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RESEARCH ARTICLE

Meaningful Text: Total Hip Replacement Patients' Lived Experience of a Nursing Care Plan Written in Lay Language

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Abstract:

Background:

Person-centred care involves respecting patients' experiences, preferences, and needs, as well as sharing information with them and involving them in care planning. Scant research has been conducted on how it influences patients to have direct access to their care planning when it has been established through the use of standardised care plans or pathways. In the orthopaedic ward in which this study was conducted, a standardised nursing care plan for total hip replacement patients (THR), which was originally written in professional language, was rewritten in lay language and used as peri-operative teaching material for this patient group.

Study Aim:

To explore the meaning THR patients ascribe to the lived experience of reading and retaining their standardised nursing care plan in lay language during their hospital stay.

Methods:

The data collection and analysis followed a method adapted by the Vancouver School of Doing Phenomenology. Data were collected through 12 in-depth interviews with six THR patients.

Results:

The main finding was that the participants acquired knowledge from the text of the care plan that was understandable and meaningful, as evidenced by the empowering impact it had on them. This impact included improved psychological wellbeing, more open communication, and the provision of a tool to keep track of care. Some revisions of the care plan were recommended.

Conclusion:

The study suggests that a patient version of standardised care plans can act as an important educational tool for THR patients that can empower them to manage their health situations.

Keywords: Nursing care plan, Person-centred care, Phenomenology, Empowerment, Total hip replacement, Patient education.

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1. INTRODUCTION

In this paper, a phenomenological study will be outlined in which Total Hip Replacement (THR) patients' experiences of using a Standardised Nursing Care Plan (SNCP) in lay language as a peri-operative teaching material were explored. The nurses in the orthopaedic unit where this SNCP was implemented were encouraged to discuss the plan with patients

on admission, and then continue doing so throughout their hospital stay. This method was considered to potentially provide an opportunity for enhancing patient involvement and partnership between patients and nurses, in line with a person-centred approach. Before turning to the details of the SNCP intervention, however, some theoretical and practical context is in order.

In contemporary health care, person-centred care is strongly endorsed by professionals in the field as well as policy makers [1 - 3]. Central to such care is viewing patients as

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unique individuals from a holistic perspective and taking into account their needs and preferences. The concepts patient-centred care and client-centred care, for which the term person-centred care has become a common denominator or an umbrella term [4, 5], both highlight patient involvement and partnership. Evidence shows that with professional support, patients can become active partners in their care [6 - 8], and that such involvement can be beneficial to them [7, 9, 10] and contribute to empowerment [11]. A therapeutic relationship and the involvement of patients in planning and negotiation of their care are prominent attributes in the conceptual analysis of partnerships [12, 13]. Yet providing patients with information about their planning of care when it is mainly pre-determined by health care professionals, such as through the use of SNCPs or clinical pathways (CP; also known as 'critical pathway'), is not addressed in these analyses in particular. These plans and pathways have been developed for organising evidence-based care for well-defined groups of patients, such as patients with the same medical diagnosis, patients undergoing similar medical treatment, or patients with similar nursing problems [14, 15]. The main difference between CP and SNCP is that SNCP is formulated according to the nursing process, within which nursing diagnosis, goals, and interventions are outlined [14]. CP is multi-disciplinary, and the outline component of health care is placed in an appropriate timeframe that provides a continuum of care in which expected outcomes are clearly identified [15]. In SNCP, nursing diagnosis, outcomes, and interventions are often outlined in nursing terminology, which allows for their integration in electronic health records [16, 17].

Although they contain important information about patient care and conditions, it is both odd and implicitly paternalistic that SNCPs and CPs have been used to a very limited extent as a medium for patient teaching. This is evident by the fact that only a few studies have been published during the last two decades about the use and impact of CP as teaching material for patients from the patients' own perspectives. Moreover, no studies have been conducted, to the best of our knowledge, about the use of SNCP for the same purpose. This is in stark contrast to the vast literature that exists about SNCP and CP more generally [15 - 18].

Studies by Clarke [19] and Nemeth *et al.* [20] conducted near the turn of the millennium were among the first to explore the impact of the use of a patient version of CP as an educational tool for patients. These CPs were designed for stroke patients and cancer patients who underwent surgery for their conditions [19]. The patients in the studies deemed that the CPs in question were easy to read and comprehend, and helped them to better understand their surgery [19], condition, and treatment [19, 20], as well as to keep track of their progress [20].

In 2012, Ryhänen *et al.* [21] developed and evaluated an internet-based patient pathway as an educational tool for breast cancer patients. This tool was based on CP for this patient group and the theory of empowering knowledge, including six knowledge dimensions or content areas. These areas aimed at empowering patients in terms of enabling them to gain control over their illness and improve their wellbeing and health [21 - 24]. The patient pathway was evaluated by patients after being

used in their treatment. Their evaluation showed that the language, structure, and technical characteristics were deemed significantly better than the content, suggesting that the empowerment dimension of patient education needed further development.

Later, Ryhänen *et al.* [25] evaluated the effect of the same patient pathway on a breast cancer empowerment process through a randomised trial. The intervention group used the patient pathway as well as the usual teaching for patients with breast cancer, while the control group had the same teaching but did not use the pathway. The results showed that there was a non-statistical difference between the groups regarding the three outcome measures: quality of life, anxiety, and side effects, which were used to measure empowerment. More positive results were found on the effects of online patient pathways for patients undergoing minimally invasive parathyroidectomy through a randomised trial study by Neary *et al.* [26]. They found that patients undergoing this surgery and using a website with an interactive patient pathway (intervention group) were more satisfied with the website than patients in a control group, undergoing the same surgery, who utilised a website in which an interactive patient pathway was not included. More specifically, the patients in the intervention group were more satisfied than those in the control group with regard to overall impressions and the organisation, usefulness, and specifications of the information.

The interest in this subject arose as a result of the first author's collaboration with nurses at an orthopaedic ward in designing SNCPs for patients undergoing similar operations. The SNCPs consisted of nursing diagnoses and interventions stated according to the classification systems of NANDA [27, 28] and Nursing Intervention Classification (NIC) [29, 30]. Nursing objectives were also stated in the SNCPs. One of those plans was for patients undergoing THR. Moreover, it was decided to write a patient version of the SNCP that the patients could retain throughout their hospital stay. To begin with, a patient version of the SNCP was written for THR patients and sent to them with other pre-operative teaching materials prior to their admission to the orthopaedic unit.

To begin addressing the absence of research about patients' perspectives of such use of a nursing care plan, it was decided to conduct a phenomenological study through which patients' experiences could be studied deeply from an open and broad perspective [31]. Accordingly, the aim of the study reported here is to explore the meaning that THR patients ascribe to the lived experience of reading and retaining a nursing plan in lay language. This plan will be referred to as an open nursing care plan (ONCP) in the paper.

2. MATERIALS AND METHODS

2.1. Methodology

The study was guided by The Vancouver School of Doing Phenomenology. This is essentially an interpretivist and constructivist approach, which assumes that the world is constructed through personal meaning, which profoundly affects the way people experience and live their lives [27]. Furthermore, it is assumed that people construct meanings

from phenomena and make constructs, which are in turn treated like phenomena by others. This school is a unique blend of description, interpretation, and explication, as well as construction of experiences [31]. The research process is portrayed in 12 basic steps that were entered into repeatedly in a reflective cyclic process throughout the study (Table 1).

2.2. Participants

Six THR patients participated in the study, selected with the help of the head nurse in the orthopaedic ward. They fulfilled the criteria of: i) being between 18-80 years old; ii) being in the ward through a planned admission; iii) being able to read and utilise written teaching materials; iv) having received their ONCP at least four days prior to admission; and v) having kept and read their ONCP during their hospital stay. Patients who did not fulfil any of these five criteria were excluded from the study. Table 2 contains descriptions of the six participants who were all given pseudonyms in the study. Their ages ranged from 50–80 years.

2.3. Data Collection and Analysis

Data collection, which was conducted over five months in

2000, began with participation in an in-depth unstructured interview approximately 14–30 days after the participants' discharge from the orthopaedic ward. In accordance with the Vancouver School, the dialogues had open and interpretative features [31]. All participants were interviewed twice during the period of the study. The second interview took place approximately 14–30 days after the first interview. The two main questions that guided the interviews were: 'What was it like to get the nursing care plan to your home?' and 'What was it like to keep the nursing care plan by your side during your hospital stay?' The interviews were digitally recorded and then written up verbatim. The first interview lasted around 60–90 minutes, and the second one lasted 30–40 minutes. In the Vancouver School, data collection and data analysis proceed simultaneously, although these processes are presented in distinct steps (Table 1). In accordance with Holloway and Wheeler [32], data saturation was deemed to be achieved when no further themes emerged from the participants and previously collected data were continuously repeated. The final stage of analysis, occurring after formal dialogues have ceased, becomes, then, a period for bringing a final order into previously developed ideas.

Table 1. The 12 basic steps of the research process of the Vancouver School and how they were followed in the present study.

Steps in the research process	The way the steps were adhered to in the present study
1. Selecting dialogue partners (the sample)	Six participants were selected by purposeful sampling.
2. First there is a silence (before entering a dialogue)	Preconceived ideas were consciously put aside by phenomenological self-reflection prior to the interview.
3. Participating in a dialogue (data collection)	Two interviews were conducted with each of the participants for a total of 12 dialogues. All the interviews were conducted by the first author.
4. Sharpened awareness of words	The transcript of each dialogue was consciously read through to get a holistic picture of the lived experience.
5. Beginning consideration of essence	Key statements were identified, coded, and written down in the margins of the transcript for each dialogue.
6. Constructing the essential structure of the phenomenon for each case	The main aspects in each participant's story were highlighted, and the most important of those were constructed into a conceptual framework.
7. Verifying the single case construction with each participant	Each case was verified with each participant.
8. Constructing the essential structure of the phenomenon from all the cases	The different dialogues were compared in order to find the 'common threads', as well as the differences. Both authors participated in this final analysis process within which the essential structure of the phenomenon was constructed.
9. Comparing the essential structure of the phenomenon with the data	Having identified the essential structure of the phenomenon, it was compared with the transcripts in order to see whether it fit the actual data.
10. Identifying the overriding theme which describes the phenomenon	The overriding theme, acquired knowledge, was identified.
11. Verifying the essential structure of the phenomenon with some of the participants	The results and were presented to and verified by three of the participants.
12. Writing up the findings	The participants were quoted directly to enhance the trustworthiness of the findings.

Table 2. Description of participants.

Pseudo-name	Age	1 st or 2 nd THR	Pseudo-name	Age	1 st or 2 nd THR
Aron	70-80	1 st	Jonathan	50-60	2 nd
Else	50-60	1 st	Kathryn	60-70	1 st
Eric	70-80	1 st	Margaret	70-80	2 nd

THR= Total Hip Replacement.

3. RESULTS

3.1. Overview of Findings

The main finding of the study was that the participants acquired knowledge from the text of their ONCP, which was understandable and had a meaningful and empowering impact on them. An overview of the findings is depicted in a schematic form in Table 3, in which the overriding theme, main themes, and respective sub-themes are outlined.

Table 3. Conceptual framework of the meaning total hip replacement patients ascribed to the lived experience of an open nursing care plan

Overriding theme: Acquired knowledge		
Understandable and meaningful text	Empowering impact	Revision of the care plan suggested
-	Improved psychological wellbeing	Add information about responses to discharge planning
-	More open communication	Combine the teaching material
-	Contributed to physical progress and participation	Add pictures to the care plan
-	Tool to keep track of care	-
-	Could be a tool for communication and evaluation	-

3.2. Acquired Knowledge

The participants' experience of reading the text of the ONCP was in general very positive. It became apparent in the interviews that the most significant part of the experience was the knowledge the participants acquired by reading the care plan. Margaret's description illustrates this very clearly:

I found it very informative to read this the nursing care plan and better in general, better to acquire some knowledge about this, what they would do, how this is, and how one should act.

The knowledge that most participants extracted from the text of the care plan consisted mainly of four areas of knowledge: i) the treatment; ii) what nurses and nursing assistants do; iii) what patients are supposed to do; and iv) patients' potential responses to treatment.

Margaret (above) emphasised her knowledge about what they did (the nursing personnel) and what she should do. In the following accounts, Else stressed the knowledge about the treatment and what she should do, and Eric emphasised the role of nurses:

Else: It appears naturally in there [the ONCP] how the treatment is after the operation and I found it very good to read about when I could first get out of bed, because I would maybe not ask directly 'When can I stand on my feet'?

Eric: It appears in the nursing care plan what nurses do, and how they work.

When the participants talked about what the nursing personnel did, they were in many instances referring to how the

nurses and nursing aids helped them with self-care and mobilisation. Other roles of nurses, for example as teachers and advocates, were mentioned on an individual basis. However, several of the participants learnt from the ONCP that the nurses were checking on them or observing them. This is evident from the following explanation:

Jonathan: Reading it [ONCP] explained how they observed you.

Some participants discussed that they had read in the ONCP about their potential responses and how they would normally feel or respond throughout the hospital stay. The following account illustrates this:

Jonathan: One had better ideas about how bad or good you should feel before you let the nurse know. The main thing is that you have good information about what people normally feel in this and that period during the process.

3.3. Understandable and Meaningful Text

Generally, the participants understood the text in the ONCP well and found it important. Accordingly, the text was meaningful to the participants. This is reflected in the following accounts:

Researcher: Did you read the nursing care plan after the operation?

Margaret: Yes, I began to look it up when I had got my intelligence back. (laughs) [referring to when she recovered from the anaesthesia]. It is very good to get safe, clear information. This is very trustworthy.

Eric: I find it important to read about this [in the ONCP], I find the job that has been done there to be excellent, which I hadn't noticed before [referring to prior hospital stays].

The participants explained that the text in the ONCP was meaningful to them because the knowledge they acquired from it was the main reason for the empowering impact of the care plan (see next section).

3.4. Empowering Impact

The ONCP had a significant empowering or enabling impact on most participants. Notably, according to the Macmillan Dictionary [33], the verb 'empower' means to enable or give power. This impact was evident by the fact that the knowledge participants acquired from the care plan enabled them or empowered most of them to gain control over or cope with the consequences of the operation or the treatment connected to it. Most participants claimed that the ONCP improved their psychological wellbeing. The apparently disempowering psychological effects, such as anxiety and insecurity related to the operation and/or the subsequent treatment, were found to diminish as a result of the ONCP. It was evident that through receiving the teaching materials a few days before their operation, the participants' anxiety decreased. The following comment illustrates these effects:

Margaret: I was actually a little bit anxious before this operation. I thought this would be more difficult because I was so old, I became somehow more secure when I had read all this at my home.

Researcher: Are you talking about the nursing care plan or the other booklets you received?

Margaret: All of them.

The participants were clearly referring to the ONCP but not to the other teaching materials when they claimed to have improved their sense of security after the operation. Kathryn's description below shows that by increasing her sense of security, the knowledge she acquired from the ONCP enabled her to cope with the consequences of the operation and the treatment connected with it.

Kathryn: I found it [the ONCP] increased my sense of security. I would not have liked to be without it. I think it has made things much easier for me regarding this operation and the treatment connected with it. It [the ONCP] enabled me to look it [things related to the operation and the treatment] up. Because of this, I knew more.

The text in the ONCP significantly enabled the participants to keep track of their care. Hence, they became more aware of or knew more about their current situation. The following accounts illustrate this clearly:

Jonathan: I went back and forth in the nursing care plan to see where I was in this process.

Margaret: I almost always knew what was next and then I found that things were more secure.

Most of the participants felt that the ONCP contributed to their physical progress and their participation in their care. The detailed descriptions of how they should get out of bed and walk were found to be of particular importance. The knowledge participants acquired from these detailed descriptions empowered them to progress with their mobilisation. The following descriptions illustrate this clearly:

Aron: It was vital, of course, to have learned before how to move about after the operation so you would not be trying out movements that were bad for you. It was listed [in the ONCP] how one should move and practice.

Researcher: Did you find you could control the pace?

Else: Yes, I think so.

Researcher: Did the nursing care plan make any difference to you regarding that?

Else: Yes, if you somehow know that you are supposed to help the personnel who are doing their job, then I think that this becomes more positive. Yes, there is more co-operation between the patient and the personnel, then this is a more united effort.

In general, participants found that the open ONCP contributed to more open and free communication. They explained that this was mainly due to the fact that they knew whom to turn to and it was easier to ask questions:

Kathryn: I found it very helpful to look it up [in the care plan], then I knew something, I found I could ask differently, then I understood, you know, what I was asking about... I found I was more secure about what I was going through, and I found it easier to discuss matters with the nurses, because I

knew more.

Eric claimed that ONCP made the communication with the personnel more free, which he explained as follows:

Eric: It [the communication] was more free. You gain more trust in the nursing personnel and get to know them a little, they become kind of your friends, and you can be free to ask.

All the participants claimed that none of the nurses had discussed the ONCP with them. Yet, most of them felt that the plan should be used as a tool for communication and evaluation. This theme first emerged in an interpretative dialogue between the researcher and Jonathan:

Jonathan: Emotional support should maybe be taken more into consideration. The nurse or the specialist should sit down with the patient and give him a little time to discuss that.

Researcher: Do you mean that the nursing care plan should be used more as a tool for enhanced communication?

Jonathan: Yes, I mean that.

Researcher: Do you think that it would be good to go through the care plan once or twice during the hospital stay?

Jonathan: Yes, and also at discharge, I think the specialist should be present if that is possible...It [the care] should be evaluated with you.

3.5. Revision of the Care Plan Suggested

Most participants suggested some revisions to be made to the ONCP. Some of them found that more information was needed regarding discharge planning. They claimed that they were not prepared for how they felt when the discharge approached or for certain responses and feelings when they came home from the hospital. Else described this as follows:

Else: People should get more information when they go home, emphasising that they must do precisely what they are told to do. I was actually looking for information about this in the care plan but couldn't find it...it is this feeling which you get when you begin to think about when you go home, your responses are quite different when you are going home, your domestic life follows a strict pattern...and suddenly you have to change something, but it can be difficult.

It was suggested by several of the patients that the ONCP and other teaching materials should be combined.

Eric: This should be more combined [the teaching material], it could be put together in one brochure.

Some participants suggested that pictures should be added to the care plan. Illustrations with pictures and drawings of movements that he received from the physiotherapist after the operation were particularly useful to Aron:

Aron: I found that these drawings said much more than many words, and it was sometimes easier to understand them than the text [in the ONCP and in the other teaching material].

4. DISCUSSION

The main finding of the study was that the THR patients

acquired knowledge from the text of ONCP, which was found understandable and meaningful, as it empowered most of them to gain control over or cope with the consequences of the operation and treatment connected to it.

The prominence of the extent to which participants seemed to acquire knowledge from the text of the ONCP has not been reported on before, as the main impact of using a patient version of a care plan as teaching material for patients. However, the result from the present study showing that ONCP in lay language was found understandable and helpful is supported by three studies showing that patients found patient versions of their CP easy to read, understandable, and useful [19, 20, 26]. The patients' satisfaction with the lay language in the care plan indicates that use of the plan was in line with a person-centred approach in which such language use and understanding are distinct features [5].

The fact that the acquired knowledge empowered the participants in the present study to gain increased control over or cope with their health situation is another significant finding. This is in accordance with Gibson [34], who defines empowerment as 'a process of helping people to assert control over the factors that affect their health' (p.359). Apparently, the participants directed the knowledge they acquired from the ONCP towards managing the problems associated with the THR operation. This indicates that they used problem-focused coping, which is directed at managing or altering problems that cause distress [35]. Such an overall empowering impact of using SNCPs or CPs as teaching material has not been supported previously. Yet this aspect of CPs had been explored in particular in two recent studies [21, 25] but without definitive conclusions.

Four areas of knowledge were found to be particularly important and meaningful for the participants in the present study. The first of those was knowledge about treatment, which parallels the salience of 'content' in the biophysiological dimension of empowering knowledge [22, 23] where the treatment and physical signs are addressed. The knowledge area, 'What nurses and nursing assistants do', emphasised in the current study, concurs with 'Help with managing consequences of the treatment', which is addressed in the functional dimension of empowering knowledge [22, 23]. The participants in the present study remarked that they had learnt from the ONCP that the nurses observed them, and this was of particular importance to them as it enhanced their security, as it meant nurses were monitoring their conditions.

The finding that the participants learnt from the ONCP what nurses do agrees with a stated purpose of the nursing process, which is to demonstrate the roles of nurses, such as their surveillance role [36], which was addressed in the present study. Strangely enough, this finding is not corroborated by the previous literature regarding care plans. In the functional dimension of empowering education, action and moving on during treatment periods, and patient participation in those processes, are both addressed [22 - 24]. These two areas contain information about what patients are supposed to do, which was an issue that the participants in our study found to be of importance.

Finally, the aspect of patients' potential responses to treatment, addressed as important in the present study, can be found in the experiential dimension of empowering knowledge, where it is outlined as feelings concerning illness and how illness or operations can affect such experiences [22 - 24]. The participants' opinions that they had acquired important knowledge from the ONCP about their potential responses to treatment is not supported in the current literature, however. Yet, this knowledge aligns strikingly with NANDA nursing diagnoses, which are defined as human responses to health conditions or life processes, as well as susceptibility for that response, either by an individual, family, group, or community [28]. Nurses have used NANDA nursing diagnoses in North America for diagnosing clients for around 50 years, and they have been used in many other countries in the past decades [16, 28]. Thus, it reflects somewhat paternalistically on previous standard practice that this is the first study in the current literature which suggests that patients actually know what nursing diagnosis is about.

The knowledge obtained from the ONCP and the other teaching materials improved the participants' psychological wellbeing by reducing the disempowering psychological effects of the operation, such as anxiety and insecurity. Except for one study, this impact of SNCP or CP has not been noted previously in the literature. The exception is one study [19] that showed that the use of a patient version of CP for cancer patients decreased their anxiety. However, it is well established that written pre-operative teaching material reduces patient anxiety and fear [37]. Still, no research was found that showed a direct relationship between pre-operative education and security. Assuming that security is the opposite of increased anxiety to some extent already supports the view that an ONCP increases security.

Most participants found that the detailed descriptions in the ONCP contributed to their physical progress and their participation by mobilising their abilities. According to Gibson [34], the mobilisation of resources is, indeed, part of the empowering process. These findings have not been confirmed in studies of the use of SNCPs or CPs as teaching materials. They are supported to some extent in research on pre-operative teaching [38], but these results vary between studies [37].

The finding that the ONCP was used as a tool to keep track of care confirms the results of a study by Nemeth et al. [20]. They revealed that a patient version of a multidisciplinary care plan for ischemic patients, consisting of icons and comments, served as a tool for the patients to keep track of care. Yet, this finding has not been confirmed in either recent studies where the use of SNCPs or CPs for educational purposes has been explored, or in the literature regarding peri-operative teaching. By helping patients keep track of care, the ONCP seems to have served the purpose of the care plans, which is to provide continuity of care [36]. Judging from the literature, traditional peri-operative teaching material does not provide patients with such continuity.

The most prominent communicational impact of the ONCP, namely more open and free communication, has not been confirmed in the current literature regarding patient teaching or the use of SNCPs or CPs as teaching material.

However, there are striking similarities between this finding and the general assumptions of critical theory that creating conditions for unconstrained communication contributes to empowerment [39, 40]. However, our study showed that the nurses did not discuss the ONCP with the patients, as had been intended, but mainly used it as written teaching materials. The participants felt that the ONCP should be used as a tool for communication and evaluation. Arguably, the participants were here asking for an empowering dialogue and a partnership with health care professionals, enabling them to gain increased control over their situation. This indicates that the ONCP has important under-utilised empowering potential.

Some participants felt they were not prepared enough for how their feelings would develop when the discharge approached. There are interesting similarities between these findings and the results of a study by Szöts et al. [41], which showed that knee-replacement patients most often had unrealistic expectations regarding their abilities and behaviour after discharge, which often resulted in distress. Both of these studies indicate that knowledge about potential responses to health situations is of considerable importance for patients. The general opinion among the participants that the ONCP and other teaching materials should be added to the care plan seems logical, because often the same information was repeated in the different teaching materials. Furthermore, the participants' suggestion that pictures should be added to the care plan is supported by prior studies that demonstrate the importance of providing education in visual and textual forms [42].

4.1. Limitations and Strengths

The main strength of our study was that it provided fresh understanding and shed new light on patients' experiences of reading their care plans in lay language. Yet, the study design does not allow for generalisation. It is certainly a limitation of the study that the data collection was conducted as early as 2000. However, many of the results have not been documented before and can thus contribute to current knowledge development about the use of SNCP. The first author's own involvement in designing the ONCP, as well as exploring participants' experiences of reading it, must be regarded as a limitation of the study. Yet, the undertaking of both authors in the data analysis enhances the trustworthiness of the study in this respect [28]. The fact that the participants received other teaching materials in addition to the ONCP sometimes made it difficult for them to distinguish between their experience of the ONCP and that of other teaching materials. This constitutes another potential limitation. On the other hand, it can be considered a strength of the study that it was most often clear when the participants were referring to ONCP and when they were referring to all the combined teaching materials they received.

CONCLUSION

This study suggests that a patient version of standardised care plans can act as an important educational tool for patients that can empower them to manage their health situations. These results can encourage health care professionals to find ways to use care plans as an educational tool for patients in their practice.

RECOMMENDATIONS

Continued use of the already implemented ONCP for THR patients on the respective orthopaedic ward was recommended in light of its overall empowering impact on the patients. Yet, our study clearly showed that improvements were needed in terms of some content of the ONCP and in enhancing its use in communicating and partnering with patients. Such practice development calls for further research on the use of the plan.

LIST OF ABBREVIATIONS

THR	=	Total Hip Replacement
SNCP	=	Standardised Nursing Care Plan
ONCP	=	Open Nursing Care Plan.
CP	=	Clinical Pathways or Critical Pathways

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Ethical approval was obtained from the National Data Protection Commission of Iceland (no. TND20000290//SJ/imbs). Official permission was obtained from the director of the hospital involved as well as the nurse and physician in charge of the respective ward.

HUMAN AND ANIMAL RIGHTS

Not applicable.

CONSENT FOR PUBLICATION

The participants received an introductory letter where the study was introduced. Written informed consent was obtained from all participants.

AVAILABILITY OF DATA AND MATERIALS

The data cannot be made available to the public due to the confidentiality agreement between the participants and the researcher.

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CONFLICT OF INTERESTS

The authors declare no conflict of interest, financial or otherwise.

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