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Full title: Nurses' views of patient participation in nursing care

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Abstract

Aims: To explore nurses' views of patient participation in nursing care on medical wards.

Background: Nurses have frequent contact with patients, highlighting their potential role in enabling patient participation. However, some nurses' actions and attitudes act as barriers, failing to achieve core requirements of patient participation. Discovering nurses' views may assist in developing strategies to encourage patient participation in hospitals.

Design: Interpretive study.

Methods: Twenty nurses were recruited from four medical wards, located in two Australian hospitals. In-depth semi-structured interviews were conducted between November 2013 and March 2014 and analysed using content analysis.

Findings: Five categories emerged from the nurses' views. The first category, acknowledging patients as partners, showed nurses respected patients as legitimate participants. In the second category, managing risk, nurses emphasised the need to monitor participation to ensure rules and patient safety were maintained. Enabling participation was the third category, which demonstrated nurses' strategies that enhanced patients' participation. The fourth category was hindering participation; encapsulating nurses' difficulty in engaging patients with certain characteristics. In the final category, realising participation, nurses believed patients could be involved in physical activities or clinical communication.

Conclusion: Nurses have a crucial role in promoting patient participation. Through acknowledging and enabling participation, nurses can facilitate patient participation in a range of nursing activities. The nurse's role in enacting participation is complex, having to accommodate each patient's risks and characteristics, highlighting the need for good

assessment skills. Education, policy and research strategies are essential to foster nurses' pivotal role in patient participation.

Keywords. communication; consumer participation; nurse-patient relations; patient-centered care; patient engagement; patient participation; patient safety; nursing care.

Summary statement

Why is this research or review needed?

- Patient-centred care, inclusive of patient participation in care, is advocated in hospitals internationally.
- Emerging evidence suggests active patient participation has beneficial effects on patient outcomes.
- Nurses are not consistently facilitating patient participation, highlighting the need for further exploration of nurses' views of participation.

What are the key findings?

- Nurses recognise their central role in the success of patient participation, through validating and facilitating patient participation.
- Enabling patient participation is challenging, with nurses having to maximise participation in patients' characteristics while minimising risks to the patient.

How should the findings be used to influence policy/practice/research/education?

- Adopting the recommended strategies may help clinical nurses involve patients in their care.
- Through training, nurses may develop skills and feel more confident in facilitating patient participation.
- Clear policy advocating patient participation and an established communication strategy may promote patient participation.

INTRODUCTION

Nurses spend more time with the hospitalised patient than any other clinician group, occupying about one-third of their time with patients (Westbrook *et al.* 2011). This places nurses in a direct position to enable and encourage patients' participation in their care. Helping patients participate in their care has been linked to higher patient ratings of quality of care (Slatore 2010), safety (Weingart *et al.* 2011) and satisfaction (Dwamena *et al.* 2012). The success of achieving these outcomes is dependent on nurses and their ability to practice in a patient-centred manner (Pelletier & Stichler 2013, Mayer 2014).

Background

There are several conceptualisations of patient-centred care, terms such as person-, client- and relationship-centred care are used interchangeably (Hughes *et al.* 2008). Kitson *et al.*'s (2013) synthesis of patient-centred care literature, defined three core concepts including the nurse-patient relationship, patient participation and the influence of context. Other definitions of patient-centred care highlight the importance of the nurse-patient relationship (Ekman *et al.* 2011), emphasising the need for respect (Berwick 2009, Institute for Patient- and Family-Centred Care 2010) and knowledge sharing between the two parties (University of Gothenburg Centre for Person-centred Care 2014). Others have highlighted patient participation as a common element of patient-centred care (Institute for Patient- and Family-Centred Care 2010, University of Gothenburg Centre for Person-centred Care 2014), especially in terms of nurses eliciting patients' experiences (Berwick 2009), preferences and beliefs (Ekman *et al.* 2011) as well as involvement in shared decision-making (McCormack & McCance 2006, Ekman *et al.* 2011). Berwick (2009) takes a more active patient stance, emphasising that patients should lead decision-making in all cases. The importance of context is particularly supported by McCormack *et al.*'s (2010) work, which recognises how certain characteristics need to be present in the environment for patient-centred care to succeed.

Like patient-centred care, patient participation in care has various definitions (Barello *et al.* 2014) and several terms used synonymously for it such as patient involvement and patient engagement (Gallivan *et al.* 2012). Traditional definitions of patient participation have commonly focused on activities like decision-making and management of chronic illness (Longtin *et al.* 2010). The most recent concept analysis of patient participation (Sahlsten *et al.* 2008) provides insight into the complexities of patient participation and how it is practiced. As per Sahlsten *et al.*'s (2008) concept analysis, patient participation has four defining attributes including an established relationship between the patient and nurse, the surrendering of control and power by the nurse, an exchange of information and knowledge with the patient, as well as mutual engagement of the patient and nurse in physical activities and/or clinical communication (Sahlsten *et al.* 2008).

The first attribute, an established relationship, means nurses and patients have to interact and get to know each other (Sahlsten *et al.* 2009) to develop trust and respect (Tutton 2005). For patients, this partnership includes establishing a meaningful dialogue where their wishes and preferences are respected (Eldh *et al.* 2014). Patient participation is facilitated when nurses know their patients and understand their capabilities (Soleimani *et al.* 2010). However, an established relationship is not easily achieved in a fast-paced acute care environment (Tobiano *et al.* 2015b).

For the next attribute, nurses must surrender their control over the patient and give patients responsibility for care. Managing self-care is an example of how patients can gain control and responsibility (Eldh *et al.* 2014). When nurses relinquish power, they need to empower the patient to take control (Sahlsten *et al.* 2008); nurses can help to instil power, knowledge and confidence in patients to enhance their participation (Pelletier & Stichler 2013). However, researchers suggest that relinquishing power appears to be difficult for

nurses, with paternalistic attitudes still evident in practice (Aasen *et al.* 2012b, Aasen *et al.* 2012a).

Exchanging information and knowledge is the third attribute. It is recognised by patients (Eldh *et al.* 2006b) and nurses (Sahlsten *et al.* 2005a) as the basis of patient participation and may enhance patient participation in all nursing activities (Tobiano *et al.* 2015b). Findings on the success of information sharing between patients and nurses are variable, with some researchers reporting a lack of information sharing (Henderson 2003), while others report it to be the most successful type of participation in hospital settings (Tobiano *et al.* 2015b).

Mutually accepted engagement is the final attribute. Researchers suggest patients are often participating less than they prefer (Poochikian-Sarkissian *et al.* 2010, Tobiano *et al.* 2015b) in physical activities such as general hygiene activities (Lomborg & Kirkevold 2008) and medication administration (Penney & Wellard 2007), as well as clinical communication such as decision-making in nursing care (Florin *et al.* 2006). The success of these activities may rely on the nurse's manner, which needs to facilitate full involvement of patients in their care (Barello *et al.* 2014). Overall, nurses (Tutton 2005) and patients (Larsson *et al.* 2011b) consider nurses' support as crucial to instilling confidence in patients to activate and encourage participation.

Many governing bodies in developed countries have committed to improving patient-centred care and increasing patients' rights to be involved in their care (Australian Commission on Safety and Quality in Health Care 2011, National Institute for Health and Care Excellence 2012, American Hospital Association 2014). However, patient-centred care practices, inclusive of patient participation (Kitson *et al.* 2013), are often difficult to implement (Ekman *et al.* 2011), with few clear indicators and guidelines on how to enact it (International

Alliance of Patients' Organizations 2012). Although nurses are in the ideal position to enable patients to participate in their care, little is known about nurses' willingness to engage patients in their care and the reasons why participation is sometimes underachieved.

THE STUDY

Aim

The aim of this study was to explore nurses' views of patient participation in nursing care. The objectives of this study were to investigate nurses' understanding of patient participation, how it was enacted and the barriers and facilitators to it.

Design

This interpretive study was part of a larger ethnographic study on patient participation that included twenty interviews with patients (Tobiano *et al.* 2015a) and 58 hours of observations of nurse-patient interactions. The setting was four wards in one private and one public hospital, located in two different states in Australia. Two medical wards were located at each hospital that included gerontology, immunology, neurology and respiratory medicine wards. Two researchers undertook data collection between November 2013 - March 2014, one at each hospital.

Participants

Across the two hospitals purposive maximum variation sampling of nurses was undertaken. Due to Human Research and Ethics requirements, the nurse unit manager (NUM), or their delegate had to initially approach nurses at both hospitals; researchers were not allowed direct access to nurses. At one hospital, potential participants were invited to attend either group or one-on-one education sessions to hear information on the project, after which they were given the option to take part. Those that agreed to participate signed a

consent form and provided demographic data. Not all nurses who agreed to participate were interviewed because of purposive sampling.

At the second hospital, the NUM or their designate, worked with the researcher to identify nurses with varying ages and levels of experience. The researcher then provided each individual nominated nurse with a verbal explanation of the project and the opportunity to participate. Nurses that agreed to participate signed consent forms and provided demographic data. Inclusion criteria for both hospitals included nurses whose main role was providing direct patient care and who worked regularly in the specific clinical areas.

Data collection

Semi-structured interviews were conducted and audiotaped and lasted approximately 30 minutes in duration. The interviewers were flexible in their approach, interviewing nurses at a time and place of convenience for them. The interview commenced with a pre-written preamble that refreshed nurses of the topic of the interview and their requirements. Nurses were made comfortable by asking general questions about their day prior to commencing interview questions. Both researchers used the same interview guide. The following questions are some examples from the guide:

1. Can you describe what patient participation in patient care means to you?
2. What are some examples of how patients currently participate in their hospital care?
3. What facilitators/barriers to patient participation do you experience in the workplace?

These questions were only used as a guide and were asked in any sequence depending on the nurse's response to previous questions. In addition, interview questions were presented using informal language. For example, question two was sometimes presented as 'Tell me about a time you involved a patient in their care?' The data collectors kept close contact

during the data collection period to ensure interview questions were consistent and to compare initial impressions.

Ethical considerations

Ethics approval was granted by hospital and university human research ethics committees. Nurse participants were provided with a plain language information statement that detailed the study background and their required involvement. Verbal and written explanations were given to nurses about the risks and benefits, their rights, how information would be de-identified and how information would be used. All nurses were given adequate time to consider their involvement and signed a consent form prior to undertaking interviews.

Data analysis

Digital recordings of the interviews were listened to by the researchers who collected the data immediately after the interview and a summary was written (Miles *et al.* 2014). This process enabled common information and gaps in the data to be identified, allowing focus in successive interviews. Interview recordings were transcribed verbatim. Researchers at each site conducted analysis independently, using the same analytic steps. Iterative, inductive content analysis was performed on transcripts, concurrently with data collection, by all researchers. The researchers initially gained an overall sense of the data by reading and re-reading transcripts (Elo & Kyngäs 2008). Line by line coding of the data was conducted and these codes were developed into subcategories and then categories (Elo & Kyngäs 2008). Because the two groups of researchers were located in geographically diverse locations, they then met to review their established categories. Confirmation of categories and subcategories common to both sites was reached by the researchers during an intensive two-day face-to-face meeting; during this process there was an overall agreement that data saturation had occurred and no further interviews were required.

Rigour

Rigour was upheld using qualitative strategies (Lincoln & Guba 1985, Krefting 1991). The interview guide was pilot tested with four nurses, who provided feedback on the questions and initial insights into the topic. The researchers undertaking interviews were reflexive to ensure their experience as nurses did not influence the data. Undertaking initial analysis after interviews, using Miles *et al.*'s (2014) summaries to reflect on the quality and content of interviews, as well as documenting their preconceptions and ideas throughout the analysis process, helped maintain the credibility of the findings. Additionally, using several researchers for data collection and analysis helped confirm aspects of the study. Furthermore, the established categories were presented to a patient advocate who helped understand the implications of the categories from a consumer perspective. Finally, the categories were presented to staff in two participating wards. Both participants and non-participants listened to the findings and shared their views on the interpretations. An audit trail of the process was maintained.

FINDINGS

Twenty nurse participants were included, five from each of the four medical wards. As can be seen in Table 1, the majority of the nurses were female, registered nurses, who had themselves been inpatients on some occasion previously. Nurse participants had been practising for approximately 3.5 years and had worked on the participating medical ward for 2 years. The median age of nurses was 28 years.

The analysis uncovered five categories, including acknowledging patients as partners, managing risk, enabling participation, hindering participation and realising participation (Table 2). Each category will be defined and illustrated with quotes.

Acknowledging patients as partners

Acknowledging patients reflected nurses' acceptance and approval of patients as rightful partners in their care. Most nurses viewed patients as knowledgeable individuals who held insights on areas such as their medication regime, usual daily care routines and capabilities. Nurses demonstrated respect, valuing the wisdom patients held: '...they [patients] know all their medications...they're very okay with their own disease' (N1, RN, > 15 years' experience). Nurses in the private setting tended to identify the patient's knowledge and capabilities for the purpose of helping them to maintain their usual routines.

Additionally, exercising choice was seen as another way for patients to be partners. While the majority of nurses supported patients' right to make choices, such as choosing their level of participation in care, some less experienced nurses appeared less confident in providing patients with choices. Other nurses, emphasized patients' right to refuse care as a way of performing choice: 'If a patient refuses, they have the right to refuse...we get pushed to get them to do things...but no means no...nurses get angry if a patient has not been showered, but if a patient refuses to be showered, that's their right' (N2, RN, 5-10 years' experience). Finally, most nurses felt patients had the right to make choices in their treatment and care. Nurses illustrated their responsiveness to patient choice, by helping patients make informed choices or by being advocates for patients:

... if they [patient] only want one of that tablet we always say 'Why do you want one of that tablet?' Then we can give them one of that tablet and we may take it up with the doctor and say, 'My patient only wants one not two, can you change that?' (N3, RN, 2-5 years' experience).

Managing risk

Although most nurses regarded patients as partners, the same nurses believed there were limits to patient participation. The majority of nurses felt bound by rules and

perceptions of safety concerns when allowing participation to occur. In terms of regulating information, the majority of nurses felt restricted when sharing information with patients due to beliefs of accountability and confidentiality. Nurses at the private hospital were particularly concerned about confidentiality issues related to bedside handover: 'I normally get handover just outside the room, just as much as possible, to make it more discreet' (N4, RN, 10-15 years' experience). In addition, nurses conveyed a sense of management and control around pressure area care and medication administration, providing minimal participation roles for patients: '...medications are a part of care...we are controlling the safety' (N5, RN, > 15 years' experience).

Nursing assessment of the patient and physical environment were key aspects of setting boundaries for patient participation. Most nurses felt they had to gain a level of understanding of their patients' capabilities prior to promoting their participation: '...you have to work within their scope of ability and you have to think about safety at all times' (N6, RN, 2-5 years' experience). Finally, the majority of nurses spoke of managing their own risk by discussing their personal limits. Contextual pressures meant some tasks took priority over participation. Taking the time to guide patients' participation was judged as not always possible due to time constraints and workloads by most nurses: 'We do have a heavy workload and we can't be super nurse' (N7, RN, < 2 years' experience).

Enabling participation

Many nurses of all ages and levels of experience shared their approaches on enabling participation, largely described by the use of various verbal tactics. Ways to promote and encourage participation included relating to patients, whereby humour, introductions and communication was used to create a climate where patients felt comfortable to participate:

I think there's a stigma about hospitals and patients...they [patients] think that they don't have control over their own care ...once you get to know them and build a rapport with them, I always do a bit of a joke with them, like 'You're the boss you have to tell me what you need and I'm here just following orders, you've got your own routine, you're going to do your medications at home.... (N8, RN, 2-5 years' experience).

Notably, having a previously established relationship with the patient made it easier to facilitate this connection. Verbal motivation was seen as a tool nurses used to promote patient independence, with nurses viewing independence as desirable for themselves and their patients: 'Prompt them [patient] ...to be involved...we need to prompt them to be really independent... and explain why that is important, to start [to] walk and to do things for themselves...' (N5, RN, > 15 years' experience).

In addition to motivating patients, providing information was also seen as a way of enabling participation: '...providing them [patients] with knowledge of why you do things. I think that probably helps them understand and makes them more willing and proactive – acknowledge them is the main thing' (N9, RN, 2-5 years' experience).

Hindering participation

The majority of nurses identified certain patient characteristics that hindered opportunities for participation, such as patient attitude. Nurses viewed patients as unique individuals with a variety of attitudes and levels of willingness, who could not be forced to participate: '...we've got to promote [participation] but then again how far can you go with a patient. How stubborn are they? And you've sort of got to treat each case individually' (N10, EN, 5-10 years' experience). Other barriers included patients' status, such as age, how well the patient was and their physical and mental capabilities. For instance, patient cognition

influenced the success of patient participation: ‘... it depends really on the patient’s ability, whether they’re able to do that... there is a chance that patients can participate...depends on how cognitive they are’ (N4, RN, 10-15 years’ experience). These barriers to participation may be related to the study settings. For example, nurses from the private hospital described patients’ cognitive impairment as the most common hindrance, while public hospital nurses stated being clinically unwell was the most common patient barrier. Culture was also viewed as an influencing factor in a small number of cases.

Realising participation

Nurses shared their experiences of participating with patients and realised that participation was enacted in two ways, physically and verbally. Participating in activities describes patients physically taking part in their nursing care, including participating in activities of daily living depending on the patient’s capabilities: ‘We are encouraging them to, as much as possible; to do things for themselves they are capable to, like their hygiene,...showering, dressing, putting clothes, feeding themselves, mobility, grooming and everything like that.’ (N11, RN, > 15 years’ experience). A few public hospital nurses suggested some types of medication were able to self-administered by some patients.

Nurses’ believed patients positively contributed to clinical communication. Patients were able to provide information on a variety of topics such as passing on information from doctors’ rounds that nurses were not yet aware of: ‘There’s been a couple of times I’ve had patients who the doctors have seen in between me reading notes and handover happening...they can...update us on what the doctor said’ (N12, RN, 5-10 years’ experience). Patients asking questions, voicing concerns about themselves and care were also seen as important elements of clinical communication. For instance, nurses believed patients could monitor their medications: ‘... often when we give patients their medications they

know what they're taking and so they'll look at them and go... 'Oh, why do I have this extra one – what's this one for?' (N13, RN, 2-5 years' experience). Additionally, a few nurses believed patients could ensure their own safety verbally, by clarifying information during bedside handover:

...things do get missed at handover...the patient knows and a lot of times they'll know exactly what goes on the dressing...if there's no wound care pathway I won't know what normally goes on it and so normally they'll be able to describe it to me and tell me exactly what goes on the dressing... (N14, RN, < 2 years' experience).

However, some older, more experienced nurses did not always encourage patient participation in bedside handover, believing patients interfered with the flow and that some of their comments were awkward.

DISCUSSION

In this study we explored medical ward nurses' views of patient participation in nursing care. Our findings revealed nurses perceived themselves as accepting and enabling of both physical and verbal participation. However, nurses felt limited by rules, perceptions of maintaining safety and patient characteristics when attempting to enact participation.

The way nurses in our study realised participation resonates with Sahlsten *et al.*'s (2008) concept analysis of patient participation, whereby patients can participate physically and verbally in nursing activities. Nurses in our study identified numerous ways patients could communicate in their care, including patients' verbally participating to improve their safety. Previous researchers have demonstrated nurses' acceptance of patients communicating aspects of their care to improve their safety (Ridelberg *et al.* 2014); a practice that is believed to complement nursing practice (Schwappach *et al.* 2010). Comparable to our findings, other nurses have considered patients intercepting errors during bedside handover to be a facilitator

of patient safety (Kerr *et al.* 2014). Nurses' link between communication and safety may be consistent with traditional patient roles, where information sharing is an accepted form of participation and promoted by clinicians (Schwappach 2010).

The way nurses' in our study perceived participation was a promising finding. Core dimensions of patient-centred care, including respect for patients' expert lay knowledge and autonomy (Hughes *et al.* 2008), were evident in nurses' perceptions. Other researchers have reported patient knowledge to be an essential element of partnering with patients (Hook 2006), which can be used to inform nurses' practice (Allen 2000, Sahlsten *et al.* 2009). This finding was exemplified in our study when nurses acknowledged patients' experiential knowledge and realised patients could contribute to clinical communication. In relation to valuing patient autonomy, others have shown that nurses have a genuine interest in supporting patients' right to choose about aspects of nursing care (Sahlsten *et al.* 2005a); viewing patient choice as the crux of participatory relationships and improving patients' sense of control (Tutton 2005).

Furthermore, nurses in our study appeared to both want and enable patients to participate autonomously in nursing care. For instance, nurses encouraged patients to participate in physical activities such as activities of daily living to maintain higher levels of independence. This resonates with other patients' goals, whereby physical participation in activities is perceived as a way to maintain routine and independence to an extent that the patient can be discharged (Penney & Wellard 2007). Further evidence of aiding autonomy in this study included supporting patients' choices, a practice other health care workers have undertaken by disseminating information (Heggland *et al.* 2014). In our study nurses ensured patients knew the consequences of their choices and elicited and incorporated patients' preferences into action, demonstrating collaborative deliberation (Elwyn *et al.* 2014). Our findings showed that nurses placed importance on informing patients, which reflects traditional

concepts of advocacy where informed consent is a pre-requisite to patients acting autonomously (Goering 2009). Informing patients is believed to promote patient autonomy (Close 2005), participation in hospital care (Sahlsten *et al.* 2005a) and patients' ability to manage their illness (Eldh *et al.* 2006a).

Despite nurses' appreciation for patient participation, conflict exists between enacting the principles of autonomy and beneficence in our findings. Enacting complete autonomy was difficult due to an overwhelming sense of ethical and legal responsibility for ensuring patient safety and well-being. This has been reported in other studies where nurses had a heightened sense of responsibility for managing patients' risk (Schwappach *et al.* 2010, Ridelberg *et al.* 2014) and controlling care (Wellard *et al.* 2003), which can limit the amount of patient participation encouraged (Huby *et al.* 2004). Like our findings, medication administration is an area where nurses found patient involvement to be risky (Lever *et al.* 2008). Soleimani *et al.* (2010) suggests, nurses had to feel confident in patients' knowledge and capabilities prior to engaging them in medication administration, possibly because the consequences of error are greater for both nurse and patient. Conversely, other researchers have implied some nurses do not involve patients in medication administration because they do not realise the opportunity to do so (McTier *et al.* 2013).

Certain patient characteristics were identified as a barrier to patient participation in this study, perhaps reflecting nurses' assessments of patients' ability to be participants. Unmodifiable patient factors are a widely reported reason for difficulties in promoting patient participation (Davis *et al.* 2007). Comparable to our study, patient age (Jewel 1994, Schwappach *et al.* 2010), being clinically unwell (Höglund *et al.* 2010, Kvangarsnes *et al.* 2013, Vaismoradi *et al.* 2014), cognitive and physical impairment (Kolovos *et al.* 2014) and culture (Höglund *et al.* 2010, Schwappach *et al.* 2010) are characteristics other nurses believe hinder patient participation. Additionally, the nurses in our study spoke about patients as each

being unique individuals with varying attitudes towards patient participation that need to be accommodated, a finding confirmed by previous research (Cahill 1996, Höglund *et al.* 2010, Schwappach *et al.* 2010). Acknowledging patients' respective willingness is reminiscent of a humanistic perspective; essential to patient-centred care. Ultimately, nurses have the capacity to judge patients' ability and willingness to participate in their care, owing to their close proximity to the patient (Cole *et al.* 2014).

For nurses in our study, managing busy workloads was seen to influence the success of patient participation. Other nurses have highlighted the restricting effects of ward busyness and heavy workloads (Sahlsten *et al.* 2005b). Previous researchers have suggested nurses feel they have to work within limits when busy (Tutton 2005) and exercise higher levels of control to ensure tasks are completed (Wellard *et al.* 2003). It has been reported that nurses may use 'busyness' as an excuse not to engage patients (Henderson 2003). Henderson's (2003) observations of practice revealed even when nurses were not busy; they did not attempt to engage patients and encourage them to participate. It would be important to conduct further observations of practice to determine the difference between nurses' perceptions and behaviours of busyness and the influence it has on patient participation.

Interestingly, participants in our study saw their role as the facilitator to patient participation, which is consistent with previous research (Tutton 2005, Höglund *et al.* 2010). Consistent with data from other studies, nurses use relational skills to enable participation including communicating, relationship building and encouragement (Sahlsten *et al.* 2005a). In particular, encouragement is viewed by nurses as essential to getting patients to participate (McTier *et al.* 2014), especially in activities perceived as more challenging (Davis *et al.* 2007). It is appealing that nurses in our study recognised their ability to directly influence patients' participation, as nurses' actions are essential to the success of participation

(Vaismoradi *et al.* 2014, Tobiano *et al.* 2015b) and can trigger patients to engage in their care (Pelletier & Stichler 2013) to enhance their own safety (Hor *et al.* 2013).

Limitations

We recognise this study has both strengths and limitations. In terms of strengths, we recruited from two hospitals, one public, one private, in two states in an attempt to gain a wide range of experiences. Most participants were female and registered nurses, which reflects current acute care hospital staffing patterns. Interestingly, participants did not identify any nurse related characteristics as hindrances to patient participation in our study, even though some researchers eliciting patients' perceptions of participation have identified nurse related issues (Larsson *et al.* 2011a, Aasen *et al.* 2012b, Nygårdh *et al.* 2012). It may be that social desirability bias influenced nurses' self-reported accounts. However, the rigorous methods we undertook for analysis, the reoccurrence of patterns in the data and divergent cases identified, helps confirm the findings. On the other hand, there is a push for hospital nurses to act in a patient-centred manner, which may have influenced the findings. The findings are not intended for generalisation but rather conceptual understanding; dense descriptions of the setting and sample have been provided which strengthens our study, allowing readers to judge applicability of findings to their own setting and practice.

Implications

The findings from this study have implications for practice, education, policy and research. Given patient-centred care, which encompasses patient participation, is documented in national and international policies, nurses clearly have a central role in its promotion. Reflection on their own practice may make nurses aware of their current approach towards engaging patients, which can lead to nurses acknowledging patients' role in nursing care and a more patient-centred manner (McCormack & McCance 2006). After assessing patients'

capabilities, willingness and risks, nurses need to tailor their approach to respond to them (Tutton 2005, Sahlsten *et al.* 2009). Practice policies may benefit from review to clarify patient roles in hospital activities; allowing nurses to feel confident in giving patients more independence. Along with policy, a communication strategy will facilitate better understanding.

Undergraduate programs and continuing education for nurses should include theories and research on patient-centred care practices such as patient participation, as nurses need to be aware of this evidence if they are to enable it. This study highlights the importance of teaching effective nurse-patient communication skills such as being patient-inclusive, building rapport and sharing information (O'Hagan *et al.* 2014); key approaches identified by the nurses in this study. Ongoing research to substantiate the effectiveness of nurses' described approaches that facilitate participation and investigating ways to promote or implement these approaches would be beneficial.

CONCLUSION

Nurse participants in the study highlighted the importance of the nurse's role in facilitating patient participation. Nurses disclosed some strategies that promoted patient participation. These approaches appeared to be respectful and empowering of patients, which are key characteristics of patient-centred care. Adoption of these strategies may underpin the success of patients' enactment of participation in hospital nursing care. Yet, the nurses' role in enabling participation is challenging, having to balance patient participation in perceived safety and legal parameters and patients' abilities and preferences. These complexities need to be considered when assessing nurses' actions associated with promoting patient participation.

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Figures and tables:

Table 1 Nurse demographic data

Characteristics	n (%) n=20	Median (IQR) Range
Age (years)	-	28.0 (20.3) 22.0-67.0
Female	15 (75)	-
Work in private sector	10 (50)	
Classification:		
- Registered nurse	15 (75)	-
- Endorsed enrolled nurse	1 (5)	-
- Enrolled nurse	4 (20)	-
Experience in classification (years)	-	2.8 (4.1) 0.2-14.0
Experience as nurse (years)	-	3.5 (11.6) 0.2-30.0
Time on ward (years)	-	2.0 (5.1) <1.0-20.0
Hours work per fortnight	-	64.0 (32.5) 16.0-80.0
Have previous experience as a patient	15 (75)	-

Table 2 Nurses' views of patient participation

Category	Subcategory
Acknowledging patients as partners	<ul style="list-style-type: none"> - Respecting patients' knowledge - Honouring patients' choices
Managing risk	<ul style="list-style-type: none"> - Regulating information - Managing medication - Controlling pressure area care - Assessing environmental safety - Gauging patient capability - Recognising own personal limits
Enabling participation	<ul style="list-style-type: none"> - Relating to patients - Encouraging independence - Informing patients
Hindering participation	<ul style="list-style-type: none"> - Patient attitude - Patient status - Patient culture
Realising participation	<ul style="list-style-type: none"> - Participating in activities - Contributing to clinical communication