

# Registered nurses' opinions about patient focused care

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## KEY WORDS

Patient focused care, nurse opinions, nursing care delivery model, management

## ABSTRACT

### Objective

The aim of the present study was to investigate registered nurses' (RN) opinions about the organisational change to patient focused care (PFC).

### Design

A qualitative explorative design and an interview guide with open-ended questions were used.

### Setting

One ward at a university hospital

### Subjects

Six female registered nurses

### Main outcome measure(s)

The interview questions included items about 'experiences of PFC', 'experiences of one's own professional role' and 'opinions about the quality of care in the model'.

### Result

All of the interviewed nurses at the ward had overall positive attitudes towards PFC and felt the care model could facilitate nursing practice. The interviewees emphasised, however, that if one is to make a fair evaluation, more experience of working with PFC as well as total implementation of the model is needed. The interviewees did report positive effects of PFC, which they believed gave all employees at the ward greater motivation to work towards continuous development.

### Conclusions

The RNs in the present study had overall positive attitudes towards PFC and felt the care model could facilitate nursing practice. The present study illustrates nurses' experiences of working at a ward that uses PFC as its organisational form, and this knowledge is valuable to nursing managers who are considering organisational changes. The interviewed nurses found that PFC had many advantages and that the organisational form could therefore be suitable in several clinical settings.

## INTRODUCTION

An organisational model at the ward level called PFC has become quite popular in Sweden during the past decade and has been introduced on many wards (Landstinget i Värmland 2010). However, few evaluations have been made of how the model works. The purpose of the present paper was to report on a study investigating RNs' opinions about working according to a model of PFC in a university hospital ward in Sweden. The paper begins with a description of the concept of PFC. Thereafter follows a short review of previous studies.

### Patient focused Care (PFC)

PFC originated in the United States of America (USA), where it was developed at Henry Ford Hospital in Detroit at the end of the 1980s. The goal of PFC is to improve care by increasing the time spent on direct nursing care and decreasing the costs of care. Professionals are encouraged to provide more individualised service that responds to each patient's unique concerns and needs (Seago 1999). The development of PFC has thereafter increasingly focused on the patient and is today regarded as a holistic care philosophy, in which the patient is seen in a comprehensive perspective (Jenner 1998). PFC is practised in several hospitals in the USA, the United Kingdom (UK) and Australia. However, there is no specified PFC model; rather each hospital frames its own. According to one common holistic care philosophy, three concepts are central: communication, continuity and congruence (Irwin and Richardson 2006). The foundation of PFC can be traced back to Florence Nightingale, who emphasised nursing care and focused on the patient instead of the illness (Lauver et al 2002).

PFC implies a shift from a task- and routine-based organisation with hierarchical structures, to an organisational model that facilitates more and closer contact with each patient. Having responsibility for fewer patients means the care provider can have closer contact with his/her patients. In PFC, care professionals are encouraged to provide more individualised care that responds to the unique concerns, needs, and wishes of the patient and

families (Mitchell et al 2000). The purpose of PFC is also to promote a more equitable patient-care provider encounter and to encourage the patient to participate more in his/her own care (Irwin and Richardson 2006). Lathrop (1991) suggested that PFC improves continuity in care and empowers staff to plan and execute their work in ways that are most responsive to patients' needs.

### PFC in Sweden

The PFC organisational model was described in an article in a Swedish journal (Landstingsförbundet 1998). A Swedish head nurse became interested in the model and introduced a modified version of it on a surgical ward. She introduced the model because she had experienced shortcomings in care, too little time for patients, and too many routines (Carlsson and Inde 2006; Inde 2007, Landstinget i Värmland 2010).

In Sweden, PFC is characterised by its aim: to increase staff members' time for patients and their possibility to come closer to patients. To enable this, RNs are relieved of a great deal of administrative work, which instead is transferred to a receptionist or coordinator. This person is responsible for the ward's communication function, all the paper work concerning patients and the distribution of incoming phone calls to the appropriate nurse. The RNs and assistant nurses work in care pairs; they plan, prioritise and allocate the work together, prior to and during their work shift, and they work as teams. They are jointly responsible for the patient's nursing care. In order to provide individualised care, it is important to have a comprehensive view of the patient. This means the team can only be responsible for a limited number of patients.

The model is based on the idea that care should take place in close connection with patients, and the prerequisite for this is that RNs be relieved of as much administrative work as possible. This should result in RNs being more available for patients and in their working time being more concentrated on direct care in encounters with patients. This, in turn, is expected to lead to more personal care and care in which the patient participates. PFC allows RNs

to do what is unique to their competence; they no longer have to prioritise administrative duties at the expense of nursing care. At the end of the shift, they jointly evaluate their day's work. Administrative duties that require the competence of a RN are carried out at small working stations, or modules, near the patients, instead of at larger nursing stations (Inde 2007, Landstinget i Värmland 2010).

### Literature review

A number of studies on PFC have been published, but the meaning of the concept is defined differently in different countries. The literature related to PFC that comes from the USA and Canada is mostly focused on emergency hospital care. The literature on PFC coming from the UK also deals with community-based medicine (Aitken et al 2001). The present review concerns only studies conducted in the hospital environment.

Studies on PFC have revealed both positive and negative opinions. Patient surveys have shown that patients prefer PFC (Irwin and Richardson 2006). Mitchell et al (2000) showed that patients felt they were seen as individuals and could participate in care. Carter et al's (2008) findings reveal that both RNs and patients on a ward with PFC organisation perceived a high level of caring. Brider (1992) described how time is saved when nurses are cross-trained and can perform as much as 90% of the services. Tonuma and Winbolt (2000) and Mitchell et al (2000) emphasised that staff members' work satisfaction increases in PFC, because they have more opportunities to become involved in each patient. Bickler (1994) and Tidikis and Strasen (1994) found that PFC reduces costs, and Seago (1999) and Redman and Jones (1998) found just the opposite. Seago (1999) showed that PFC did not entail any advantages for patients. Seago (1999) also showed that RNs' work satisfaction decreased when PFC was introduced. Ingersoll et al (1999) revealed that introducing PFC entails considerable work for nursing managers as regards trying to get the model to function in practice.

However, few studies have looked specifically at RNs' opinions about PFC. No study was found that investigated RNs' opinions about PFC in Sweden,

only a few small-scale evaluations showing positive results, such as fewer calls from patients' rooms and higher work satisfaction among staff (Landstinget i Värmland 2010).

### Aim

The aim of the present study was to investigate RNs' opinions about the organisational change to PFC.

The specific study questions were:

What has the transition to PFC meant for RNs on the ward?

What are RNs' views on their own professional role in PFC?

What are RNs' experiences of quality of care after implementation of PFC?

### METHOD

#### Design

A qualitative explorative design was chosen using an interview guide with open-ended questions.

Settings – description of the hospital and ward

The study was performed in central Sweden at a university hospital with 1,100 patient beds and 8000 employees, 2,800 of them RNs. It was conducted on a ward for infectious diseases, with 28 patients beds and 57 employees, 31 of them RNs. The development project initiated to introduce PFC had started one year before the study began. The aim of introducing PFC in the ward was to improve the quality of care as well as to increase the care staff's work satisfaction. The organisation of nursing care was to change from a task- and routine-based working system to a much more patient-focused way of working. The care staff would then have more time to spend with the patients. Before implementation of PFC on the ward, the care staff worked in larger groups and the work was fragmented when so many people shared to entire administrative responsibility. Much of the nurses' time was stolen when they were disturbed by constantly ringing telephones and had to answer phone calls that did not concern their own patients. In PFC, administrative duties and incoming phone calls are instead handled by a receptionist, and this

gives RNs more time for their patients and enables them to work in a more patient-focused manner. The smaller number of care staff around each patient leads to higher continuity of care, and working closer to the patient leads to more individualised care with opportunities for increased participation. The work in care pairs is dependent on close communication and cooperation between the RN and the assistant nurse, and this is meant to increase collaterality between the professional groups.

In planning the implementation, most of the staff participated in different working groups that discussed and planned how the development project should be carried out. This preparatory work also included some measurements, such as the number of telephone calls and calls from patients' rooms. The present study began after PFC had been in operation on the ward for half a year. Note, however, that at this point the ward had not been appropriately reconstructed to fit the care model. Part of the development project was to make continuous evaluations of how PFC was working, and the present study was part of these efforts.

#### **Selection of participants and procedure**

Permission to carry out the study was obtained from the head nurse at the ward. Informants were chosen so as to include RNs with experience of working both in PFC and in wards with a 'traditional' organisation. All six informants were women in the age range 28-33 years, and they had worked on the ward between one and a half years and four years. The mean age of the RNs on the ward at the time of the study was 32.5 years.

#### **Data collection**

The qualitative interviews were performed using an informal interview technique, in the form of a conversation focusing on the informant (Kvale 1996). The interviews were jointly conducted by two persons (AK and LK). One was responsible for the interview and the other followed up with complementary questions and operated the tape-recorder. The interview technique was open-ended, and an interview guide with target themes was used. The themes were 'experiences of PFC', 'experiences of one's own

professional role' and 'opinions about the quality of care in the model'. The interview started by asking RNs to describe their experience of working at a ward with the PFC organisational model. All questions were supplemented with follow-up questions that encouraged informants to provide rich descriptions and allowed them to describe their opinions and feelings. The interviewer's role was to encourage the informants to reflect on the question and to make additional comments such as 'please tell me more about that'. Interviews took place at the informant's workplace in a quiet room. Each interview lasted between 30-60 minutes. Interviews were tape-recorded with the informant's permission and then transcribed verbatim by the interviewers.

#### **Data analysis**

The interviews were analysed using a qualitative method, i.e. latent content analysis, inspired by Graneheim and Lundman (2004). The analysis began by reading the text several times in order to become familiar with it and to understand its overall essence (Sandelowski 1995). The next step was to make detailed marginal notes, including open coding: 'working headings' based on all of the information in the text related to the aim of the study, i.e. RNs' opinions about PFC. Meaning units that dealt with the open coding were then identified. All meaning units were critically analysed and contemplated until suitable categories emerged. These categories were then sorted under target themes, which are the same as the specific study questions (Graneheim and Lundman 2004, Sandelowski 1995). Data analysis was carried out in 2008.

Describing both data collection and the steps in the analysis constitutes a way of establishing credibility, which is in line with Lincoln and Guba's (1985) description of establishing the quality and trustworthiness of qualitative data and analysis. Dependability is a criterion used to measure trustworthiness. This is met in the present study by demonstrating the credibility of the findings. Procedure descriptions and the discussion linking the present study to other studies with similar findings are the most important ways of establishing dependability

here. Furthermore, quotations are provided that are illustrative of each theme. Confirmability has been established through description of the analyses.

### **Ethical considerations**

All participants received information about the aim of the study and were told that participation was voluntary. The two people who conducted the interviews had no connection to the interviewees. The data have been treated confidentially. Thus, the recommendations made by the Swedish Council for Research (Codex) have been followed.

## **FINDINGS**

The themes and categories are summarised in table 1 and presented in detail in the text.

**Table 1: Themes and categories.**

<b>RNs' experiences of the transition to PFC</b>
The process of change
Decreased administration
Cooperation in care pairs
Workload
Patient contact
Reconstruction
<b>RNs' views on the nursing profession in PFC</b>
Changed focus
<b>RNs' views on the quality of care in PFC</b>
Change in quality of care
Factors affecting quality of care

### **RNs' experiences of the transition to PFC**

#### ***The process of change***

All of the interviewed nurses at the ward had overall positive attitudes towards PFC and felt the care model could facilitate nursing practice. They thought PFC is a model that focuses on the right thing: the patients. The interviewees emphasised, however, that more experience of working with PFC is needed if one is to make a fair evaluation of the model. Total implementation of PFC is also needed. For instance, the ward needs a proper reception and several stationary modules for the nurses to work at. The interviewees also emphasised that the transition to PFC is a process of change that takes time. It must be a gradual change, given that the care model has

to be modified according to the specific needs of the ward. The process of change is also individual, and the nurses must all be patient with each other and let it take time. The interviewees did report positive effects of PFC, which they believed gave all employees at the ward greater motivation to work towards continuous development.

'It's good that we're introducing it gradually, because it's a process of change that has to happen and we're a big group of staff, but the changes we've made so far have encouraged us to continue with this concept... you can see that in the end the care is better and you have more control over what is happening with the patient.'

#### ***Decreased administration***

Among the interviewees, the most appreciated change associated with PFC was that a ward secretary now takes all incoming phone calls. The nurses only have to answer calls directed at them and that concern their patients. This frees the nurses from unnecessary phone calls and stress, and more time is available to spend with patients. The working environment is now less stressful and quieter without the disturbing telephone signals. The ward secretary also has administrative responsibilities, and because the nurses no longer have to handle patient logistics, more time is left for patient care.

#### ***Cooperation in care pairs***

Most of the interviewed nurses experienced better cooperation with the assistant nurse in the care pairs when working with PFC. Nurses are now more accessible when they are stationed closer to the patients, and this makes their work more efficient. There is a feeling of really working in a team with the joint aim of focusing on the patient.

'What we've carried out so far has done a lot for... well, for the ward but also for me, my way of thinking about working with the assistant nurse who is part of my team, so I think it's and I think generally on the wards it's made a lot of people think, we've learned to prioritise our duties not only based on what I have to do, but on what we have to do with the patient.'

Making a plan for the day at the beginning of the work shift and having continuous communication in the care pairs in order to reprioritise are two aspects that are important to the cooperation. The interviewees stressed the importance of two-way communication.

### **Workload**

In the implemented PFC model, the nurses, working with the assistant nurse in their care pair, are supposed to provide basic nursing care for five to seven patients. Some of the interviewees experienced this as a heavier workload than before and felt it was sometimes impossible to accomplish the actual nursing care because they still had their medicine assignments. This of course depends on the type of patients being cared for. Some of the interviewees felt guilty when they did not have enough time to help the assistant nurse. The RNs also perceived frustration among the assistant nurses when they sometimes had to do the nursing work alone. On the other hand, some of the interviewed nurses experienced an easier workload, because they now had fewer patients and less information to keep in mind. Some of the interviewees, however, reported not experiencing any difference in workload with PFC.

### **Patient contact**

When working with the PFC model, the nurses are physically closer to the patients, and this was a very positive experience for the interviewees. The nurses are supposed to work at small modules situated close to the patient rooms, and this makes it much easier for them to answer calls from the patients. Half of the interviewees experienced that their time for patients had increased with implementation of PFC and they were now more involved in direct care. The fact they now spend more time with patients allows nurses to get to know their patients better, which results in a better and more comprehensive understanding. One nurse felt increased patient contact improved work satisfaction. Some of the interviewees still thought they had too little time for the patients and that the assistant nurse was the one actually seeing the patients most of the time.

### **Reconstruction**

There was consensus among the interviewees concerning the need for reconstruction of the ward. The fact that, at the time of the present study, the workplace was not yet appropriately constructed to fit the new care model made it difficult to fully work according to the model. The nurses need real working modules with a stationary computer at a desk and a chair to sit on. In the studied situation, the nurses had to stand in the corridor and work at temporary modules consisting of medicine carts equipped with a laptop. This made it difficult to write in patient journals owing to disturbances in the corridor and the lack of privacy. It was also difficult to make phone calls to relatives. Some of the interviewees, however, thought that, thanks to the more accessible working modules, it was now easier to carry out continuous documentation during the work shift than it had been before.

Most of the interviewed nurses emphasised the need for a proper reception in conjunction with admittance onto the ward. The receptionist should take care of visitors and relatives, showing them to the right room.

### **RNs' views on the nursing profession in PFC**

#### **Changed focus**

Most of the interviewed nurses did not experience any difference in their professional roles when PFC was introduced. However, it has brought about changes in the nurses' attitude towards their work and has put more focus on patients. Some nurses felt the focus had shifted from their own manifestation of the work to the patients. They now always worked in a patient-focused manner. Before PFC, the nurses' work had been more focused on specific tasks and routines and the patients themselves were sometimes in the periphery. Some of the interviewees pointed out that they are all in the midst of a major process of change and the focus is therefore sometimes more on the collaboration in the care pairs than on the patients.

Many of the interviewed RNs experienced more distinctive roles as team leaders when working with PFC. They felt responsible for planning and structuring the work in the care pairs and this ability had developed.

'...I've become better at making a plan for me and my assistant nurse, for our team, and that's a large part of our ... professional role, I mean ... planning my own and the assistant nurse's actions. So I think in that way I've developed a bit. I sort of boss more, not really, but almost!'

However, some of the interviewees wished the assistant nurses were more independent and better able to take the initiative. Nevertheless, the work in care pairs did give increased understanding of the different professional roles in the care pair, which is important to making a good team.

#### **RNs' views on the quality of care in PFC**

##### ***Change in quality of care***

Most of the interviewees agreed PFC had given them an improved comprehensive view of the patients, and this was seen as a quality indicator. When nurses participate more in direct nursing care, they get to know the patients better and can provide more patient-focused and individualised care. The nurses who experienced having more time for each patient when working with PFC felt this facilitated higher quality of care. They now had more time to do additional things for their patients, things that are often of great importance to patients. Some of the interviewees, however, had not observed improvements in the quality of care with the PFC model, but they were now less stressed at work, which made it easier to maintain the quality of care. These nurses felt they still did not have enough time and more personnel were required. They did not believe that PFC alone could solve the problem of the sometimes very heavy patient load experienced on the ward.

##### ***Factors affecting quality of care***

There was consensus among the interviewees about the improved cooperation in the care pairs and this has had a positive effect on the quality of

care. Another positive effect is that the nurses work physically closer to the patients and are therefore more accessible. The fact that the assistant nurses now participate during rounds was also seen as a quality indicator. This gave assistant nurses a better understanding of the patient, making them more highly motivated to do the work. The assistant nurses also provided a great deal of valuable information about the patients.

'They're more motivated to take blood pressure measurements, temperature, weight and everything... when you understand why they should be taken it's easier to take them... and that improves the quality.'

There was consensus among most of the interviewed nurses the patients seemed to be more satisfied and secure with PFC, due to the decreased number of staff around the patients. Some of the nurses emphasised the importance of making decisions together with patients to increase their participation in the care.

## **DISCUSSION**

The result of the present study reveals overall positive attitudes towards the PFC care model amongst the nurses at the ward, but also that more experience of working with PFC is needed.

PFC, as performed in Sweden, is supposed to increase the RN's time for direct nursing care (Inde 2007). This was only experienced by half of the interviewees in the present study. These nurses felt they had more time for patients because they no longer had to perform administrative duties and take incoming phone calls. They were now instead more involved in direct nursing care. The other interviewed nurses still thought they had too little time for their patients and nursing care. They also felt a heavier workload than before PFC owing to the nursing care. These nurses felt the change from administrative duties and phone calls towards expanded nursing care had given them even more things to do, and this could be stressful. One reason why only half of the interviewed nurses experienced more time for patients could be that the nurses still had their medicine assignments, which

take time. When there are many patients requiring extensive care, this often implies that the nurses have to prioritise the medical part of their role at the expense of nursing care. In these situations, the nurses' focus was drawn away from the patients and back to the tasks and routines again. Jenner (1998) showed that during introduction of PFC, the focus was on cross-training and the specific task skills. Hopefully, as the care staff develops along with PFC, the focus will gradually be shifted to the patients.

Another reason could be the PFC model had not yet been completely implemented on the ward at the time of the study, and the nursing staff were in the midst of a major process of change. It takes time to change work routines and to change people's approaches to their work. Mitchell et al (2000) emphasised that it takes time to implement a new care model in hierarchical structures and that PFC constitutes a change in the entire healthcare paradigm. PFC means shifting from a mechanistic paradigm, in which patients are seen as parts and problems, to a holistic healthcare paradigm that sees human beings and their health experiences (Mitchell et al 2000). PFC also implies a shift from a task- and routine-based organisation, to an organisational model that can facilitate more and closer contact with each patient: having responsibility for fewer patients means the care provider can have closer contact with his/her patients. This could help nurses provide more individualised care that responds to the unique concerns, needs, and wishes of the patient and families, as described by Mitchell et al (2000). Furthermore, nurses could promote a more equitable patient-care provider encounter and encourage the patient to participate more in his/her own care, as emphasised by Irwin and Richardson (2006). Utilising PFC could be one way of trying to apply the ideas of Florence Nightingale, who emphasised nursing care and focused on the patient instead of the illness (Lauer et al 2002).

Ingersoll et al (1999) showed that nursing managers found their leadership role difficult after the introduction of PFC, largely owing to the tension between the old and the new paradigm. However,

the nurses experienced that PFC brings with it a comprehensive view of patients that facilitates the work and also gives increased work satisfaction. Tonuma and Winbolt (2000) and Mitchell et al (2000) emphasised that work satisfaction increases because staff have more opportunities to get involved in each patient when working with PFC. Reisdorfer (1996) also showed an increase in staff work satisfaction as a benefit of PFC, and the highest scores were found with respect to collaboration among team members

Irwin and Richardson (2006) showed that patients prefer PFC, and Mitchell et al (2000) showed that, with PFC, patients feel they are seen as unique individuals who can participate in their own care. Seago (1999) found no change in patient satisfaction after implementation of PFC. In the present study, there were divided opinions as to whether PFC leads to higher quality of care. Some of the interviewees did not experience any difference in the quality of care and did not think PFC could solve the problem of the heavy patient load. These nurses wished for more care staff. Some other of the interviewees experienced that, with PFC, the patients seemed to be more secure and have more faith in the nursing staff owing to the limited number of nurses involved in caring for them. Patients also emphasised the nurses at the ward were more accessible when working at the modules, and that this and the improved cooperation in the care pairs were positive factors that improved the quality of care. Most of the interviewees agreed, however, that the improved comprehensive outlook on patients brought about by PFC is an indicator of higher quality of care. However, there is a need to investigate patient satisfaction with PFC in Sweden. The present study discusses only the nurses' experiences of and thoughts about the quality of care, but it says nothing about patients' opinions of PFC.

In the present study, the majority of nurses interviewed experienced better cooperation and team work in the care pairs when working with PFC. They plan and structure their work together, and this gives an improved understanding of the different

professional roles. This also involves the doctors in the ward, because they meet the care pair during rounds and can communicate directly with both the nurse and the assistant nurse. Redman and Jones (1998) identified the unifying effect the implementation of PFC had on the overall organisation. Achieving a stable organisational change depends on having good leadership (Inde 2007). Ingersoll et al (1999) investigated the effect implementation of PFC had on midlevel nurse managers and found they had difficulties keeping up with the demands of the change. Redman and Jones (1998) also found that managers faced considerable challenges and changes in their responsibilities when the new model of care was implemented. Because redesigning a care-model also affects nurse managers to a great degree, studies of how nurse managers experience the move to PFC on Swedish wards would be valuable.

Bridger (1992) discussed the issue of whether nurses' professional role could be diminished by PFC and specifically the cross-training required. There is no such training in the Swedish model of PFC, but it raises the question of whether the nursing profession should be mixed with the profession of the assistant nurse. In the present study, most of the nurses did not experience any difference in their professional roles with PFC, even though they now do more nursing care, which in traditional care models is performed mostly by the assistant nurses. The interviewed nurses felt that nursing care is a self-evident part of a nurse's job and the expanded nursing care resulting from PFC does not cause the nursing role and the nursing assistant role to be mixed. PFC implies flattened management structures (Aitken 2001) and focuses on teamwork across professional boundaries, the aim being to benefit from the total competency (Inde 2007). This should not blur the professional roles, but rather increase nurses' and nursing assistants' understanding of each other's work, thus helping to reduce the hierarchical structures found in the healthcare system.

Because the model of PFC used on the present ward was modified by a Swedish nurse, it has been difficult to compare the work on the ward with the

literature on PFC as it is performed in the USA and Canada. A comparison of the implementation of PFC in different countries also means comparing the nursing profession and nursing education, which differ considerably across countries. Although there are different variations of PFC, they all originate from the same holistic care philosophy and they all aim at improving the care provided and at focusing on the patient.

At the time of the study, working with PFC was still new to the staff at the present ward, and the care model had not yet been completely implemented. The transition to PFC may take many years, as it involves a fundamental shift in the worldview or paradigm underlying how nursing staff think about their work. It is not enough to tell staff they must think differently. Changing beliefs, values, and practices is no small matter.

#### **Methodological considerations**

Having two interviewers working together was an advantage, as it made covering all themes in the interview guide easier. On the other hand, it may have been stressful for the interviewees. The conformability of the data was strengthened by presenting several quotations in the results; this helps the reader understand the interpretation (Sandelowski 1994). To strengthen dependability, analysis of the text was carried out by two authors and validated by the other authors (Polit and Beck 2007). The relatively small convenience sample could be a limitation and may affect the study's transferability. It would also have been interesting to investigate the assistant nurses' opinions about working with PFC, but there was not enough time for this during the study period.

#### **CONCLUSIONS**

The aim of the study was to investigate RNs' opinions about the organisational change to PFC. The results show that the interviewed nurses had overall positive attitudes towards the new care model and that PFC could be a way of facilitating nursing practice. More experience of working with PFC is needed as well as total implementation of the care model, including

reconstructions. Further research will focus on patient satisfaction, the opinions of the assistant nurses as well as the impact the shift to PFC has had on nurse managers.

During the literature review, no studies on RNs' opinions about PFC in Sweden were found. This study is therefore important in that it highlights the Swedish model. It is also valuable for further research and for other hospital wards that wish to introduce PFC.

#### Implications for Nursing Management

The present findings show that the interviewed RNs had overall positive attitudes towards PFC. They found that PFC had many advantages, and the organisational form could therefore be suitable in several clinical settings. The study illustrates nurses' opinions about working on a ward with PFC as an organisational form, and this knowledge is important to nursing managers who are considering organisational changes.

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