronic medical records systems used in the healthcare organization, there are substantial problems in terms of registering, downloading and sharing data between healthcare centers. In 2011, the Swedish National Board of Health and Welfare^[14] noted that the Patient Data Law creates new opportunities for the exchange of patient information, but that such exchanges are still limited and that information sharing is particularly problematic with regard to exchanges of information between healthcare and social services, as the law does not allow the sharing of patient information between these organizations.

The informants said that person-centered care is hindered by lack of time, lack of choice, resistance to change, and a strong focus on routines. Sweden has a long history of organizing and operating a comprehensive, modern and well-developed public healthcare organization, which, however, is characterized by its slow sequential working methods rooted in fixed structures and traditions.^[33] Schoen, *et al.*,^[34] in a study of patients in 11 countries, found deficiencies in the processes used to coordinate care and to ensure good continuity of care. Sweden was found to perform poorly on several of the dimensions involving coordination and continuity, which reflected a structural characteristic of the Swedish healthcare system. Most patients receive their primary care at a particular healthcare center, but not from a specific physician or other health professionals at the clinic. Since 2010, healthcare providers are required to provide a permanent healthcare contact for patients requiring coordinated care efforts, but according to the National Board of Health and Welfare^[35] a majority of primary care clinics, and about half of the hospital wards, do not have any patients who have been assigned a permanent healthcare con-

tact.

4.2 Knowledge-based power over people

The knowledge that gives power over people is about the power imbalance existing between professionals and patients who are invited to discuss and partake in decisions. With power and knowledge the subject, in this case the nurse, can act in a way that results in both marginalization and insufficient patient participation. As regards elderly patients, Ekdahl *et al.*^[36] showed that despite the majority of elderly patients describing themselves as both being informed and enjoying good contact with their caregivers, they did not want to participate in decision making about their medical treatments. Approximately half of the elderly patients who were asked said they were involved in their healthcare decisions as much as they wanted.^[36] At the same time, roughly one-third said they were less involved than they wanted to be and about a quarter reported that they were more involved than they desired.

The result of this study shows that nurses use different terminology for describing the persons seeking care, namely patient, user and customer. To consider the patient as being a person in a context means having a holistic view of the patient.^[37] The informants expressed that they wanted to have a holistic perspective, and be able to talk with the patient at his or her level. The informants indicated a desire to sit down with the patient and the physicians to plan the care based on the person's overall situation. In such meetings, caregivers may perceive the person's semantic and episodic memory, as well as the person's subconscious and bodily memory.^[18] Such an approach requires the ability to provide the necessary time to create a true relationship; to provide time for long conversations and not just for providing technical information and fixing urgent problems.

4.3 Power hindering knowledge

The form of power that hinders knowledge has not been clearly found in this study. The one expression of such power could be the management's relative disinterest about the informants' need for deeper knowledge and experience in order to handle new demands, which in turn were seen by the informants as being an obstacle to person-centered care.

The informants emphasized that it is difficult to provide person-centered care and that they therefore require specific skills. Such training would enable nurses to integrate experiences with theoretical content and to develop a more analytical and investigative approach for meeting the patient's health needs.^[38] The nurses would also be able to take advantage of how nurses from other healthcare centers assess patient needs.

4.4 Power encouraging and promoting some knowledge

Power encouraging and promoting some knowledge can be found in the statements indicating biomedical dominance in relation to human science. Management could either facilitate or hamper interaction between healthcare centers. The skills found in the various centers must increase and change direction, *i.e.* focus more on human science. During the interviews the informants highlighted the importance of teamwork between the nurses and physicians regarding the medical treatment. This was seen as a “grey zone” traditionally handled by the physicians only. However, such collaboration requires theoretical knowledge in terms of both nursing *per se* and scientific understanding.^[38] Thus nurses would be able to combine their nursing skills with a more analytical and investigative approach to meet the patient’s health needs.^[39]

Furthermore, by uncovering unconscious norms and stereotypes about different professions a deeper understanding of the respective work situations of nurses and physicians and their complementarity can be achieved. Collaboration between healthcare professionals requires that participants come to realize the importance of developing shared skills for the sake of achieving person-centered care. By applying the methods of work integrated learning during education, opportunities for new way of thinking could promote an open mind and thus both deepen and broaden the understanding of patients’ health problems, their needs and resources.

4.5 Knowledge revealing power

The last relationship between power and knowledge, *i.e.* knowledge that reveals power, was not considered relevant within the framework of the informants’ statements.

5 Study limitations

To ensure reliability the interviews were transcribed verbatim, the text was coded, and the categories and themes were discussed continuously within the research group during the

analysis process.^[27] The possibility to compare interpretations of the same text can be seen as strengthening the validity of this study. The fact that the analysis showed that the statements obtained from the individual interviews, the focus group interviews and from the questionnaires were consistent in meaning further strengthens the study’s validity.

As the study result is based on statements from nurses working in one healthcare region in Sweden, the extent to which the findings can be generalized to other healthcare organizations remains to be assessed. However, in order to strengthen the quality of our analysis, we have presented examples of contextual details that will help readers assess the degree to which our findings are transferable to other settings.

6 Implications

The provision of person-centered care is threatened by unclear structures and work practices, *e.g.* the absence of a shared documentation system. Similarly, conflicts of interest related to resources and task prioritization can cause disagreements at the expense of person centeredness. There is also a risk that person centeredness is being held back because of insufficient interaction between healthcare organizations.

In order to develop person-centered care the following aspects of an integrated care chain are important: (1) A joint documentation system; (2) Efficient use of the resources allocated to the needs of the various healthcare centers; (3) A change of focus from the professional to the person seeking care.

7 Conclusion

In order to develop person-centered care and an integrated chain, it is crucial that factors as organizational transparency and structure, leadership and collaboration between healthcare centers, partnership, sole caregiver attitudes and skills are improved. These factors can be related both to the organization and to the individual nurse.

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