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ORIGINAL ARTICLE

A learning process towards person-centred care: A second-year follow-up of guideline implementation

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Abstract

Background: Research claims that 'learning by doing' creates new thinking, often leading to new practice.

Objectives: The aim was to explore and describe the staff learning process from the first to the second year when adopting person-centred care into clinical practice in a nursing home for persons with dementia.

Method: The data consisted of poster texts from staff and written notes by researchers obtained from the group discussions. The study involved 24 care units (200 staff). Content analysis was chosen as method to explore the learning process.

Result: The staff described the actions that they took during year 1 and year 2, in which five categories emerged, activities, environment, information, priorities and staff routines. With researchers' analysis the categories together created the learning process and formed a sub-theme. They further formed an overarching theme from simplicity to complexity and consensus. Staff changes year 1 pertained more to planning and doing, while year 2 changes constituted a larger complexity of person-centred care with reflection, collaborative learning and a mind-set change.

Conclusion: Staff chose the development area, and the learning process was illuminated by the researchers. This underscores the value to visualise and verbalise the steps of change as well as include these steps in the design of an implementation process. The concept of person-centred care could be viewed on different levels. The findings may contribute to a more comprehensive understanding of staff learning process when implementation of person-centred care.

Implications for practice: Making staff's learning process visible can be a guide for improvement and change from a generic care towards person-centred care. The Regional Board of Research Ethics approved the study (Reg no. 2010/1234-31/5).

KEYWORDS
action research, behavioural change, dementia, person-centred practice, qualitative methods

What does this research add to existing knowledge in gerontology?

- The research presents a valuable view on person-centred care, which progresses from simply, 'starting an activity group' to a more complex level of 'being present, listen, ask questions and speak to a person with dementia in a respectful way'
- The awareness of these levels may guide the understanding of person-centred care in a more concrete and distinct way by visualising and verbalising the tacit dimension.

What are the implications of this new knowledge for nursing care with older people?

- One implication is to guide improvement stepwise from the care staff's point of view based on their knowledge and experience.
- The implication for nursing care is to visualise the gradual improvement and guide staff's own knowledge or competence from generic care towards person-centred care.

How could the findings be used to influence policy or practice or research or education?

- The findings may contribute to students' and care staff's education on the multi-dimensional concept of person-centred care, the different levels and tacit dimension.
- The researcher may use the finding to reduce challenges and facilitate development of care by visualising care staff's own steps of improvement/change.
- The findings may also influence the conception that improvement or change occurs in small steps, ranging from simplicity to complexity, relating to the different levels of the concept of person-centred care.

1 | INTRODUCTION

This paper seeks to describe the staff learning process when implementing Swedish national guidelines for care of people with dementia in a nursing home (NH). One of the fundamental ideas of the guidelines is to shift from a generic, provider-centred care model, towards a person-centred model of care. The national guidelines address several evidence-based care recommendations with different priorities. Those related to this study are physical activity, meal/environment and eating, physical and psychosocial environment, support for relatives and person-centred care (PCC). The highest priority of the guidelines is the use of PCC (National Board of Health & Welfare, 2010). Staff should thus focus on the person's well-being rather than focussing on the disease itself by actively listening to the persons' story, being aware of who the person is and what his/her wishes and needs are (Edvardsson et al., 2008). PCC is a socio-psychological treatment according to the World Health Organisation (2015). Empathy as part of PCC was included in staff training in eleven of nineteen studies (Kim & Park,2017). Ekman et al. (2011) refer to three important routines to facilitate implementation of PCC into daily practice 'preferences, partnership and documentation'. The concept of PCC relates to a number of definitions, for example patient-centeredness, person-centred assessment and empowerment (Diffin et al., 2018; Holmström & Röing, 2010; Scholl et al., 2014). All these different perspectives of PCC indicate a broadness of the concept. Ontologically, PCC has its origin in phenomenological and existential philosophy with a strong focus on verbal and non-verbal communication (Edvardsson et al., 2008). Everyday actions, clinical practice and communication skills are mainly related to peoples' unconscious behaviour, to their tacit or implicit knowledge (Fugill, 2012; Polanyi, 1967).

1.1 | Change

It is a challenge to change practice by breaking a routine in establishing a new habit (Gerrish et al., 2012). Ekman et al. (2011) mention the complexity of PCC and that it is easy to revert to old habits. A review on implementation of evidence-based practice posits that nurses tend to show improvement of knowledge, but to a lesser extent, change in clinical behaviour (Munten et al., 2010). Implementing guidelines relate to healthcare providers' perception of the guidelines, attitudes, the level of knowledge and experiences (Diffin et al., 2018; Forsner et al., 2010). The goal of implementation according to Nilsen (2015) is to facilitate staff process towards change and also to focus directly on changing practice.

1.2 | Learning strategies and educational design

Learning usually occurs in steps; new knowledge is built on and integrated with previous knowledge (Elmgren & Henriksson, 2018).

TABLE 1 A checklist during the seminars

PAR process year 1	KISAM process year 2
1. Delineating problem	1. What works well and what works poorly?
2. Choosing action	2. Identify a development area
3. Design and assessment	3. Seek knowledge through the National guidelines
4. Engaging in action	4. Decide a change and make a plan to implement the change
5. Gathering data	5. Implement and evaluate the change
6. Reflexive knowledge	6. Back to 1

Different foci are guiding different learning outcomes. Focusing on one's own body can increase body awareness, while focusing communication is to support someone else (Kindblom-Rising et al., 2007). Reflective learning and reflective practice can guide a deeper understanding in some people, develop self-awareness in others and support the view from another person's perspective for some (Griggs et al., 2018). Active participation of the learner is central in Dewey's pedagogy (Dewey, 2007). Learning through action practitioners can reach an understanding of what they are doing by doing it. This can create new thinking often leading to new practice (Diwan et al., 1997). By comparing actions and different experiences, the ability to assess the consequence of a conscious action can increase (Schön, 1995).

This paper derives from a 2-year longitudinal research intervention programme with a multifaceted approach to implement Swedish national guidelines in a NH. Staff, relatives and persons with dementia were involved using pre- and postquestionnaires, seminars and a poster exhibition. A significant reduction in conscience stress and an increased climate for PCC were reported among staff in the same NH as described above (Edvardsson et al., 2014). Furthermore, the implementation process was described to be meaningful and beneficial for both staff and residents after 1 year (Vikström et al., 2014). Implementation of research findings into practice is still a field in development. It is related to improvement and behaviour change and in need of further explication (Alharbi et al., 2012; Munten et al., 2010). The aim of the study was to explore and describe the staff learning process from the first to the second year when adopting PCC into clinical practice in a NH for persons with dementia.

2 | METHODS

2.1 | Design

The design was a 2-year intervention with a descriptive, exploratory and a qualitative approach.

2.2 | Study setting

The study was conducted in a Swedish NH, which was located in a large city. Prior to the study, the residents were treated with provider-centred care, which focussed more on physical support and passive treatment. The researchers and managers designed the overall intervention together. They had a vision to divert to a person-centred approach and to develop the NH onto an academic centre, whereby student activity was included. Staff played a key role during the whole project, in choosing and working on the relevant areas of development related to PCC. The first year of the implementation of the innovation was used as follow-up to the process of learning to the end of year 2.

2.3 | Participants

The study involved 200 staff members from 24 care units in the NH. The staff consisted of 170 nurse's aides, 20 registered nurses (RN) and 10 other health professionals and managers. The majority of the staff was females, and the mean age was 48 years. The majority of the staff had a basic education and a mean work experience of 19 years in old-age care and nine years in the present NH. The rate of turnover was low. Most of residents were diagnosed with dementia. Approximately eight residents lived at each unit and had a single room with their own furniture (Edvardsson et al., 2014; Vikström et al., 2014).

2.4 | Participatory action research (PAR)

Action research has been described as an approach to research, improving practical knowledge from participants' need through active participation (Taylor et al., 2004). As a facilitator, the researcher supported staff development towards change, using the checklist 'PAR process'. The PAR process was simplified into the KISAM process (Karolinska Institutet in cooperation with the nursing home) year 2. The checklist included six written steps to guide discussions during seminars. The first step was 'What works well and what works poorly?' the 5th step was to implement and evaluate the changes made, and the 6th step was to start from the 1st step again, see Table 1

2.5 | Educational intervention

2.5.1 | Unit-based seminars

Managers arranged for staff on each unit to meet. Four researchers led the seminars as facilitators (PhD) and were responsible for six units each. The facilitators supported the staff to raise

consciousness of the specific development area, the daily work and the practical improvement from seminar to seminar. Also the PCC, and a booklet with the national guidelines, was discussed. The chosen areas were activity, meal/environment, routines, relatives and behaviour/treatment. The most common choice of area for year 1 was activity and for year 2 meal/environment. During year 2, the 24 units were merged to 16 for the unit-based seminars to comply with staff interest and logistic challenges experienced during year 1. The leadership was gradually transferred from the facilitators to the RNs to continue with the seminars and sustain the improvement once the research project ended. For a summary of the intervention, see Table 2.

2.5.2 | Posters

The posters were produced during and/or between the last two-seminar meetings each year. The managers provided the material needed for the posters. The staff was free to develop the posters in the way they wished, using text, photographs and/or illustrations. They were prompted to have the learning process in focus, and a number of headings were suggested: development area, rational, knowledge and result/reflection. The construction of the posters had a similar structure for both first year and second year.

2.5.3 | Poster exhibitions

The poster exhibition of year 1 was offered twice during one day with 31/32 persons per half-day (total 63). The exhibition started with a lecture and a quiz related to the dementia guidelines. Participants were seated in a lecture theatre. At half time, a poster mingle and short presentations were offered to discuss and share the results between the units. The poster exhibition of year 2 was offered four times in two days with approximately 45 persons per half-day (total 184). The poster exhibition started with the focus-group discussion. Participants were seated in a circle to facilitate interaction. Poster mingle took place in the same way as year 1. The exhibitions were open for staff and visitors during 2 weeks.

TABLE 2 A summary of the parts of the educational intervention

Educational intervention			
Unit-based seminars	3–6 staff/each seminar	1.5 h	5–6 times/ semester
Small-group discussion	10 groups	1 day	
First Poster exhibition	2 groups	1 day	24 posters
Focus-group discussion	4 groups	2 days	
Second Poster exhibition	4 groups	2 days	16 posters

2.6 | Data collection

2.6.1 | Data set 1—Posters

The year 1 posters (24 posters/24 units) and year 2 posters (16 posters/24 units) were collected as the main foundation for exploring the learning process from year 1 to the end of year 2. The posters were photographed, and the poster text was transcribed verbatim with the same procedure the first (27 A4 pages) and the second year (11 A4 pages).

2.6.2 | Data set 2—Handwritten field notes

The first-year data were collected from the one-day small-group discussion (10 groups with 5–9 participants each group). An adjoining summarising discussion completed the day, and the researchers took written notes (13 A4 pages). The second-year data were collected from the focus-group discussions and based on the five chosen developmental areas. One area at a time was discussed to receive thoughts and experiences from the staff regarding each development area. All four focus-group discussions with 45–47 participants in each group were recorded by hand. The two researchers, who did not write the notes at the small-group discussion, recorded the notes by hand (25 A4 pages). The notes for year 1 and year 2 were gathered as addition to the poster text and were used as quotations.

2.7 | Data analysis

Qualitative content analysis was chosen to analyse the poster texts (Graneheim et al., 2017; Graneheim & Lundman, 2004). It is a method suitable for a variation of text. The text was coded related to the aim of the study and grouped into categories. A sub-theme and a theme were formed. The category addresses the question of what (manifest content). The sub-theme and theme constituted the question of how (latent content). The structure of analysis is shown in Table 3

2.7.1 | Steps of analysis

Staff learning process and the PCC were in focus when analysing the poster text. Initially, two researchers read each poster text repeatedly to gain a broad understanding of what the poster text described. Consequently, they extracted the codes mainly from the result/reflection part of the poster text. The researchers then grouped the codes into suitable categories depending on the content of the code and selected quotations from the handwritten field notes. The quotations were used to illuminate the content of the categories. In addition, a sub-theme to serve as bridge between the categories and also a theme to understand the result on a higher level of abstraction were formulated. A poster number related to the development area was presented to each category 1F (First year) and 3S (Second year). A group of research

TABLE 3 The structure of analysis

Theme ***Sub-theme***	**Simplicity—Complexity—Consensus** ***Learning process—from doing, through reflection, to change***				
Categories	**Staff approaches to activity**	**Residential environment**	**Use of information**	**Staff priority**	**Staff routine**
Codes ↑ Year 2	Understanding residents' experiences and interaction	Calmness when dishwasher stopped	Internet info meaningful affirmation	Shape mutual trust	Teamwork to strengthen each other
	Sleeps better when being outside	Find new seat for interaction	Exchange practical. mutual knowledge	See to residents' need	Part of everyday work
Codes ↑ Year 1	Counting participating residents	Set the table, make home-like	Info Google scholar and National board of health/welfare	Appreciation for staff work	Documenting routines
	Peeling potatoes, Sitting gymnastic	Re-arranging furniture	Reading national guidelines		Fragmented new routines

peers read the poster text, to ensure the confidentiality in transcription and the process of analysis. They gave their view and interpretation of the findings to improve the trustworthiness of the study.

2.8 | Ethical approval

The Regional Board of Research Ethics approved the study (Reg no. 2010/1234-31/5). To ensure confidentiality in transcription and the process of analysis, the names of persons and their workplaces were not transcribed.

3 | RESULTS

Staff described the actions that they took during year 1 and year 2, in which five categories emerged as follows: staff approaches to activity, residential environment, use of information, staff priority and staff routine. The structure towards change from year 1 to year 2 within each category created the learning process and the researcher employed a sub-theme as a bridge between the categories. The researchers further created an overarching theme 'Simplicity to Complexity and Consensus' to indicate the development to a higher level of abstraction on how change takes place through learning. Staff changes during year 1 described more planning and physical doing, while year 2 changes contained more reflection, collaborative learning and a mind-set change.

3.1 | Categories

3.1.1 | Staff approaches to activity

Staff described the activities undertaken during year 1 as spontaneously performed, non-planned and easily interrupted. Staff highlighted more difficulties to begin with.

> .... sceptical at first. Did not know what it was about

Some staff members stated that the activities could only be offered when the everyday work at the unit was running smoothly. Group training with movements or balloons was introduced to the residents by the staff at some units; folding napkins and peeling potatoes were activities at other units. Outdoors activities, reading, games or music activities were introduced at some units. The staff at two units created an activity box with different games and tools for the residents. The staff at a couple of units evaluated the activities by counting the participating residents. At other units, the staff made an overview board, where the activities of the week were displayed to inform residents, staff and relatives about these activities. *Poster 1F* (First year)

> We have a schedule with the name of the staff so everyone knows who is responsible for the activity

Staff described activities year 2 from the residents' ability, emotions or social interaction when taking part in scheduled activities. The staff gathered the residents' experiences during physical and outdoor activities at few units, to evaluate the activities. They mentioned the natural way of speaking by walking.

> to get out in the air... hear the birds singing, getting to be a human and not just an object receiving help from others

The staff encouraged residents to get involved with each other, and they described an understanding that preferences for participating in activities could differ. Some guided the residents to a suitable activity. This category illustrated changes in the staff between year 1 and year 2 from a spontaneous activity to a planned, structured and reflective approach. *Poster 3S* (Second year)

3.1.2 | Residential environment

During year 1, the staff described how they re-furnished to use the space in a better way. Staff at some units changed the environment

from an institutional to a more homely space with tablecloth and curtains. In another unit, the staff changed the environment by cultivating spices on the balcony. This influenced both staff well-being and residents' well-being. At one unit, staff members described meal situations as problematic and they relocated residents to reduce anxiety. *Poster 22F*

> We moved the residents who were verbally abusing each other

During year 2, staff described how they promoted the need of the residents by planning and serving meals in a more flexible way. They arranged the seats during mealtimes in a way to promote interaction among residents. The psychosocial environment with interpersonal aspects was described to reduce stress and anxiety. Staff members reported that calmness was induced when they stopped doing the dishes during mealtime.

> Would I like anyone to wash dishes while I eat? Would I like you to clean, while I eat? It's just a matter of turning to one's own preferences

This category illustrated changes in the staff from simple adjustments transformed into residents' overall comfort. *Poster 4S*

3.1.3 | Use of information

During year 1, staff members gathered information and searched for knowledge within the specific area of development. They used the booklet with national guidelines for persons with dementia and continued to search knowledge on Google, publications at the website for the National Board of Health and Welfare and the Swedish work environment authorities. The staff at one unit developed a 'Brochure' for temporary employees to facilitate general work and for the permanent staff to receive more time with the residents. Another unit developed a welcome sheet entailing support and advise for visiting relatives and friends. *Poster 14F*

> We do have a more personal introduction to the ward… and a more welcoming layout

Searching for information and knowledge was less pronounced during year 2. Staff members from a few units described how they inspired and shared practical knowledge more with staff at other units. The 'Brochure' for temporary employees was evaluated. They described how they received reliable guidance in the work, by having the 'Brochure' at hand.

> go to myself that I'm as uncertain as the temporary staff if I go to another unit, although I've been working for a long time

This category illustrated changes in the staff from using guideline-based information to research and experience-based knowledge. *Poster 7S*

3.1.4 | Staff priorities

During year 1, staff described a lack of time, and a high workload and the need to get appreciation for the work that was already performed. Some staff members indicated that the priority was to meet each other and discuss their work. They described that the national guidelines prioritised the residents and not just the staff. *Poster 8F*

> I have worked many years and the main focus has been on the staff, it is good that the focus has changed to the residents

During year 2, the staff described that the priority was more multifaceted in the work. The staff at a few units identified the benefit of being a diverse group. They appreciated each other as individuals having different professions, personalities and strengths. Having this disposition, they described more sensitive topics such as ethical and moral issues and spent more time with the residents. At one unit, the staff specifically worked to involve change in their thoughts during the work and thereby meet the residents need. Some staff members described reflections from the residents' point of view and pondered more on the consequences of the influence of their actions on the residents.

> It is important what I radiate. The residents are mirroring themselves in me.

> Another paradox is that the heaviest job is to be present, listening to the residents. Do the dishes and clean up are not so heavy. Many may escape to the doing to not "need" to be with the residents

> The residents own habits are important

> Affirmation means positive reinforcement and a way for us to guide our thoughts

This category illustrated changes in the staff from adhering once own work habit to prioritise the residents' needs. *Poster 1S*

3.2 | Staff routines

During year 1, the staff described the routines as fragmented, but several units developed a planned activity, a homely environment or described an accommodating atmosphere towards each other in the work group. *Poster 4F*

> We have had difficulty to get started and the trouble is to plan and get the plan into routines
>
> We see a greater need to meet and develop
>
> We received new ideas and we have managed to create planned groups
>
> We think we are better and we're nicer to each other than before

During year 2, the staff described that the collaboration gradually extended, and they opened the door between several units and developed routines together. The 'Brochure' for temporary employees came into routine at several units. The staff in these units supported each other as a team in a variety of actions and in case of sick leave. Another routine was to offer the choice to shower in daytime or evening. This was incorporated at some units. Other units developed a routine with the choice of breakfast.

> 'We have to go to ourselves and how important it is for us to have breakfast just the way we want' 'We have started with breakfast buffet'
>
> 'Small changes can mean much and are easier to perform' 'Routines that was agreed on and has been written down gave more freedom to the resident'

This category illustrated changes in the staff from unit-based work, towards teamwork between units or within a unit. *Poster 16S*

3.3 | Sub-theme

The changes within each category had the similar structure and visualised, verbalised and constituted the learning process as a bridging part for all categories.

3.4 | Theme

The overarching theme from simplicity to complexity and consensus illustrates how change takes place through learning.

4 | DISCUSSION

The main findings were the staff's description of the changes, divided into categories by the researchers between year 1 and year 2. The staff's series of changes, which was visualised and verbalised, thus constituted the learning process. The process of learning had a similar structure in each category. The researchers viewed PCC as a broad and complex concept, dealing with simple actions to different levels of ethical knowledge. The implication is that the learning process for the staff starts with their existing experiences. It is necessary to meet people from their level of knowledge, if the researchers' desire is to support a change (Elmgren & Henriksson, 2018; Kierkegaard, 1859).

4.1 | Learning

Critical evaluation is a precursor to learning, which may indicate that a critical view of the national guidelines should be part of the learning, process. According to Forsner et al. (2010), this way of acting is common. In this study, staff discussed the critical thinking as part of the learning process before choosing the development area. Staff at the different units started the learning process from various development areas, but the structure of learning was similar in all categories. To plan, a group, to gather the residents and carry out the activity, gave time to replicate. These actions seemed necessary for the staff at some units before they could focus the residents. To compare previous forms of doing and working with new one's seemed as a way to learn. The strength of 'learning by doing' is the emotions that can arise in comparisons. It appeared that the staff was made aware of the consequences of different activities. This is in line with the core reasoning by Dewey (2007). A review on learning by doing provides similar arguments, but also state the complexity and broadness of learning by doing (Van Poeck et al., 2020). Learning in general takes place as self-awareness, through one's own body at first, and afterwards the possibility to take another person into consideration (Kugel, 1993). Another step in the learning process, according to Nilsen et al. (2017), is to transfer explicit actions into tacit dimension to reach a change. Polanyi (1967) identified the structure of tacit knowing and argues for the opposite. In our study, it is supposed that staff at some units translated the tacit dimension of work into explicit actions in the way they presented the poster.

4.2 | Change

All staff were able to implement basic activities for the residents, for example group training, potato peeling, decorating or re-furnishing the environment. These activities apparently provided inspiration to take the next step. Staff repeated the chosen actions and reached the goal stepwise. Actions need to be repeated to develop a new habit (Elmgren & Henriksson, 2018; Nilsen et al., 2012). A general shift in mind-set encourages change (Kimberly et al., 2019). The changes and the level of change differed between the years and the units. Not all units reached the advanced level of PCC, to listen and meet the wish or existential need of the residents. Few units reached consensus, others worked more as a team or collaborated with the residents on an individual level. PCC is a broad concept, which shows complexity (Scholl et al., 2014). Changing a provider-centred care into a PCC is a challenge and according to Nilsen et al. (2017) a multi-dimensional approach. He argues that some changes promptly

turn into habits (Nilsen et al., 2012). This could in our study refer to the basic activity, like group training, which require physical attendance and may not be difficult to implement. To be a good listener need mental presence and may for some staff be more difficult to implement than to lead a physical activity. Persistent reflection and the repetition of the chosen activities are needed to break a habit and create a new one (Nilsen et al. 2012). Activities and a homely environment are important for general well-being and parts of a PCC (Hendriks et al., 2016). This may be one reason for the staff to start with a basic activity as preparation for a more advanced PCC. Wickford (2014) states that self-awareness is a need to understand others. Kindblom-Rising et al. (2007) reason that persons with little experiences promoted self-awareness, while those with more experience promoted skills to communicate with others.

4.3 | Competence

Competence in this study was interpreted by the researcher as not only being knowledgeable, but also being able to verbally communicate knowledge to others. Some staff increased their competence by sharing knowledge within or between different units, especially those units, which were merged together during the second year. Hill (2009) described the importance of speaking clearly and emphasised the benefit of exchanging emotions or knowledge through interaction with others. In order to communicate according to PCC principles, the knowledge needs to be processed several times, understood and then translated into simple words. This indicates a high score on the Solo taxonomy (Structure of Observed Learning Outcome) and shows a hierarchical structure from details to complexity (Biggs & Tang, 2011). Tacit or implicit knowledge is unconscious or taken for granted, hidden in practice (Fugill, 2012). When verbalising tacit knowledge into explicit knowledge, it is possible to share the knowledge (Polanyi, 1967). Such act can develop communication skills and support competence building (Karlsson et al., 2015).

4.4 | Methodological aspects

4.4.1 | Strength

PAR was a valuable model with a bottom-up perspective and a design for active participation (Taylor et al., 2004). The staff took an active part in the intervention by choosing the development area and guided the development from their point of view towards improvement, being supported by the researchers. The action research design gave the staff the opportunity to discuss their critical thinking, work pattern and collaboration on the unit. PAR was also of value in implementing such a broad concept as PCC. With the help from the staff, PCC was divided into different levels of difficulty. PAR is a flexible method with few predefined factors. According to one study, predefined factors in a study are least effective in interventions (Caspar et al., 2016). The poster was a good complement to PAR, providing the staff on unit level with a further opportunity to evaluate their actions together. The act of writing seemed to have given the poster text reality in the sense that staff needed to reflect and edit the thoughts to compose them on the posters. If the text is not written down, the formulation in the mind may not have sufficient structure and may just disappear. Creative writing provides a different dimension to experience than reflective practice according to Bailey et al. (2015). A qualitative research method best suited the exploration of the process of learning. Qualitative content analysis as choice of method gave support with the combination of manifest 'categories' and a latent approach 'sub-theme and theme', which are presented on different abstraction levels (Graneheim et al., 2017; Graneheim & Lundman, 2004). To reach a change in implementation studies, the process needs to be in focus (Nilsen, 2015).

4.4.2 | Limitations

The study was performed between 2010 and 2012, which may present as a limitation. It is a challenge to implement research into practice, and we have not found any study with a similar approach. The data collection was restricted and the amount of data limited. Different researcher collected notes during the 1-day seminar and the focus-group discussions. This may have influenced the quality of the notes. The researcher had different professions (RN, OT, PT), which may have influenced the content of the seminars and maybe the posters. Different professions may also be a resource and provide greater opportunities to meet different staff. A limitation could be that changes were described on unit level and the researcher could not evaluate the individual staff. The action research requires flexibility and awareness from the researcher's point of view, and it may need more attention to follow staff and the changes during the process of learning.

5 | CONCLUSION

The findings of this study show a learning process highlighted by the researchers, which was created from the staff choosing the development area, collegial reflection, creative writing, executed practice, small changes and the time needed to break a habit and make a change. This underscores the value to visualise, verbalise and describe the steps of change. These steps also identify the similarity in the structure within each category. Another identification was to divide the concept of PCC into different explicit levels. To include these levels in the design of an implementation can contribute to a more comprehensive understanding of the process of learning when implementing PCC. More research is needed to investigate, explore and evaluate the levels of PCC and change based on the learning process.

One implication is to guide improvement stepwise from the care staff's point of view based on their knowledge and experience. The implication for nursing care is to visualise the gradual improvement and guide staff's own knowledge or competence from generic care towards person-centred care

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CONFLICTS OF INTEREST

There are no conflicts of interest

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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