

Strategies and lessons learnt from user involvement in researching quality and safety in nursing homes and homecare

Strategies,
rationales and
lessons

Ingunn Aase, Eline Ree and Terese Johannessen

University of Stavanger, Stavanger, Norway

Elisabeth Holen-Rabbersvik

Kristiansand Municipality, Kristiansand, Norway

Line Hurup Thomsen

Stavanger Kommune, Stavanger, Norway

Torunn Strømme

University of Stavanger, Stavanger, Norway

Berit Ullebust

Sogn og Fjordane County Municipality, Leikanger, Norway

Lene Schibevaag and Hilda Bø Lyng

University of Stavanger, Stavanger, Norway

Jane O'Hara

University of Leeds, Leeds, UK, and

Siri Wiig

*SHARE – Centre for Resilience in Healthcare, University of Stavanger,
Stavanger, Norway*

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Abstract

Purpose – The purpose is to share strategies, rationales and lessons learnt from user involvement in a quality and safety improvement research project from the practice field in nursing homes and homecare services.

Design/methodology/approach – This is a viewpoint paper summarizing how researchers and co-researchers from the practice field of nursing homes and homecare services (nurse counsellors from different municipalities, patient ombudsman and next-of-kin representatives/and elderly care organization representant) experienced user involvement through all phases of the research project. The project included implementation of a leadership intervention.

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Findings – Multiple strategies of user involvement were applied during the project including partnership in the consortium, employment of user representatives (co-researchers) and user-led research activities. The rationale was to ensure sound context adaptation of the intervention and development of tailor-made activities and tools based on equality and mutual trust in the collaboration. Both university-based researchers and Co-researchers experienced it as useful and necessary to involve or being involved in all phases of the research project, including the designing, planning, intervention implementation, evaluation and dissemination of results.

Originality/value – User involvement in research is a growing field. There is limited focus on this aspect in quality and safety interventions in nursing homes and homecare settings and in projects focussing on the leadership' role in improving quality and safety.

Keywords User involvement in research in nursing home and homecare, Leadership, Patient safety, Quality improvement

Paper type Viewpoint

Background

Research exploring quality and safety healthcare interventions often appears straight forward, well planned and executed, and managing all eventualities (Aase *et al.*, 2021). However, it is often challenging to translate research evidence into healthcare practice (Straus *et al.*, 2013). There have been several suggestions on how to bridge the gap between research and practice, such as the “Researcher-in-Residence” model where researchers are a part of the healthcare delivery team in which the research is being conducted (Marshall *et al.*, 2014). Outside of advocating a particular model, using a participatory approach in the research design with close collaboration and shared reflections between researchers and practitioners, can result in co-creation of knowledge and shows promise as a mechanism for bridging the gap between research and practice. In our “Improving Quality and Safety in Primary Care – Implementing a Leadership Intervention in Nursing Homes and Homecare” (SAFE-LEAD) project, we used multiple strategies of user involvement in research to support the implementation of a quality and safety leadership intervention in Norwegian nursing homes and homecare services, with healthcare professionals' integral to the research team (Aase *et al.*, 2021; Johannessen *et al.*, 2019).

User involvement in healthcare has traditionally been focussed on involvement in one's own care and treatment (Tritter, 2009; Brett *et al.*, 2014) or to improve the quality and safety of healthcare services (Sutton *et al.*, 2015; Renedo *et al.*, 2015; Bergerum *et al.*, 2020). However, user involvement is increasingly being seen in a more nuanced and expansive way, with both researchers and practitioners exploring the myriad of roles for users in research (O'Hara *et al.*, 2019a, b; Tritter, 2009; Staley, 2015; Malterud and Elvbakken, 2020). This varies from being involved in patient and stakeholder advisory boards, providing input to research proposals, active involvement as co-researchers in parts or phases of projects in data collection, to being involved throughout the entire research process (Staley, 2015; Vindrola-Padros *et al.*, 2017; Garfield *et al.*, 2015). A review of the literature about embedded research in quality improvement pinpoints how different strategies have been applied to foster knowledge coproduction. These strategies focus on partnerships between academic researchers and healthcare organizations and stakeholders. These types of strategies imply that the partnerships serve as boundary spanning roles and knowledge brokers when establishing links between academic and practice-based organizations. Such embedded research has the potential to strengthen understanding of organizational culture, focus research appropriately, secure engagement from staff in the organizations and to contribute to translate research into practice (Vindrola-Padros *et al.*, 2017). Previous research has also demonstrated that involving users as co-researchers in implementation programmes seems to have a positive effect on individual-level motivation and meaning making (Vaughn *et al.*, 2018) as well as on organizational outcomes (Collins and Holton, 2004), especially if the programmes are integrated into the organizational culture (Amagoh, 2009).

In our previous research outlining “tips for success” in intervention studies, we highlighted the advantage of including the expertise of co-researchers to ensure the context-specific competence that was required (Aase *et al.*, 2021). The purpose of this paper is to elaborate on these findings and share our viewpoints, rationales and lessons learnt from the co-creation of the research process between researchers and co-researchers and from involving diverse users and user representatives at different stages of the research process by using a variety of activities and strategies (Staley, 2015; Vindrola-Padros *et al.*, 2017; Garfield *et al.*, 2015; Marshall *et al.*, 2014). These reflections have arisen from the five-year SAFE LEAD project (Wiig *et al.*, 2018). Our approach was to promote user involvement in research – including involvement of users from the practice field – throughout all phases of the research project, from the design, planning, intervention implementation, evaluation and dissemination of results.

In the following, we present our study setting and our strategies and experiences from user involvement in the different research phases.

Study setting, co-researcher participants and intervention

The SAFE-LEAD research project (2016–2021) includes a 12-month intervention study consisting of the implementation of a research-based dialogical leadership tool (the SAFE-LEAD guide) to support managers in nursing homes and homecare services in their quality and safety improvement work. The guide included a three-step process where the managers started by rating their organizations on seven common quality challenges (Step 1), made specific goals related to the challenges they chose to focus on in their quality improvement work (Step 2) and then made specific quality improvement action plans (Step 3) (see Figure 1). The intervention programme consisted of online video lectures and workshops with the management teams, where researchers facilitated use of the guide, including discussions and work processes (Wiig *et al.*, 2018; Johannesen *et al.*, 2019; Aase *et al.*, 2021).

The SAFE-LEAD project has adopted a broad perspective on user involvement and in its inclusion of who is considered as a user in the project. We use the concept “user involvement in research” when we refer to different strategies adopted in this study. Our conceptualization of “user” is integrating (1) potential users of the SAFE-LEAD guide (leaders); (2) patients and users of services and their next of kin as according to the Norwegian Patient and User Rights Act (1999) and (3) stakeholder representatives from the service field such as representatives in the development centres for nursing homes and homecare and the Patient Ombudsman.

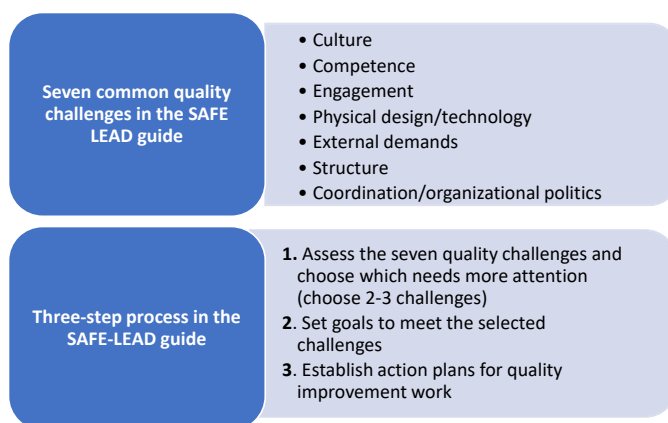


Figure 1.
SAFE-LEAD guide

The co-researchers when referred to, have different roles and affiliations and are mainly professionals with practice experience in the field, but also next of kin representatives. Both the co-researchers who are partners in the project and are paid to contribute, as well as managers who are end users of the guide, are involved and considered as users or user representatives in this study. As this project focuses on managers and their role in quality and safety improvement, we considered healthcare professionals with current or present experience with management roles in nursing homes and homecare, as key users. Moreover, patients and next of kin, and their representatives were also considered users. Hence, several perspectives and representatives were relevant for user involvement in our research project. In line with the literature on user involvement in research (e.g. [Vindrola-Padros et al., 2017](#); [Marshall et al., 2014](#); [Staley, 2015](#)), critical issues regarding power dynamics between the co-researcher and the researcher, and the empowerment of the co-researcher were included and continuously illuminated in discussions and reflections that took place in our regular meetings throughout the project period.

A total of seven co-researchers were part of the research team in the study (see [Table 1](#)). The co-researchers were nurse counsellors from different municipalities and next-of-kin representatives (one next-of-kin and one elderly care organization representative). Three of the co-researchers (EHR, LHT and BU) have co-authored this paper. The recruitment of study participants from Norwegian nursing homes and homecare was conducted in collaboration with two centres for development of institutional and homecare services and one municipality in South-West Norway. Two centres for development of institutional and homecare services were involved in the project development and application for funding. The Patient Ombudsman – which is subordinate to the Norwegian Directorate of Health – was a partner in the project from the start. In addition, three municipalities were project partners. Norwegian municipalities are responsible for providing nursing home and homecare services to their citizens and were therefore central partners in our intervention study (see [Table 1](#)). The application for funding to the Research Council of Norway included funding for one full-time position (over four years) for co-research which we divided into part-time positions that enabled a diversity in occupational, leadership and educational backgrounds and experiences amongst the employed co-researchers. There was no attempt to exploit the payment of the co-research to influence results. Payment was done to compensate for part-time engagement from those with limited involvement (implying payment for each hour of engagement based on a standard hour rate), while contracts with institution or direct employment at the

User-representative	Affiliation
3 Nurse counsellors (1 having the role as head of development and research)	Centre for developing institutional and homecare services
1 Nurse manager	Head of centre for developing institutional and homecare services
1 Next-of-kin representative	Long experience as wife of husband with early dementia in need of healthcare services from the entire healthcare system (primary, secondary, tertiary care)
1 Patient and user ombudsman	The patient and user ombudsman is subordinate to the Directorate of Health. The ombudsman has an independent role in supporting patients and users who find it difficult to safeguard their own interests. There is an ombudsman in each county
1 Senior representative	Representing a national interest organization for the elderly population
<i>Total 7</i>	

Table 1.
Participating
co-researchers

university were done with those co-researchers representing partners in the project consortium.

User involvement strategies and experiences

In this section, we describe our diverse strategies and lessons learnt from user involvement in research in the SAFE-LEAD leadership intervention study. We divided our project in four phases: (1) project development planning, (2) intervention design and pilot testing, (3) intervention implementation and (4) evaluation and dissemination. An overview of the phases and diverse strategies is given in [Table 2](#).

Phase 1: Project development and planning

In this phase, the project proposal was developed, and the project activities were prepared for execution. This comprised forming the research team and consortium, developing the

Project phases	User involvement strategies	Involved co-researchers
Project development and planning	Partnership with municipalities	3 Nurse counsellors from centre for developing institutional and homecare services
	Employment of co-researchers	1 Head of centre for developing institutional and homecare services
	Involvement in translation and context adaptation of leadership guide and design	1 Patient and user ombudsman
Intervention design and pilot	Establishment of a group of co-researchers with varying competence and involvement	1 Senior representative
	Co-researcher contribution in recruitment of sites	1 Next-of-kin representative
		3 Nurse counsellors from centre for developing institutional and homecare services
	Involvement in further context adaptation of leadership guide	1 Head of centre for developing institutional and homecare services
	Involvement in context adaptation of intervention design and programme	1 Next-of-kin representative
	Involvement in development of a context mapping tool for primary care (safe-lead context)	1 Patient and user ombudsman
	Involvement of local site managers in pilot-testing	1 Senior representative
Intervention implementation	Involvement in design and development of learning material (next-of-kin in film)	
	Intervention teams established with a combination of competence from university-based researchers and co-researchers	3 Nurse counsellors from centre for developing institutional and homecare services
	Co-researcher involvement in data collection and analysis	1 Head of centre for developing institutional and homecare services
Evaluation and dissemination	Involvement in context mapping	
	Co-researcher led evaluation of the context mapping tool	3 Nurse counsellors from centre for developing institutional and home care services
	SAFE-LEAD light – co-researcher driven testing together with team	1 Next-of-kin representative
	Joint presentations and dissemination activities	

Table 2.
Project phases and
belonging user
involvement strategies

detailed project plan and establishing the overall framework and tools that were going to be used in the intervention (Wiig *et al.*, 2018).

The SAFE-LEAD guide – which was implemented in our intervention – is based on the QUASER Hospital Guide (Quaser, 2013). The first project activity included the translation of the English QUASER guide version into Norwegian by a professional translation service. Further language adjustments and adaptation of the leadership guide from the hospital setting to the Norwegian nursing home and homecare setting were conducted in collaboration with the researchers, co-researchers in the project and with future users of the guide (managers from nursing homes and homecare). The development process lasted from November 2016 to November 2017.

In the development and planning phase of the project, an important strategy was to develop sound partnership with the municipalities and to establish formal employment with the co-researchers. It was important to involve a group of co-researchers with varying expertise and backgrounds in the project. The co-researchers contributed to the contextual adaptation of the guide to the Norwegian nursing home and homecare setting, and in the designing of the intervention. In this phase, the co-researchers and the university-based researchers together made modifications to the guide, obtained feedback on language, format and content, and we had monthly meetings with the co-researchers/team meetings, a total of 17 h (1.5 h × 12). In these meetings, the three nurse counsellors (co-researchers) participated. In addition, we conducted two workshops with the entire SAFE-LEAD partner consortium including seven researchers and all seven co-researchers ensuring sound user involvement with perspectives from the senior representative, the next-of kin representative and the user ombudsman to adapt the guide to the context (see Table 1). Here, the structure and the content of the guide were discussed in addition to brainstorming about intervention design to serve the purpose of supporting managers in their quality and safety work. In addition, nursing home and homecare managers were recruited and provided their input to the research team, as future users of the guide (Johannessen *et al.*, 2019).

From the co-researchers' perspective, the importance of being involved from the beginning of the project was highlighted. This was echoed by the university-based researchers. Co-researchers involved in the research team provided input from their clinical practice and were central in the discussions and planning related to preparing the intervention. Physical meetings were positively experienced in this early phase, while digital meetings worked well when being familiar with the research team. In this phase, we had some challenges making appointments for all to meet. Involving co-researchers in all regular project meetings implied a larger number of participants in the research team, more coordination in the research and could be considered more time-consuming.

Phase 2: Intervention design and pilot

In the second phase, the SAFE-LEAD intervention programme and content were designed with significant involvement and input from co-researchers and end users in municipalities. It was pilot tested for feasibility in two organizations located in the same urban Norwegian municipality (Johannessen *et al.*, 2019). The pilot testing lasted three months. One of the co-researchers from the Centre for Development of Institutional and Homecare Services in the municipality recruited the study sites. The organizations chosen for the pilot test were one large nursing home and one large homecare service, which tested both the SAFE-LEAD guide and the intervention programme. In the pilot, management teams were involved, and the SAFE-LEAD intervention and guide were tested by these management teams. The feedback from the management teams in the pilot was central in adapting the guide to the nursing home and homecare context. This was also a way to optimize the guide and intervention design with real users.

Our strategy in this phase was to let the co-researchers contribute to recruitment of sites. The co-researchers also contributed with contextual adaptation of the leadership guide and context adaptation of the intervention design and programme. The main rationale was to ensure relevance to the target group. Further, design of the intervention programme included developing videos illustrating scenarios where the actors played managers using the guide in their work practice to demonstrate possible use of the three phases of the SAFE-LEAD guide. University-based researchers acted in the videos, in addition to the next-of-kin representative who contributed to the scenario design and as actress in one video playing the role a next of kin. The role was inspired by lived experiences with an early dementia-harmed husband experiencing too many healthcare professionals arriving from the homecare services.

Furthermore, a key task in this project phase was developing a specific context mapping tool tailor-made to map contextual aspects in municipalities and the settings of nursing homes and homecare (Wiig *et al.*, 2019). In this work, the co-researchers' experiences and competences were key to ensure identification of contextual aspects and relevance of the tool, as this was the first tool in the literature taking these settings into account. Several workshops involving co-researchers and university-based researchers were conducted, and the context mapping tool went through several iterations, based on the variety of input (Wiig *et al.*, 2019).

In this phase, the three most involved co-researchers had been fully integral to the research team and involved on a regular basis for over a year. The project had operated with a clear vision of all members being equal in the team and focussed on an atmosphere of mutual trust and enthusiasm over the variety of knowledge and competence. The co-researchers experienced it as highly inspirational to participate in this phase. One of the key benefits identified was the ease of access for the research team to the field and participants. The co-researchers were familiar with the nursing homes and homecare services, making the recruitment process easier. However, connecting different professions during the intervention design and pilot entailed some challenges as it took time to involving all, the language had to be adapted and some training regarding how to implement the SAFE-LEAD guide was needed.

Phase 3: Intervention Implementation

In Phase 3, we implemented the intervention programme. All intervention teams took responsibility for one study site over the entire intervention period of either six or 12 months. The intervention programme was centred on implementing the SAFE-LEAD guide in management teams through workshops, support material and quality improvement work (Johannessen *et al.*, 2019). The content and procedures involved in this intervention were designed and developed in close collaboration and through multiple meetings with the co-researchers in the research teams in the previous phases and were therefore well-known to all intervention team members. We intentionally composed intervention teams of two persons with a combination of competences. There was one co-researcher from the practice field and one university-based researcher working together with the management team over time. The co-researchers were involved in both data collection and analysis and were central for speaking the same language and reducing the distance between research and practice. In the intervention phase, the next-of-kin representative, paid and unpaid co-researchers were not included, as this phase required prolonged engagement in the field and could not be expected from any representatives working full time outside the project. In hindsight, involvement of all co-researchers could have been solved by for example presenting finding in workshops and meetings to get input and further reflection.

The co-researchers experienced being part of the intervention as very useful, rewarding and educational both for them as individuals but also for their organizations. The dynamics between co-researchers and academic researchers contributed to the ease of implementation of

the intervention and contributed to honest feedback during interviews and intervention workshops. From the co-researchers' perspective, they knew the field of practice and assumed they could build a bridge between practice and academia, just as a researcher knew academia and could build bridges and insights into how researchers work. This combination created more validity and usefulness for the development of a leadership guide to be used in practice.

The co-researchers also highlighted a sense of commitment to participating in the workshops and to be a part of the whole SAFE-LEAD study, since the researchers from the university came to their practice field and contributed with their competence in quality improvement. This reduced the distance between the practice field and the research environment in this project. Co-researchers contributed to discussions and reflections before and after the workshops together with the academic researcher in their intervention team. This contributed to better interpretation of the intervention activities. The combination of academic researcher and practice-based co-researcher created a good dynamic within the focus groups, where the interviewers were largely able to complement each other in questions. The challenges regarding adapting language were smaller in this phase of the project, compared to the previous phases. The researchers and co-researchers had trained and agreed upon what to ask about before they conducted the focus group interviews. During the entire intervention phase, the research team gathered monthly to discuss experiences from the different intervention activities on the intervention sites. The reflections during these meetings combining the perspectives from the academic and co-researchers contributed to a more nuanced understanding of the response from the involved intervention sites, in addition to identification of possible adaptations that were required to adapt the intervention to the context and management challenges faced in each site (Aase *et al.*, 2021).

Phase 4: Evaluation and dissemination of results

In the evaluation and dissemination phase, the project analysed the results and developed varying ways of communicating these to different audiences (academia, practice field, policy makers, public). The three co-researchers from the Centre for Developing Institutional and Home Care Services were taking an active part in this phase. As described earlier, the project created a context mapping tool during the development phase (Wiig *et al.*, 2019). This tool was evaluated with co-researchers at the forefront of this. The co-researchers had the main responsibility for this process which resulted in a paper in which they were first authors (Holen-Rabbersvik *et al.*, 2020). In addition, co-researchers were involved in other data analyses (e.g. reading transcripts, commenting on paper drafts); they were co-authors on several academic peer review papers and contributed with presentations on conferences, seminars and courses. For example, the next-of-kin representative participated in a presentation at a national carer conference, in addition to participating in teaching and sharing experiences of participating in research projects. The next-of-kin representative also wrote a book in which she has shared experiences of being a co-researcher (Pedersen and Kvalheim, 2018). The fact that the co-researchers were involved in the analyses and writing process as well as dissemination of results, contributed to raising competence for the co-researchers themselves, as well as for the municipalities, and for the university-based researchers. In addition, trustworthiness in the analyses and interpretation of the results is an important aspect in this setting and was positively influenced by the thorough co-researchers' involvement.

Furthermore, in this phase, the co-researchers in the team took the initiative to conduct what was titled the "SAFE-LEAD Light" intervention together with the research team. This limited version of the SAFE-LEAD intervention was conducted as a dissemination activity in 2020 in the form of two-half day online workshops where participants got access to the entire intervention programme material including the paper-based and web version of the SAFE-LEAD guide, studio lectures, instruction and case videos. One of the co-researchers was

responsible for this activity in collaboration with the university-based researchers. A total of 70 managers participated from the region of one of the centre for development of nursing home and homecare services that was part of the project. The participants in the SAFE-LEAD Light intervention also conducted an evaluation of this way of implementing the intervention, which gave valuable insight into interventions with low degree of researcher involvement and resources used. The SAFE-LEAD Light is being repeated in 2021 with similar number of participants.

The co-researchers had a positive experience of being given responsibility for specific research tasks, both in evaluation activities, writing research papers and in developing and running the SAFE-LEAD Light programme. Their contributions led to a common understanding of the area being worked on, where the final product (the guide, intervention programme, peer review articles) has been developed through co-creation between academia and the field of practice.

Discussion

In this viewpoint paper, we have shared our diverse strategies, reflections and lessons learnt from user involvement in research through all phases of a quality and safety leadership intervention study in nursing homes and homecare in Norway. In line with previous research on user involvement in research (e.g. [Marshall et al., 2014](#); [Vindrola-Padros et al., 2017](#); [Garfield et al., 2015](#); [Brett et al., 2014](#)), multiple strategies were used (e.g. partnership, co-researchers, user-led research), and both university-based researchers and co-researchers experienced it as useful and necessary to involve or being involved in all phases of the research project.

Taken together, these reflections on the experience of and value for the role of user involvement in the research process can be broadly brought together into three key issues: (1) legitimacy, (2) access and (3) insight. In line with previous research exploring patient and public involvement, these three themes are key factors to reflect on. For example, [Brett et al. \(2014\)](#) concluded that patient and public involvement had positive impacts and enhanced the quality and appropriateness of the research in health and social care ([Brett et al., 2014](#)). [Howe et al. \(2017\)](#) illuminated the importance of learning to work together with public involvement to enrich the process and the outputs in research project. This is also in line with the review of [Vindrola-Padros et al. \(2017\)](#) who found that embedded researchers, with dual role as researchers and practitioners, can use their presence and relationships to facilitate meetings, share knowledge and build trust in the interface between the academic and practice organizations in co-producing knowledge. However, there may be a “dark side” of coproduction if the costs outweigh the benefits for health research. This means that there is a need for a more reflective and open discussion exploring when to undertake coproduction, the ethics of coproduction, as well as how coproduction influences the research process ([Oliver et al., 2019](#)). We agree with [Williams et al. \(2020\)](#) that careful planning and execution should ensure sound academic practice in the field. Our experience is that it takes some training and interest in learning across academics and the practice field to develop such good collaborative work practices. In our project, this was accommodated and promoted by the egalitarian and utilitarian potential of co-produced research. Open dialogue and respect were keys. However, ethical considerations along the entire project period were fundamental. These included particular reflection on the ongoing power differential between researchers with formal training, academic degrees and positions in research, and the practice-based co-researchers with potential research educational needs when entering the project. We provided basic training on the research process in the initial phase and in particular investigated time on the project’s procedures for identification and observation of misconduct in practice while doing observation. The procedures for handling malpractice were discussed in project meetings to ensure a sound foundation for being involved in the research activities.

Focussing on *legitimacy*, our study experiences suggest that use of diverse strategies of user involvement in research, and in particular the specific and visible role of co-researchers, served to legitimize the research for those working or living in the nursing homes and homecare settings. Our co-researchers were employed in these settings and knew both the people and the organizations. All the employed co-researchers had experience of management roles within healthcare, which further contributed to the legitimization and value of this research project. The strategies of involving next-of-kin, senior representatives, the Patient Ombudsman, and real end user managers in the design and development of the intervention programme also ensured sound context adaptation of the study in the nursing home and homecare setting, supporting the implementation and likely success of the research.

Regarding *access* to the research field in the nursing homes and homecare, the co-researchers served to effectively “smooth” some of the challenging tasks such as site recruitment. By knowing local needs and by identifying potential problems ahead of time, the research team could make minor changes to the plan in advance of implementation. Further, co-researchers were able to gain access more easily to the field, as well as ensure proper follow up over the course of the research process.

The project employed diverse strategies of user involvement in research over the different phases. These included involvement in planning and partnership in the consortium, through to co-researchers who were integral to the research team, and involved as paid researchers by the project with regular participation, as well as representatives participating on a less frequent basis. An early challenge in the project was to recruit all the co-researchers. In hindsight, it is easy to see that this was perhaps somewhat insufficiently planned. A clearer strategy and relations could have been developed and established when the project proposal was submitted to the Research Council of Norway. We therefore adopted a strategy where the seven co-researchers were involved in different ways. In our research project, one can separate between those who were employed and those who were not but represented a project partner or were representatives from next-of-kin or senior users. The employed co-researchers were involved to a greater degree from the start to the end, while the project partners and representatives were involved during the planning phase and pilot phase but less in the intervention and evaluation phases. This was due to practical issues as fewer scheduled meeting points for next-of-kin representative than the paid co-researchers which were involved through all project phases.

Finally, our experience from the five-year project is that user involvement in research creates additional *insight* for the research and the research team. It is likely that the diverse strategies of user involvement in our research contributed to increase the relevance of the research and sound context adaptation of the guide development and intervention programme. This is also shown in the interest in the ongoing SAFE-LEAD Light programme, which may also indicate a way of ensuring sustainability over time. Our results echo those of others showing stronger relevance and better translation of research into practice due to the adopted strategies (Vindrola-Padros *et al.*, 2017). The competence and context-specific experiential knowledge gained from co-researchers and taking advantage of the diverse strategies of user involvement in research, strengthened our research process (Staley, 2015).

In addition to their important role in research planning process, the co-researchers strengthened the interpretation of the findings through their contextual understanding and expertise. By having knowledge about managerial and clinical procedures, as well as being familiar with the professional language in the practice field, they were able to bridge the academic and healthcare professional practice communities involved in a quality and safety leadership study in nursing homes and homecare (Aase *et al.*, 2021). We did not experience any tensions either between the involved university-based researchers and the co-researchers

or the academic and the healthcare practice field in this study. A clear co-design philosophy and project management approach of seeing all team members as equal researchers with a specifically needed competence in the project were keys to succeed in our strategies of user involvement in research.

Key learning points

- (1) Involving users with varying perspectives and experiences from the practice field in research project is an important measure for bridging the gap between research and practice in all phases of a research project.
- (2) In the planning and design phase of the SAFE-LEAD project, the involvement of the co-researchers with diverse perspectives facilitated partnership with and recruitment of participants in the project and provided useful feedback on the design of the intervention.
- (3) During intervention implementation, the co-researchers played an important role as part of the intervention team, bridging the gap between the practice field and research and thereby ease the implementation process.
- (4) Some challenges were encountered along the project such as time spent getting all participants involved, joint meetings and to adapt language.
- (5) In evaluation and dissemination of our findings, the co-researchers had an active role through co-creation with academia. The co-creation amongst researchers and co-researchers resulted in a broad perspective in the evaluation phase, and dissemination to a broader audience close to the practice field.

In our view, user involvement in research needs a broad approach on representation and perspectives and has the potential to improve the research quality, relevance and contribute to mutual competence building in academia and in the practice field of leading quality and safety in nursing homes and homecare.

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Corresponding author

Ingunn Aase can be contacted at: ingunn.aase@uis.no