ORIGINAL ARTICLE

Implementation of person-centred care: management perspective

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Abstract

Objective: In this study the implementation of a care model was examined in a public hospital in Sweden. The aim was to identify, from the management perspective, barriers and facilitators with respect to the implementation. A further aim was to study the explanatory power of a theoretical framework, normalization process theory (NPT).

Method: Semi-structured interviews were conducted with all of the members of a hospital departments' managerial group. Interview transcripts were analysed by means of directed deductive content analysis, applying NPT as theoretical frame work.

Results: The respondents identified factors, which were perceived as facilitating or obstructing the implementation process. These factors were; organizational culture, distribution of power, patient characteristics, resistance to change, teamwork, efficiency, time and speed of implementation. The theoretical framework, NPT, was partly supported by the data. There was however an absence of collective action and reflexive monitoring constructs.

Conclusion: The implementation process, according to NPT, was incomplete and there was a risk that it could regress to the previous work routines. However, implementation theories, including NPT, do not have a timeframe for the implementation process. Even though theories are able of describing in detail the steps for successfully embedding and sustaining an innovation, they do not describe or identify factors influencing the speed of the implementation. A possible reason might be that time is a subjective factor.

Key words

Person-centred care, Implementing care, Health care models, Implementation strategies, Health management

1 Introduction

The development of healthcare models, to empower the patient and improve the quality of healthcare, has been shown to fall in the gap between theory and practice. In an attempt to fill the gap, implementation science researchers have reported that the choice of organizational strategies to implement a care model depends on the efforts of the management as well as on those of the healthcare professionals [1-3]. Furthermore, healthcare professionals tend to reinforce the status quo rather than embracing change. This is a well-known phenomenon in Swedish public hospitals such as the one in this study. Therefore, choosing implementation strategies that take into consideration the healthcare professionals can possibly have a significant influence on the outcome of the implementation efforts [1]. Insight into factors affecting the implementation is useful, because it can improve the outcome of the change process and, as a consequence, it contributes to a successful implementation. The aim of this study was to identify, from the management perspective, barriers and facilitators with respect to the implementation of a care model empowering the patient in a Swedish public hospital. The purpose was also to find explanations and study the explanatory power of a theoretical framework, normal process theory (NPT) within a public hospital context in Sweden.

1.1 Background

An implementation process, which involves a shift from a perspective of a passive patient to a new perspective, where the patient is active and regarded as competent and responsible, is a complex challenge [4, 5]. Such a shift requires a change in the organizational culture, for which a redistribution of power, responsibilities and resources between the health professionals and the patient is deemed necessary. Managers try to transfer teams, departments, wards or whole hospitals from a present state to a novel state. In every case, the challenge is to understand what is needed and move the behaviour of the collective to a wanted state. A broad variation of influencing factors has been identified influencing the implementation process [6].

1.2 Change, barriers and facilitators

Obstacles to improve the interaction between staff and patients are often identified as communication barriers, a lack of resources and resistance to change. Facilitators mentioned are improved transfer of information, discussions about diagnoses and treatments, reimbursement and monetary compensation.

Suurmond and Seeleman described barriers to improve interaction between hospital staff and patients. They suggested that a hospital staff and patient may not share the same linguistic background. They may not share similar values about health and illness and may not have similar role expectation. Therefore, the authors suggested that an improved transfer of information, clear formulation of diagnoses, and a broad discussion of treatment options could facilitate the patients' active participation [7].

In a study, exploring intention and control, the fact that physicians proved to be more eager to control healthcare decisions than did the patients was considered as a barrier. Patients however did want equality when it came to decisions about their own care plans. It was suggested that evidence-based information regarding diagnoses and shared treatment options during a consultation could be facilitators improving the interaction between staff and patients. There was however no suggestion for how this could be achieved in practice [8].

Another common barrier to change is a lack of resources. Holmes-Rovner *et al*. described factors influencing change in practice of a shared decision-making routines in private hospitals. They found that productivity and time pressure could severely constrain the change processes. Furthermore, it was suggested that reimbursement or monetary compensation should be provided to motivate professionals to put a program into practice [9].

Davis *et al*. explored the way in which general practitioners in the UK manage the responsibilities associated with treating patients and making the most equitable use of National Health Service resources in the context of the policy of greater patient involvement in decision-making. The general practitioners regarded patient involvement in positive terms and considered that their involvement could have a helpful purpose. However a severe barrier to change was identified as scarcity of resources, including time and staff. They considered the workload to be too high to broadly introduce patient involvement [10].

A major barrier to implementation is resistance to change. Kotter and Schlesinger described the most common reasons for resistance to change, which include; self-interest, misunderstanding of the change, having a different assessment, a low tolerance to change and saving face. Individuals or groups with a significant self-interest may resist change when they think they will lose something of value such as power. This often results in a political behaviour, which is when the best interest of one person or a group is not in the best interest of the total organization or of other individuals and groups. As a result, resistance could be initiated by people who feel they are facing a potential loss of power as an effect of change processes. They may perceive change as an abuse of their everyday existence, daily routines and implicit agreement with the organization [1].

A misunderstanding of the incentives to change was reported as a common reason for change resistant behaviour. Staff members resist change if they feel it might cost them more than what they or the organization will gain [11]. Another common reason for resisting change is when people assess situations differently from their managers or those initiating the change [1]. Moreover, there is a low tolerance to change when individuals or groups resist change because they fear that they will not be able to acquire the new behaviour or skill required of them. Resistance to change could also stem from a view where implementing change is perceived as an admission that some of the past decisions or beliefs were wrong.

1.3 Implementation of care models, successes and failures

Two extremes of implementation can be identified in the literature. On the one hand there is success-stories describing linear implementation processes when introducing new care models and on the other hand there are rather pessimistic reports of failures. Very few reports balance between advantages and disadvantages when implementing something new in hospital contexts.

Success-stories are often presented as an intervention of a model expected to improve the patient involvement. The intervention is described as implemented without mention any barriers or facilitators and the activities are followed up with data collected from patients and compared to control groups [12, 13]. One example of such success-stories is Lingren *et al*. who reports of the implementation of a team model that rapidly changed the culture at a community based hospital. The model improved communication and coordination of care and emphasized patient/family participation. Such reports have seldom accounted for difficulties during the implementation process and the studies are seldom a description of a prolonged process but instead a snapshot of the effect of something new [14].

The other extreme, failures is often a pessimistic report about difficulties when implementing something new. One such example is Conolly *et al*. who report the failure of implementing a guideline advocating multidisciplinary rehabilitation delivered throughout the continuum of recovery. The results showed a lack of implementation even though the model was a national guideline. The main reasons were identified as lack of funding and understaffed [15]. Studies of implementation processes have shown that staff makes calculations about how feasible and successful an implementation is expected to be. This is based on an estimate of the expected impact of the new model, its potential gain and whether the upper management's goals and the middle manager's personal goals correspond [16].

Even if implementation of care models has been studied previously, very few have dealt with change processes in mature public organizations, such as in Sweden, from a management perspective. The Swedish healthcare industry has long been regarded as conservative, backwards looking and severely change resistant [17, 18]. Explanations, as reviewed above, often give fragmented answers for the influence of different factors on the implementation process. They are often more concerned with the staff’s beliefs and their opinions than with their actions and, if actions are mentioned, they are often presented in a normative way. Theories can have a tendency to be idealised, for example, suggesting a way to accomplish successful implementation [19].

There is also a concentration on barriers rather than facilitators in the data, and few studies explore both obstructive and promoting factors within the same study [20]. Consequently, there is an importance to diagnosis possible resistance to change and factors that influence the introduction of change within a social context. Because, depending on the reasons of the resistance and the nature of the change itself, Kotter and Schlesinger suggest different methods for dealing with the resistance such as education, communication, participation and support [1]. In this study, the ambition is to give a coherent picture of the change using the concepts of barriers and facilitators, with the help of a broad implementation theory embracing different factors of activities presented in a stepwise manner.

1.4 Implementation theories

There are a number of theories of individual and group behaviour that can be applied for planning and evaluating implementation processes within hospital context. It has been suggested that there are four levels at which interventions to improve the quality of healthcare might operate: (1) the individual health professional, (2) healthcare teams, (3) organizations, and (4) healthcare system [21]. Different theories may be applicable to interventions at different levels; for example, theories of individual behaviour are more relevant to interventions directed at individual health professionals or teams, whereas theories of organizational change may be more applicable to interventions directed at hospitals. Therefore, there is no single unified theory of change that is applicable in all circumstances. Theories that may operate within a health context include diffusion of innovation, institutional change, learning, social cognitive and reasoned action [22-25].

The diffusion of innovation theory has four main elements: (1) innovation, which is described as "an idea, practice or a project that is perceived as new by an individual or other unit of adoption", (2) communication channels, which are viewed as a process in which participants reach mutual understanding by sharing information, (3) time and (4) social system, which is a set of interrelated units active in problem solving to accomplish a common goal. According to the diffusion of innovation theory, the innovation-decision process goes through five steps; knowledge, persuasion, decision, implementation and confirmation [24]. Institutional change theory describes a change in the value structure of an institution, which may become "regressive" change or a "progressive" one [25]. Learning theory suggests that complex behaviour may be learned gradually through simpler behaviours by adoption, imitation and reinforcement methods. Social cognitive theory has three elements, which affect each other; environmental, personal and behavioural. The framework suggests that change in behaviour could be achieved by acting to change the environment [22]. The strength of these theories is their ability to explain the very mechanisms of change. Generalised theories, such as those presented are however not developed to a certain context or to categorize facilitators and barriers within this context. They rather describe the process of change.

Because of the aim of this study a theory developed from health care contexts which is used to identify barriers as well as facilitators, has been selected [26]. It presents a set of sociological tools for understanding and explaining the social processes through which the implementation and integration of new treatment structures and ways of organizing care are operationalized in healthcare settings. It is named NPT because of its action theoretical framework, which means it is concerned with explaining what people do, rather than describing attitudes or beliefs. NPT is concerned with three core issues; implementation, embedding and integration. Implementation is viewed as a social organization for putting a practice into action and embedding is viewed as the processes through which a practice become, or does not become, routinely incorporated in the everyday work of individuals and groups. Integration is viewed as the processes by which a practice is reproduced and sustained among the social matrices in a hospital organization [27].

Normalization in NPT is taken to mean the work that "actors" do as they engage with some collection of activities, which may include new or changed ways of thinking, acting, and organizing, by which it becomes routinely embedded in the matrices of already existing, socially-patterned, knowledge and practices [27]. The NPT theory is "focusing on factors that promote or inhibit routine embedding". Furthermore, it is postulated that practices become routinely embedded – or normalized – in social contexts as the result of people working, individually and collectively, to enact them, and enacting a practice is promoted or inhibited through the operation of generative mechanisms; (1) coherence, (2) cognitive participation, (3) collective action, (4) reflexive monitoring (see the table). Coherence (1) refers to the "sense-making work" that people do individually and collectively when they are attempting to implement a new set of practices. The second mechanism cognitive participation (2) is the "relational work" needed to build socially and sustain a new set of practices. The third mechanism is collective action (3), which is the "operational work" that people do to enact the new set of practices for healthcare intervention. The final mechanism in NPT is reflexive monitoring (4), which is the "appraisal work" that people do to assess the ways in which the healthcare intervention affects them and others around them [28].

Table. Normalization process theory, coding frame for the implementation of PCC

Coherence (Sense-Making Work)	Cognitive Participation (Relationship Work)	Collective Action (Enacting Work)	Reflexive Monitoring (Appraisal Work)
Differentiation: Respondents understood the difference between PCC and the usual care	Initiation: The respondents were working to drive change forward	Interactional Workability: The work that respondents did with each other to operationalize PCC in everyday settings	Systematization: When staff attempt to determine how effective and useful the care model was for them and for others
Communal specification: Respondents building a shared understanding of the aims, objectives, and expected benefits of PCC	Enrolment: Respondents organize or reorganize themselves and others in order to contribute to the work collectively	Relational Integration: The knowledge work that respondents did to build accountability and maintain confidence in a set of practices and in each other as they use them	Communal appraisal: When staff attempt to evaluate the worth of PCC
Individual specification: Actions which help staff understand their specific tasks and responsibilities	Legitimation: Respondents believing it is right to be involved, and that they can make a valid contribution to the change	Skill set Workability: Describes the distribution and conduct of the practices as they were operationalized in the real world	Individual appraisal: When staff attempt to appraise the effects on them and the contexts in which they were set
Internalization: Respondents understand the value, benefits and importance of PCC	Activation: Respondents collectively define the actions and procedures needed to sustain PCC	Contextual Integration: Refers to the incorporation of PCC within a social context.	Reconfiguration: Appraisal work that may lead to attempts to redefine procedures

Note. The different subheadings of the theory represent a stepwise development from basic and necessary steps in order to proceed to the next and more complicated step. One basic idea is that none of the different steps can be jumped over before the next step is accomplished.

Ideally, according to NPT, the implementation process passes through four different levels, starting with coherence to start up the implementation and ending with reflexive monitoring to ensure sustainability. Within the implementation process, facilitators promote the implementation (see Figure 1).

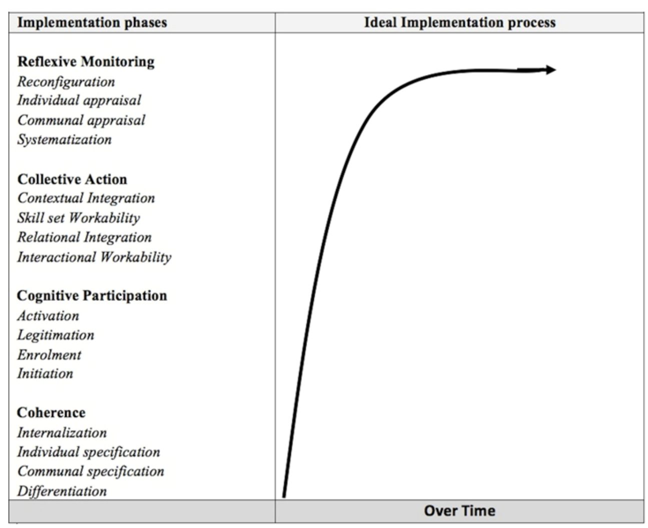

Figure 1. Within the implementation process, facilitators push up the implementation and barriers pull them down

Note. An idealised figure of the implementation process over time successfully including all the steps in change as expressed theoretically based on NPT. The implementation starts stepwise with sense-making contributing to coherence, and continues with a broad cognitive participation in the organization. The collective actions follow and, after a period of practice lead to a reflexive monitoring of reconfiguration. Passing all steps contribute to sustainability.

2 Method

2.1 Study design

We used explorative case study method to identify facilitators and barriers to the implementation of Person Centred Care at a university hospital in Western Sweden. A directed deductive content analysis was selected [29]. The directed approach was guided by a more structured process than normally used in a conventional approach. According to Potter and Levine-Donnerstein, the deductive process requires the use of a theory to design the coding framework which contains definitions of the categories [30]. By using existing theory analysis was started by identifying key concepts from the NPT theory. A secondary aim of the study was to validate or extend the concepts of NPT theory. The theory provided predictions about the variables of interest and the relationships among variables. This has been referred to as deductive category application [31]. The strength of the chosen analysis method was the high degree of reproducibility. However, to our understanding, in the directed deductive content analysis there is a risk of verifying rather than identifying weak theoretical points, however, since we were methodologically aware of it, the interviews were semi structured to minimize the risk of pushing respondents to a desirable answer and the analysis followed a strict textual analysis, through deductive content analysis [29-32]. Interview transcripts were coded electronically, using QSR NVivo 9 software.

2.2 Setting

The care model was implemented in an internal medical clinic at a university hospital in Western Sweden. The decision to implement the model, called the Gothenburg person centred care model (gPCC), was made around one year prior to the interviews. That decision was based on a clinical intervention study aiming to compare the care model to the usual care [5]. The study included patients treated for worsening heart failure.

The implication of the care model was a shift in the way the staff view and collaborate with patients/carers. The intention was to regard the patient as persons who are more than their illness that is represented by their diagnosis. According to Ekman *et al*. person-centred care emanates from the patient’s experience of his/her situation and his/her individual resources and restraints. Examples of these resources or capacities are will, responsibility and motivation [4]. The gPCC model included a new type of admission, leading to a health plan being developed within 24 hours, which was based on the patient’s narrative. More specifically, the healthcare professionals’ moves from providing standardized care to a care based on the patient’s resources and an agreement of collaboration between the healthcare professionals and the patient. The transition into gPCC requires changes both in working routines and in the way the patients are viewed which affect all of the staffs daily routines. The new care also demand a change in the way the staff’s works together, in gPCC each profession works independently after all parties agreeing on the health plan. However, according to Jacobs (2012) this is one of the main challenges in such organizations. More specifically, it is about the difficulty to integrate different individuals and groups and connect them to the overall aim of the organization [33].

The key features of person centred care comprise three core elements: (1) initiating the partnership: Documenting patient’s narrative which was considered to be the starting point of a person centred care process. (2) Working the partnership: Narrative communication involved sharing experiences, learning and building common ground. (3) Safeguarding the partnership: Documenting patient preferences, beliefs, and values in patient records [4].

The implementation process started with a mandatory educational activity adapted to the different professions in the clinic. It included the philosophy of person-centred care, teambuilding and the introduction of new routines. The core activities in the model were the patient narrative and team decisions, where the patient was included in the team [5]. Tools developed for guidance and documenting patient narratives were introduced during the training course.

2.3 Informants

The whole departments’ managerial group, consisting of nine people, were invited to participate in the study and they all accepted. They were all clinically experienced the physicians and the registered nurses, four men and five women, with management experience ranging from two years up 15 years. All managers were still actively working as physicians/ registered nurses in their wards to some degree, which is customary in most Swedish hospitals. No prior ethical approval was recommended by the regional ethical committee because the members of the management were to be regarded as competent as long as they were given both oral and written information about the study. The study complied with ethical procedures according to Swedish law and the Declaration of Helsinki. Participants fulfilling the inclusion criterions were included with the help from the human resource department. A letter was sent out were the background of the study was described. It contained detailed instructions and information stating that participation was voluntary. Participants were informed that they were free to withdraw at any time. They were assured of strict confidentiality and secure data storage. Swedish statutes do not require ethics approval for research that does not involve a physical intrusion that affects the participants [34].

2.4 Interviews

Semi-structured interviews were conducted by the first author, and digitally recorded, at a location chosen by the respondents, during May and June 2012. The interviews lasted about 45 minutes each, and open-ended questions were asked regarding the implementation of the care model and possible factors affecting it. The interviews were transcribed verbatim. The respondents were pleased by the opportunity to discuss the implementation process and provided 54 pages of data. All respondents were given the opportunity to speak Swedish during the interview. Since the interviewer was an English speaker, a professional simultaneous translator was present during the interviews if the respondents chose to speak Swedish. Two of the respondents preferred to speak Swedish using the translator during the interview. During the analyse process, two of the co-authors, fluent in both Swedish and English, validated the translations independently. They listened to the recordings and they also compared the recordings and the text looking for errors in the translation.

2.5 Analysis

All of the authors discussed and agreed on how to conduct a deductive content analysis applying NPT. Based on the published work describing NPT, a coding framework was developed, which represented the core constructs and the specific components of the theory (see the table). In the next step, the research question guided the identification of meaning units within the textual data, then; two of the authors (TA and LEO) discussed the meaning units, in relation to the NPT framework, and critically analysed, questioned, read, and compared them in order to achieve reasonableness [35]. A third author (EC), not involved in the analysis process, confirmed the two authors' analysis by a random check on part of the transcribed texts [29]. Data that could not be coded by NPT component was identified and analyzed later, to determine if it represented a new category or a subcategory of an existing code.

3 Results

3.1 Coherence

3.1.1 Differentiation

The respondents demonstrated a variety of understanding regarding the aim, objectives and expected benefits of the care model they were implementing. They were aware of factors that were perceived as facilitating or obstructing the implementation process. They assumed that the care model would have implications in areas such as organizational culture, distribution of power, responsibilities and patient characteristics. They were however unsure how to meet them.

The respondents were aware of the need for all of the staff to know the difference between the care model and the usual care and that it would be a time consuming process to achieve a complete change.

Respondent 3: "The staff thought that they worked person-centred before but then they start to realize that they actually don't do so, it's still a long way away".

3.1.2 Communal specification

The implementation process revealed problems of which the respondents were unaware. Physicians focused on medical issues and nurses on care issues and they did not have routines to meet and discuss these. In the care model, this became obvious since it was part of the admission process for all patients.

Respondent 1: "We have to meet together and talk, and plan, does this patient have to stay in the hospital or not and that's what we have to discuss together".

They also saw a gap between educational activities and practice. It was suggested that educational activities needed to be repeated. However, because the subject touched upon sensitive areas, they thought the way these educational activities were delivered would be important.

Respondent 6: "... so you have to make them understand that they don't work with person-centred care, but in a very kind, a very wise way, so you don't offend them too much".

3.1.3 Individual specification

They were also concerned with the difficulties for the staff to change routines. They were worried this could trigger negative feelings among the staff, which could promote resistance to change.

Respondent 5: "... if someone, who sits behind a desk, come up with a fantastic idea it still may not work in practice. I mean, we have been subjected to good and not so good ideas, and that has made a lot of physicians very sceptical to new ideas".

One respondent felt discussing the new way to view the patients with the staff was a delicate issue. In the old care model, patients were usually only informed about the treatment whilst now, in the care model, patients were to be seen as partners. This was regarded as a shift in power and, at least for some physicians, it would be difficult to get used to.

Respondent 8: "It's quite a delicate issue to talk about the physicians not giving patients total participation in the care. So, there is a lot of work to do in that perspective. It may have something to do with tradition, the physicians know best, and now we are changing the focus to the patient, that the patient knows best".

Some of the respondents were concerned with the strengthened position of the patient and the subsequent effect on the information-flow. They were concerned about the risk of being overwhelmed by it. The information concerned not only implementation of the care model but also other things, and the respondents found it necessary to weed out some of the information in order to avoid confusion.

3.1.4 Internalization

It was emphasized that the care model would result in an improved structure. In the new care model, the admission process was different, compared to the old care model. Nurses and physicians worked more closely together in teams and the patients became important partners, in order to develop a plan for care. The respondents felt this kind of method gave a clear view of the efforts required from all of the staff and this was an improvement. However, the new model required a major change in the way of thinking. On the other hand, one respondent felt unsure if they could take advantage of the new structured care. Many of their patients needed some sort of care effort from the community after discharge. The community could obstruct the discharge and thus, nothing would have been gained.

Respondent 5: "We cannot decide what day the patient will leave the hospital because it's not our, totally our, decision because the community representatives have to give us their okay".

It was stressed that, even though the benefits and the importance of the care model were well known to the staff, resistance to the implementation could still be expected. The respondent doubted whether all of the staff was prepared to invest effort in the intervention. Some of the staff preferred working as if the new model did not exist at all. They continued their daily work in a traditional and path dependent manner.

Respondent 3: "It's like healthy eating, everybody knows that it's important to do it, and how to do it, and you think you are rather good at it, but you are not and you always go back to bad habits because it's difficult to change bad habits".

3.2 Cognitive participation

3.2.1 Initiation

The respondents were determined to build and sustain the new set of practices based on the care model. They were aware, however, not only of facilitators but also of barriers to the implementation process. One of the respondents stated their determination in an unusually strong way.

Respondent 7: “The head nurse and I, we’ve both got to believe in it and we do, and we work in the ward ourselves and we see that it is implemented and it’s very very important; because, I will not allow any of the physicians say it’s crap, I will not allow it, you have to work like that and the head nurse will not allow the nurses to say, we do not want to work like that”.

3.2.2 Enrolment

It was suggested that the implementation should be slow in order to be successful. There was a need to improve the internal communication to build a common ground on the philosophy behind the care model. The respondents were familiar with the everyday work in the wards and they were concerned with the tension between the present heavy workload and the implementation process. They knew that applying pressure upon the staff could contribute to action but, later on, when the pressure was taken off, there were a risk that the implementation process could stop or even regress to previous work routines.

Respondent 6: “You have to keep the flame burning all the time, because it’s like a rubber band you have to keep the pressure on, if you let it go, it will go back to its original shape”.

Furthermore, they believed that there should be repeated reminders about the direction of the implementation efforts, preferably delivered as a bottom-up process. The managers were aware of the importance of avoiding a top-down imposition, because of the risk of clashing with the philosophy of the care model itself.

Respondent 4: “I think it’s very important that the nurses and physicians themselves are seen as individuals in their work…...if you’re not seen as an individual, it’s very difficult to see the patient as an individual, if you think that you are a part of the machinery, it's very easy to see the patient in the same way”.

3.2.3 Legitimation

The barriers to the implementation were believed to have their origin within the staff themselves, while patients were expected to favour the care model. The ward culture could have an even stronger influence on the implementation. The respondents thought that where the ward culture promotes discussions and openness it could work as a facilitator for the implementation. However, some wards resisted change and one respondent perceived the nurses in those wards as possessing an inappropriate amount of management control.

Respondent 4”: “They wanted to maintain the culture they had, the nurses on those two wards, in my view they were resisting, I don’t consider them nurses, and I consider them mini doctors”.

The respondents realized that in the previous care model, the nurses had a similar instrumental perspective as the physicians and, as an effect, it would be just as difficult for them to change. Turning from old routines, where biological signs and lab-results were the all-embracing guidance, to inviting patients to participate as partners was regarded as a major crossroads.

Respondent 6: “We don’t really know which way would be the best way, which would lead us to person-centred care in the quickest way”.

3.2.4 Activation

It was stressed that it was better to lean towards commitment rather than compliance in the implementation of the care model. In one ward, even though the staff embraced the care model, they felt that they had not been invited to collaborate enough in developing new routines in the admission process. They went their own way and developed routines with which they felt comfortable.

Respondent 9: “We had this research project with the care model and the nurses did not like the forms they had to fill out, so they changed it”.

3.3 Collective action

Interactional workability

In their attempts to enact new set of practices, they met with difficulties related to organizational efficiency. One of the respondents speculated that there could be a resistance to the care model because it may increase the workload.

Respondent 3: “The truth is that, the shorter the time of stay in the hospital the more you actually have to do. If the patient stays for two weeks, you only have one or two a week, but if you have a new patient every other day you have a lot more to do…. subconsciously maybe you think, oh we wait another day”.

They were however, aware that increasing the length of stay was not for the best for the average patient. Even if patients seek help, and usually never complained about their length of stay in hospital, they usually wanted to go home as soon as possible.

Respondent 8: “I think not all, but most, patients don’t want to stay at the hospital unnecessarily long; in most of the rooms you share, someone is snoring and suchlike, and it’s not your own home, you do not want to stay there, you want to go home”.

4 Discussion

The theoretical model (NPT) used in this study was partly supported by the data. The categories embodied the implementation process, even if the later categories were not presented by the data. The absence of large parts of the collective action dimension, and reflexive monitoring, suggests that the implementation process had not been completed. Consequently, according to the theory, the implementation will possibly not be sustainable. The results indicate that the change may slow down, stop, or even reverse, and previous routines will dominate again [36]. Another explanation would suggest a potential shortcoming in the theory. The intervention studied did not reach the stages of collective action and reflexive monitoring, because very few implementation processes ever reach such a level (see Figure 2). This explanation would suggest that normalization process theory is an ideal model, rather than an ideal type [37]. The idealised model is normative. It points out how something should be. It describes something worth attaining, signals the direction to success and judges what is attractive. The ideal type, on the other hand, is used as a tool in order to understand or to describe and analyze a certain social entity or circumstance. It is not meant to be normative, but it is developed instead to understand an extreme position, which works as a point of reference in analysing a phenomenon [37]. There is, however, a need for more studies, in different healthcare contexts, to judge whether NPT has the character of ideal type or idealised model.

Within the care model there were efforts to change old routines and make a shift in power and responsibility, to more equality, between staff and patients. This shift in power and responsibilities has been described by Kotter and Schlesinger to be part of the reasons why staff may resist change. Furthermore, Kotter and Schlesinger suggested that the risk of losing power could lead to political behaviour, which is when the best interest of one person or a group is not in the best interest of the hospital clinic [1]. This political behaviour was identified, in the implementation of the care model, in the form of efficiency. It was perceived that the individual staff workload could increase to overall organizational efficiency. Managers who were attempting to overcome reasons that could lead to resistance to change, misunderstanding of the care model or not believing in it, initiated educational activities. Educational activities have been described to be an essential part of implementations projects [38, 39]. Furthermore, managers stressed that educational activities should make clear to the staff the importance of, and all supporting evidence for, the care model. However, managers found that, due to the time gap between education and practical implementation of the care model it was necessary to re-educate the staff again.

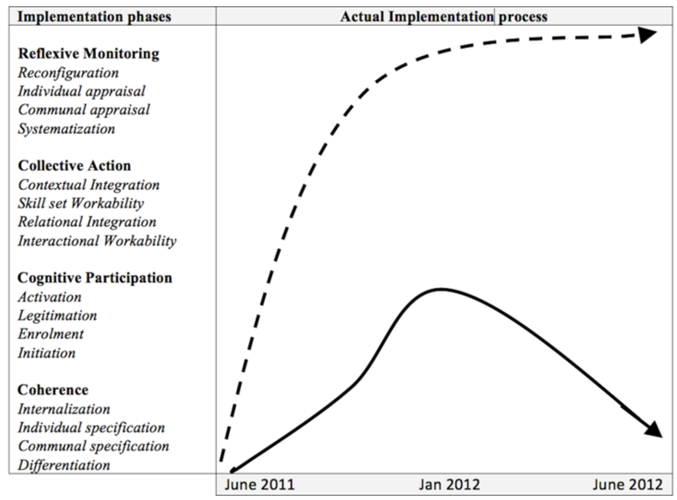

Figure 2. The idealised figure of the implementation process compared to the actual process. The implementation started stepwise with sense-making contributing to coherence and continued with broad cognitive participation in the hospital. However, there was an absence of collective actions and reflexive monitoring during the intervention. As an effect of only partly passing all of the steps, according the theory, the sustainability can be questioned.

During the implementation of the care model there were other normal and every day changes going on. Therefore, the implementation was perceived as an increase in the ward workload. As a result, it was felt that there was a lack of a valuable resource, time. This finding was not surprising, because time constraints have been identified as the most common barrier to implementation processes in healthcare settings [9, 10]. However, the mangers perceived a time-saving potentials in the care model, which has been highlighted in previous studies focusing on potential benefits of person-centred care [4, 5]. Apparently, the staffs were not fully agreed of such benefits. Some of them resisted the implementation of the care model.

This illustrates the challenge to establish consistence between staff and management. Staff comments such as: “It’s like a rubber band you have to keep the pressure on, if you let it go, it will go back to its original shape”, and “they wanted to maintain the culture they had”, revealed a fragmentation between staff and management. Even though the educational activity was carefully adapted to the different professions, there were still see a gap between practice and the philosophy of the care model [3].

The results indicate a hospital care model governed by work schedules and routines in sharp contrast to the proposed care model based on individual needs of the patients. A mechanistic structure, consisting of repeated and simple procedures coincided with adaptive ways of organizing the care [40, 41]. On the other hand, conservatism and change resistance has sometimes been identified as a protection from narrow-minded organizational models contributing to an impaired quality [11]. Consequently, the effects of facilitators and barriers cannot be interpreted in a linear manner, imposing that introducing new care models always will improve the care to something better than common practice.

The mangers in this study found that patient characteristics such as age, culture, language, cognitive status and physical environment could be barriers to the implementation of the care model. These barriers were identified by Suurmond and Seeleman in their study, which focused on improved interaction between physician and patients [7]. They also found that modifiability and measuring effectiveness of the new model were important factors in sustaining the change and stressed on the importance of monitoring and changing the flexible parts of an innovation [7].

Speed of implementation was an interesting influencing factor in the implementation process. On the one hand, when the implementation process for the care model was slow, the whole process needed to start again in the form of re-educating the staff. On the other hand, when the implementation process was fast, the staff actively resisted change, because they felt it was exposing them to enormous time pressure. It is reasonable to assume that an implementation process could be greatly influenced by the speed at which mangers drive the implementation forward. Even though theories are able to describe in detail the steps for successfully embedding and sustaining an innovation, they do not describe or identify factors influencing the speed of the implementation. A possible reason might be that time is a subjective factor. For example, it was felt by some managers that the implementation of the care model could take up to two years while other mangers felt it could take generations to changes old routines into new care models. However, even if time is a subjective factor, it can potentially considered and used as a tool and controlled by the management. A senior management can tend to support a mechanistic view of implementation by supporting a sequential view of implementation instead of understanding dynamics. Therefore, if the leadership is decentralized and not a top down management governed by performance targets and regulations then local staff can possibly be in accordance with the management during change processes and be less resistant to it. Therefore, it needs a strategy in which perceptions of the costs, benefits and reasonable speed of the change is being considered before the decision is made to implement.

Limitation

Since the data collection were limited to the implementation project of gPCC, which was in one hospital in Sweden, the transferability of the results should account for the possible difference in the context described in this study. Another limitation is the small number of managers participated in the study; however, they represented the whole departments' managerial group and provided rich textual data.

5 Conclusion

The implementation process in the present study, according to NPT, was incomplete and there was a risk that it could regress to previous work routines. However, implementation theories, including NPT, do not have a timeframe for the implementations process. Even though theories are able of describing in detail the steps for successfully embedding and sustaining an innovation, they do not describe or identify factors influencing the speed of the implementation. A possible reason might be that time is a subjective factor.

Competing interests

The authors declare that they have no competing interests.

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