KEYS TO UNLOCKING SERVICE PROVIDER ENGAGEMENT IN CONSTRAINED CO-PRODUCTION PARTNERSHIPS.PDF

Professionals arguably need more competence regarding involving service users, ‘ particularly in relation to user centred communication and relational skills ’( Bee eta l., 2015, p. 1835).

Researchers have focused on the needs of service users when involved in designing treatment( Stringer eta l.,2008).

Modest attention has been given to professionals ’ role in co production( Osborne, Rad nor, eta l., 2016), and more research around optimising the co production of public services is needed( Brand sen eta l., 2012; Osborne& Str oko sch, 2013).

Here, the identification of crucial skills to optimise the potential for co production is important, ‘ as well as mechanisms for enabling the development of these skills ’( Osborne& Str oko sch, 2013, p. 44). Co production partnerships Co production is defined as a process where service users and providers collaborate to improve, challenge, transform and innovate public service delivery( Osborne& Str oko sch, 2013).

A key challenge is to unlock the potential of genuine co production partnerships( Osborne& Str oko sch, 2013).

prisons )( Drake, 2014), an inherent structural power imbalance challenges the ideal of parity in action research.

Neither staff nor their organisation operate in a vacuum, free to re frame all operating rules and principles: Elements like organisational policy and professional codes of conduct may constrain the relationship between service users and providers( Larsen& Sag vaag, 2018).2 Action Research 0(0)182 Action Research 20(2) Although admission to treatment and participation in the inquiry was voluntary for patients, staff job descriptions support power imbalance: Patients can not take possession of their own treatment completely, but they can participate in improving selected services.

However, through reports and patient records, staff may contribute to the involuntary discharge of patients who do not accept or follow the rules of treatment.

This dilemma arose in the inquiry, where the idea was for existing services – such as consultations with specialised professionals and certain therapeutic activities( occupational and milieu therapy, sports and more) – to be co produced on an equal footing. Professional learning, empathy and dialogue Communicative space in action research ‘ refers to the social arenas for constructive dialogue and creative problem solving among stakeholders on issues of common concern ’ (Bo dork �os& Pat aki, 2009, p. 314).

Awareness concerning process facilitation and power relationships is therefore important( Ariel i eta l., 2009; O spin aet al ., 2004).

However, suppression of affect hinders processes of emotional and cognitive transition and learning.

This can be difficult, but facilitators can promote this capacity among participants in dialogue.

Dialogue is regarded as vital to human inquiry because it can be abounded space for ‘ cool inquiry ’ – a ‘ container ’ for the instability and intensity of human exchange( Isaac s, 1993, p. 2; Pal us& Mcguire, 2015).

Dialog ic leaders can, through self reflection and facilitation, cultivate 4 Action Research 0(0)184 Action Research 20(2) practices that enhance the quality of conversation, such as (a) cultivating the capacity to listen, (b) suspending certainties, (c) respecting others and (d) ‘ speaking in an authentic voice and encouraging others to do the same ’( Isaac s, 1999, p. 4). Isaac sis supplemented in more recent accounts concerning mediated dialogue – an approach in which artefacts such as images and texts enhance dialog ic exploration( Pal us& Mcguire, 2015). Isaac s (1999) describes dialogue action capabilities across four complementary roles: Movers initiate ideas, offer direction and voice their advocacy; followers complete the movers ’ initiatives by supporting them, inquiring into issues and helping others clarify; opposer scan correct the direction by challenging and questioning the validity of the claims – they may also advocate a different path; and bystanders provide perspective, as they observe the process and can inquire into it. A dialog ic leader must be able to take on each of these roles and facilitate their continuous interplay among the members of a group.

Genuine partnerships are the foundation for utilising knowledge that may challenge existing paradigms, and transform and code sign new services.

However, it is not enough to facilitate self empowerment among service users and expect them to begin total innovation.

We suggest that, to explore the potential for optimising co production, a crucial first step is to consider service providers ’ needs when collaborating with service users.

Staff, leaders and patients participating in the inquiry appeared to have no prior knowledge of co production conceptualisation or experience with involving patients systematically in service development. Design The cyclical principles of action research (Bryd on Miller eta l., 2003; Reason& Bradbury, 2008) were applied as a single case study( Fly vb jer g, 2006; Mab ry, 2008;Yin, 2009), starting with conceptualising and particular i sing the problem in collaboration with stakeholders, and moving through several interventions and evaluations( Heron, 1996; Heron& Reason, 2008).

Following the action research process, the action researcher withdrew from the action context to explore the data. In addition to service meetings and the scheduled inquiry( Figure 1), there we read hoc inquiry meetings with leaders, staff and or patients to address issues raised in the inquiry: The dialogue meeting was facilitated when staff and Pcs encountered communication difficulties, to resolve conflict between leaders, staff and Pcs. In this meeting, a new fixed meeting 2 was established for patients, staff and leaders to discuss treatment quality and code sign services. Inquiry phases The project used the four phases of knowledge development in cooperative inquiry as a framework 3( Heron, 1996; Reason, 1994).

Minutes were thus predominantly condensed descriptions of conversations, not verbatim transcriptions( Hammers ley, 2010; Poland, 1995).

Three themes 6 concerning patient – staff communication emerged from the data once the theoretical lens was applied.

This produced the three themes described in the discussion. The inquiry was approved by the Norwegian Centre for Research Data. Results Through our investigation of the critical conditions for co production in mental health and substance abuse services, three themes connected to communication emerged: (1) encounters preceding the meeting, (2) communication ambience and power imbalance and (3) constraints and dialogue. Encounters preceding the meeting Direct communication between patients and staff seemed challenging to both parties.

The researcher informed the Pc about this concern, and he ‘ concluded that the morning meeting was not the appropriate arena to address such a substantial matter; he would prefer to address it in the new forum ’( Journal ).

The Pc, however, did not propose this to the staff member directly. I met the Pc in the corridor and he seemed rather upset( his hands were shaking ).

Several encounters were thus necessary to establish a suitable meeting space in which a specific topic could be discussed with relevant parties – one of many examples of the challenges around facilitating direct communication between stakeholders. Communication ambience and power imbalance Issues around communication and power were ongoing.

Some patients explained how staff could make them feel subordinate: The co researchers from the patients report that the staff can overrule them and talk to them and set limits on them as if they were children.

( Patients, joint report )8 Action Research 0(0)188 Action Research 20(2) Although staff and patients were cautious about speaking openly in front of one another, patients could be explicit. A co researcher has observed that patients who have previously been critical in the unit have been discharged, saying that it is not necessarily advisable to shout too loud while on the ward.

As a result, co researchers also feel uncomfortable about participating in the research project, as there may be a threat that people who create conflict or ‘ the one who shouts loudest ’ may be discharged.

The patients also urged staff not to take their feedback personally.

However, in their response, the staff changed the topic, thus avoiding patients ’ concerns about involuntary discharge :SCs agree that the response should be perceived as constructive feedback and that focus should be placed on the services.

At the same time, constructive criticism from patients is a great way to ensure that we do not stagnate, but move on.

( Staff, joint report) As demonstrated above, challenges arose from the ambience surrounding communication between stakeholders.

Staff were perceived as paternalistic, and it appeared that some issues risked being bypassed – however important they may have seemed. Constraints and dialogue Involuntarily discharge became a concrete risk in the subsequent phase.

One day, the researcher was urged by staff to come to multidisciplinary treatment meetings, as they were concerned that Pcs might be discharged due to their core search activities.

Staff and leaders both reported that it was difficult for them to reassure decision makers who were not participating in the inquiry.

She encouraged[ the researcher] to guide the co researchers regarding their role in the environment, given that they are often ‘ going after ’ the staff.... We agreed that I should talk with staff and leaders to facilitate a meeting where patients, staff and leaders can enter into dialogue about this challenge.

189 Staff and leaders were concerned with the communication ambience and staffs ’ working environment, as Pcs ’ way of questioning existing practice was perceived as querulous and pushy.

Though the Pcs ’ involvement was essential to resolving this conflict, the urgency of their situation was kept a secret – they were led to believe that communication difficulties were the main issue. After several mediation meetings with the researcher, staff, Pcs and leaders agreed to meet to resolve the conflict and engage in dialogue.

Here, a staff member appealed to the Pcs ’ empathy: It makes one feel inadequate as a staff member, and perhaps the patients get the feeling that they are not respected when the staff member can not answer all their questions.

The staff must be included in the dialogue... Discussing changes is good milieu therapy, but you need to have good communication and not hide in the trenches.

The stakeholders agreed that this would be a meeting where they could resolve conflict, practise dialogue and develop the services. After facilitating this dialogue and attending three multidisciplinary treatment meetings, the researcher was confident that the discharge risk had been mitigated. As the above shows, the ‘ backstage ’ activity preceding direct communication was evident.

It is unclear whether the researcher ’s guidance and several encounters preceding meetings mitigated the discharge risk; however, in such an imbalanced power hierarchy, mediation and facilitation of dialogue seemed imperative. Discussion The results highlight key requirements for establishing genuine and balanced co production partnerships between service providers and users: First, the power imbalance embedded in the institutional structure must be equalised; second, a dedicated communication platform conducive to open dialogue for genuine 10 Action Research 0(0)190 Action Research 20(2) inquiry and mutual learning must be developed; and third, effective learning processes must be ensured. Dialog ic leadership and power Although we identified difficulties with direct communication, complementary roles india logic leadership also emerged.

As co researchers, patients often proposed inquiry pathways in a ‘m over ’ role( addressing the staff ’s paternalism, requiring change of search procedures, questioning existing practice, demanding change ).

However, the staff, when in the presence of patients, appeared hesitant to provide perspective( bystander ), challenge validity( opposer) or offer new directions (m over)( Isaac s, 1999).

This backstage opposition was one reason the dialogue meeting was facilitated, so stakeholders could cultivate a practice of direct communication. Even so, serious issues still remained hidden from the patients. The power relationships in this setting benefit from a simplified analytical dichotomy regarding movers and followers or opposer s.

On the one hand, staff and leaders may have struggled with their power disadvantage.

After all, in this relationship, staff and leaders held the power to ‘ grant or deny, facilitate or hinder ’ fulfilment of the inquiry ’s aim( Emerson, 1962, p. 32).

For one, the Pcs ’ fear of involuntary discharge may have been mitigated at such an early stage because it was a difficult topic for staff to explore with patients.

Confidentiality requirements may have made dialogue challenging, as staff could not discuss the involuntary discharge of former patients. However, staff avoided exploring the issue even on a more general level( as bystanders ).

Such a power laden topic may have been difficult for staff to address in the presence of patients without preparation and support from leaders and colleagues.

Under these constraining circumstances, patients were dependent on staff, leaders and the researcher to direct patients ’ behaviour( and thus have the power advantage ), without revealing to them what was at stake. Dialogue facilitation and co production Constructive dialog i cal roles seemed to be difficult for staff to enact, even if they complemented the patients ’ role in the core search process.

Also, while completing the initiated topic of ‘ communication difficulty ’ by supporting it( follower ), he advocated a different path out from the trenches( opposer) and urged patients to include staff in dialogue.

This suggests that, although he did not disclose the discharge risk, the leader role modelled authentic communication. It is possible to balance and enhance the quality of dialogue with awareness, reflection and cultivation of communicative practices and, as the power balance tilts in favour of professionals who are more securely positioned than service users, they have greater responsibility to promote inclusion through equal and authentic communication.

However, the staff ’s avoidance and backstage opposition suggests that they were in need of training and guidance concerning inclusion and balancing dialogue and power in patients ’ presence.

We now turn to some related opportunities for future learning in experience among staff. Learning in the presence of each other Patients appeared fairly direct about topics that seemed uncomfortable for staff; they also appeared courageous and genuine when revealing their fear of discharge. However, it seemed that patients ’ voices were not truly heard, as the staff appeared to engage in defensive organisational routines to avoid empathetic inquiry: They changed the topic, and, together with the leaders and researcher, pretended that communication difficulties were the reason for the dialogue meeting.

For instance, staff members were concerned about patients ’ reactions when they were unable to respond adequately to patient questions or demands.

Because of this, staff may have felt the need to shield themselves, through avoidance tactics and only discussing issues in patients ’ absence.

Staff may also have empathise d with the patients ’ expressed needs but were unable to accept the affect ivity that resonated within themselves.

Either way, genuine listening would have been difficult in this context .12 Action Research 0(0)192 Action Research 20(2) It may also have been challenging for staff to practise authentic communication in patients ’ presence, without engaging in the emotional labour necessary to understand their own feelings and needs.

Here, staff and leaders could air their fears and Pcs could empathise and agree to adjust their communication. However, this communicative space was not equal for all stakeholders.

By avoiding certain issues, staff may have indirectly limited patients ’ contributions in the dialogue, as they lacked knowledge about the whole situation. Secrecy may thus have prevented the direct affective exchanges that can enable deeper interpersonal relationships, communication and learning, and genuine meeting and learning on an equal footing.

However, speaking with a genuine voice is a main challenge of dialog ic leadership, and it did seem that staff needed some time before they could reveal their subjective truth in front of patients. Further, though discussions occurring in patients ’ absence may have reduced conflict, they may also have postponed staffs ’ professional development.

Bypassing learning in experience opportunities may have hindered or postponed their emotional and cognitive transition and learning.

repeating attempts to solve the same problem( uncomfortable confrontations with patients ), with no variation of method( avoidance) and without questioning the end goal( service quality )( Arg yris, 1995). With sufficient skills, however, the parties may have been able to support each other ’s double loop learning processes and mutual growth.

Informed by learning from being emotionally present in dialogue, the parties could have redesigned their actions and made more persistent changes within themselves and the services. Methodological considerations and limitations A participative perspective( Gay á Wicks& Reason, 2009) guided the relationship between the researcher and co researchers.

193 These principles required extensive consultations between participants, including transparency and access.

The value of applying this perspective in co production studies lies in the idea that knowledge should not be limited to its theoretical implications but to the practical value of the theory in use( Arg yr is& Sch €on, 1974).

As an action research project, our study inherits the strengths of this kind of approach: it addressed a practical challenge( to increase patient involvement ), generates new knowledge( co production ), enacted change (a fixed co production meeting ), was participatory( power sharing) and relied on a cyclical process( four phases of inquiry ). However, some have argued that a single case research design can contain pitfalls concerning methodological rigour, researcher subjectivity and external validity (Yin, 2009).

Others have argued that by clarifying and developing the methodological techniques and epistemological grounding of single case studies, these issues are of little concern( Bennett& Elma n, 2010; Fly vb jer g, 2006). Regarding the issue of general is ability, this is of limited relevance when the aim is one of particular is at ion, as in our action research project.

As such, the trustworthiness of the study is not compromised by combining action research with a single case design( Lincoln& Guba, 2007).

To establish genuine co production partnerships and facilitate organisational learning, service providers need tools to unseat unproductive defensive patterns.

This should be co developed and signed by service users and providers( including decision makers ), and should reveal agreed upon principles for how to approach issues of power, exclusion inclusion, confidentiality transparency; and expectations around trust openness, communication, collaboration, decision making and the scope of co production.

This should be a safe, contained space for feeling, thinking, monitoring developments, building sustaining relationships and participative co production. Here, empathy can be cultivated, threatening issues discussed, and deep seated fears and dilemmas clarified .• Joint dialogue training may encourage affective reflexivity and learning growing together.

Comparative cross country action research may be needed to assess different conditions for organising co production processes. Acknowledgements Our sincere thanks to all stakeholders involved in the process.

195 Declaration of conflicting interests The author (s) declared the following potential conflicts of interest with respect to the research, authorship, and or publication of this article: Division of Psychiatry, District General Hospital of Før de has been the first author ’s employer.

knowledge expressed through story, sculpture, movement and drawing – was not explored, the cooperative inquiry method was not strictly followed( Heron ,1996): Rather, the knowledge development phases were used as a framework for facilitating co production focused action research using qualitative data collection methods .4.

Finally, the joint work group report – based on the previous work group reports and field notes from the joint work group meeting – was member checked by both parties. The social construction complexity of such threads is not analysed here .6.

(1) Issues raised by patients ‘ in the presence of ’( Newton& Goodman, 2009) staff and or leaders, (2) issues raised in the absence of patients and (3) issues raised in the presence of patients .16 Action Research 0(0)196 Action Research 20(2) Reference sab ma, T. A.

Initiating action research: Challenges and paradoxes of opening communicative space.

), Social research: Issues, methods and process (pp.

Co production and third sector social services in Europe: Some crucial conceptual issues.

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1 Abstract Background: Chronic obstructive pulmonary disease( Cop D) is a life limiting condition with palliative care needs.

• Although the recognition of Cop D as a life limiting condition with palliative care needs is increasing, palliative care provision in Cop D remains underdeveloped • Integrated palliative care aims to create continuity of care within a patient ’s care network, thus avoiding care fragmentation with all individuals involved What this paper adds?

• Development of a new integrated palliative care model through a participatory action research with key stakeholders who care for patients with advanced Cop D • Identification of essential elements to foster care integration, as these key features are often overlooked in clinical practice • The use of a Theory of Change (ToC) framework as a theory to support reflections about the need to change care delivery for patients with advanced Cop D and foster palliative care integration • Institutions that are supporting change of care delivery for these patients are challenged to develop educational programmes for healthcare professionals caring for patients with advanced Cop D and their families Implications for practice, theory or policy?

3 • Multidimensional assessment, healthcare professionals ’ education and interdisciplinary team meetings are the pillars of this new integrated palliative care model for patients with advanced Cop D • Raising awareness among healthcare professionals working for palliative and respiratory care services about the role palliative care might play in advanced Cop D • Availability of a theory to guide implementation that can be tested in both local evaluation processes and in further research • Future research on service development, implementation processes and outcomes, including evaluation of the financial impact of integrated palliative care provision is deemed necessary to foster this care approach across all patients ’ settings Introduction Chronic obstructive pulmonary disease( Cop D) is a leading cause of worldwide morbidity and mortality in adults .1 Advanced disease is characterised by a decline in overall function, a progressive loss of independence and an important multidimensional symptom burden .2 Although the recognition of Cop D as a life limiting condition with palliative care needs is increasing, palliative care provision in Cop D remains underdeveloped .3 The disease unpredictability, the misconceptions about palliative care being restricted to cancer and perceived to be only relevant in the last days of life often prevent a timely integrated care plan for patients with advanced Cop D.4 Several national and international guidelines on care provision for patients with Cop D include the role of palliative care in advance disease, suggesting a palliative care approach and involvement of a palliative care team .58 However, they seldom advise how to provide palliative care in advanced Cop D services, thus fostering debates on key components of palliative care delivery in this population.

Prior to this research, the institution delivered specialised palliative care through inpatient consultations for every hospitalised Cop D patient presenting with advanced disease; however outpatients in the respiratory service did not benefit from a systematic palliative care provision.

Consequently, further strategies were judged to be needed to promote greater utilization of palliative care for patients with advanced Cop D.

Review and need for reflection 7 participants were selected through purposive sampling among 38 healthcare professionals from different professional background( physicians, nurses and physiotherapists) and from both services who expressed an initial interest to participate.

Moreover, Theory of Change embedded in this action research encouraged reflections about the need to recognise different levels of an institution where changes may be facilitated or prevented .25 To support a fundamental change in care delivery for patients with advanced Cop D and foster palliative care integration, it was essential either to rethink the system where care is delivered or to adopt different models for care provision compared to the current situation .26 Key elements of a Theory of Change approach( the “ how and why ”) were applied to understand how to further shape and develop the new integrated care model and to provide a framework for monitoring and promoting future evaluations.

A higher level of detail could not be provided due to anonymity concerns.

Table 2: Identified themes for integrated palliative care in Cop D Identified themes for the development of integrated palliative care in Cop D Multidimensional assessment (“ Focus on patients ”) Clinical assessment( patients ’ needs) Identification of palliative care patients Palliative care timing Healthcare professionals ’ education (“ Focus on professionals ”) Theoretical knowledge of general palliative care approaches Shared practical knowledge Reflective practice Interdisciplinary team meetings (“ Focus on care delivery ”) Some of these themes had been previously described as integrated care criteria for palliative care initiatives .11,27 These themes were considered as key elements which helped to develop a new integrated palliative care model for patients with advanced Cop D.

The starting point of this new integrated palliative care model was the assessment of needs.

The identification of advanced Cop D patients as palliative care recipients, the timing of palliative care provision in 11 standard respiratory care and a holistic evaluation of patients ’ needs, were key features of this first component of the new model of care provision.

Interdisciplinary team working was understood as integrating knowledge and competences from all healthcare professionals towards a common, patient centred approach of care delivery .28 This is different to multi disc ip lina rit y, where collaborative work approaches among healthcare professionals with different competencies and skills are practice d within discipline borders .29 Further elements of interdisciplinary team meetings were not explored by participants during the Cig meetings.

Discussion This research reiterates already known essential elements for palliative care integration in advanced Cop D, such as holistic needs ’ assessment, educational initiatives and modalities of service delivery .3032 However, this study addresses the identification of key features each 12 essential element should include to allow and foster the process of palliative care integration in patients with advanced Cop D, while being supported by a Theory of Change framework.

Firstly, multidimensional needs ’ assessment should consider three aspects, such as patients ’ needs( the “ what ”), palliative care timing (“ the when ”) and identification of palliative care recipients( the “ who ”).

This shift from elements identified in the Cig meetings towards a pathway of change helped to understand what is needed to further develop the implementation and broader dissemination of the integrated care model in advanced Cop D.

The elements of the pathway of change in relationship to the proposed integrated palliative care model are listed as follows: 1) Long term outcome: cantonal integrated palliative care model for advanced Cop D 2) Interventions: educational training, choice and implementation of patient identification and needs ’ assessment tools, development of inter disc ip lina rit y within caring teams 3) Intermediate outcomes: • education: personnel is trained in palliative and respiratory care( acquiring theoretical, practical and experiential knowledge) • needs ’ assessment: tools are used in daily clinical practice • service delivery: interdisciplinary team meetings are regularly held 4) Indicators: they need to be discussed with key stakeholders in order to evaluate the integrated initiative( for example number of healthcare professionals who are trained, patients ’ and carers ’ satisfaction with care delivery, healthcare professionals ’ experiences with care model, economic impact ).

Nevertheless, a patients ’ palliative care 14 identification tool was implemented, fostering shared consultations with pul mono log is ts, palliative care physicians and physiotherapists .35 Furthermore, the definition of milestones on the disease trajectory of all patients, such as the introduction of long term oxygen therapy or loss of recreational activities triggered palliative care referral.

Shared consultations addressed patients ’ needs assessment through a specific validated tool that helped to tailor care provision according to patients ’ needs .36 Virtual educational conferences for healthcare professionals within the respiratory service were conducted to foster general palliative care knowledge, albeit focussing on issues concerning respiratory diseases.

Strengths and limitations The strengths of this study need to be highlighted.

Furthermore, this study identifies elements of a pathway of change that are needed to 15 implement the new intervention in standard care.

The limitations of this study need to be acknowledged.

The assessment of quality and rigour in action research remains an open debate .37 However, this research was supported by already established criteria, such as evaluation of worthwhile practical purposes, participative and democratic inquiry, inclusion of different forms of knowledge and maintaining a continuum of research development over time .38 Furthermore, it is important to highlight the role of the researcher, as practising action research within a practitioner ’s group with hierarchical relationships is challenging.

The risk of developing asymmetrical relationships and thus preventing a truthful capture of all opinions and voices needs to be constantly assessed .39 The Cig presented a dual power imbalance: one between the researcher and the nonmedical professionals( nurse, physiotherapist ), the second between the researcher, a senior consultant in palliative care and her medical colleagues.

Continuous reflexivity and ongoing discussions about power relationships and sources of inequity were helpful to address potential study limitations .40 In addition, the use of few practicalities, such as participants interacting by first name, creating an informal Smartphone chat app to schedule all group meetings and attending meetings in plainclothes, thus avoiding white coats within the physician group, helped to overcome potential power imbalance.

This research would not have been possible without a raised awareness among healthcare professionals working for the palliative and respiratory care service about the role palliative care might play in advanced Cop D.41 This aspect is fundamental for promoting integrated care models into practice .42 Supporting knowledge dissemination on this topic could mitigate preexisting misconceptions about palliative care, such as being relevant only in end of life and oncological settings, thus increasing interest and initiatives towards palliative care integration in advanced Cop D.43 Healthcare professionals ’ education was recognised as a pillar of this integrated care model.

Hence, institutions that are supporting change of care delivery for these patients are challenged to develop educational programmes for healthcare professionals working with advanced Cop D patients and their families.

Inter disc ip lina rit y requires integrating knowledge and competences from all involved healthcare professionals towards a common and patient centred approach of care provision .28 Learning how to work together in an interdisciplinary way needs training and the use of individual and group reflective practice.

This is a process that is time consuming and 17 requires guidance from professionals who are used to working in and conducting interdisciplinary teams .45 Lastly, respiratory care services that are interested in implementing integrated care models should consider the impact of professional resources needed for palliative care delivery.

Therefore, facilitators and barriers for implementation need to be explored and acknowledged during future service developments.

Lastly, understanding the perspectives of end users and of professionals working within and across services may foster quality improvement and ongoing model adaptation to changing needs.

Declaration of conflicting interests The author (s) declared no potential conflicts of interest with respect to the research, authorship and or publication of this article.

Understanding the challenges of palliative care in everyday clinical practice: an example from a Cop D action research project.

37 Mc Tag g art R. Participatory Action Research: issues in theory and practice.

39 Casa ret t D. Ethical Issues in Palliative Care Research.

40 Grant J, Nelson Gand Mitchell T. Negotiating Challenges of Participatory Action Research: Relationships, Power, Participation, Change and Credibility.

Non cancer patients in specialized palliative care in Germany: What are the problems?

THE DEVELOPMENT OF A STAKEHOLDER ENDORSED NATIONAL STRATEGIC PLAN FOR ADVANCING PAIN EDUCATION ACROSS CANADIAN PHYSIOTHERAPY PROG.PDF

However, there is little research to inform the collaboration and coordination across stakeholders that is needed for its implementation. Aims: This article reports on the development of a stakeholder generated strategic plan to improve pain education across all Canadian physiotherapy (PT) programs. Methods: Participants included representatives from the following stakeholder groups: people living with pain (n= 1), PT students and recent graduates (n= 2), educators and directors from every Canadian PT program (n= 24), and leaders of Canada ’s national PT professional association (n= 2).

For instance, a set of core pain management competencies was developed to serve as high level educational outcomes for inter professional health education programs .6 National and international surveys of entry level health education programs have established the need for improving pain education by revealing an overall lack of curricula content and time dedicated to pain education across different professions programs, including medicine, nursing, and physiotherapy (PT).7–12 Other work has created pragmatic guidelines and reported on exemplar programs illustrating how pain management competencies can be integrated within individual health professions programs .13–16 However, an important challenge that remains under addressed within the pain education literature includes potential avenues for facilitating collaboration across the different stakeholders within health professions.

In this context, people living with pain can be considered downstream stakeholders because they may receive treatment from newly trained clinicians but are not always positioned to influence how clinical students learn about pain.

We recently reported on this workshop ,17 which established stakeholder consensus on the need to improve PT pain education across Canada, and began to explore the barriers, facilitators, and preliminary strategies that influence how stakeholders might work together to achieve this improvement.

These stakeholders abstained due to their concern for a potential conflict of interest in relation to their roles within the profession as autonomous evaluators; these same stakeholder groups also abstained from endorsing the previously reported consensus statement related to this initiative .17 These groups represent two of the four stakeholder groups that form the National Physiotherapy Advisory Group (NPAG) that governs the PT profession in Canada; the other two NPAG members( The Canadian Council of Physiotherapy University Programs and The Canadian Physiotherapy Association) participated in the present work, as well as our previous research in this area .17 Consistent with an integrated knowledge translation approach, the authors of this article included members of the PT pain educator (G.B., L.C., J.H., J.M., K.P., D. W., T.W.)

To summarize, these strategies included integrating International Association for the Study of Pain competencies within national standards and regulatory policy, encouraging the development of best teaching practices among PT pain educators across the country, partnering with people living with pain, building increased awareness of the need to improve pain education, and setting clear goals and outcomes to guide national collaboration on improve dpt pain education. Stakeholder interviews( Figure 1, 1b) were used to assess support and further develop these workshop generated strategies.

An interviewer not involved in the interview reviewed the audio recordings and field notes to resolve any discrepancies. Interview data were compiled and thematically anal y zed( Figure 1, 1c) following qualitative description .23 Qualitative description is rooted in subjectivism and seeks to understand a phenomenon, a process, or the perspectives and worldviews of participants .24 Qualitative description aligned with our data analytic goals of providing a rich and literal description of participants ’ perspectives, while striving to adhere to the verbatim data as closely as possible .23 Other common qualitative methodologies were not well aligned with the goals of this study, because they do not aim to address culture( ethnography ), lived experience( phenomenology ), or theory building( grounded theory ).25 Data were anal y zed using a combination of deductive and inductive coding.

In addition, data that did not fit within the five workshop generated strategies were anal y zed separately to determine whether new themes emerged.

A third member of the research team was consulted if any discrepancies could not be resolved.

Once all working group members were satisfied with the strategic plan, it was emailed to each of the participating stakeholders for endorsement( Figure 1, 3a). Assessment of Stakeholder Endorsement of the Final Strategic Plan A single item online survey question was used to assess stakeholder endorsement of the strategic plan( Figure 1, 3b); participants could indicate whether they supported or did not support the strategic plan or whether they abstained.

Stakeholder endorsed strategic plan for improving pain education in Canadian PT programs. Strategic priority 1: Support members of the National Physiotherapy Advisory Group (NPAG) in identifying and addressing current clinical and educational best evidence related to pain management. Key strategies :● Help NPAG members identify best evidence related to pain management by generating consensus recommendations and or providing resources related to pain education .● Support NPAG members in developing strategies for addressing best evidence on pain management within their respective national governance and regulatory resources, such as the NPAG Competency Profile for Physiotherapists in Canada, Entry to Practice Physiotherapy Curriculum guidelines, Accreditation Standards for Physiotherapy Education Programs in Canada, and or the Physiotherapy Competency Examination Blueprint. Strategic priority 2: Facilitate the integration of pain management competencies a within individual entry to practice physiotherapy programs and their associated inter professional educational programs and encourage the use of best teaching and assessment practices. Key strategies :● Develop a community of practice for pain educators and clinical supervisors across Canada that promotes mentorship, sharing of resources, best practices in teaching and assessment, and connections with local networks that support implementation .● Provide exemplars outlining different models of how pain management competencies can be integrated within physiotherapy training curricula .● Offer training on the development and assessment of curricula based on pain management competencies .● Develop guidelines for incorporating pain management competencies within inter professional education initiatives. Strategic priority 3: Engage people living with pain as partners in the design and implementation of curricula to ensure strong alignment with patient needs and priorities. Key strategies :● Partner with organizations and or individuals who aim to support people living with pain .● Develop a network of people living with pain that can partner with local physiotherapy programs to improve pain education.

Create resources that can facilitate this partnership .● Develop teaching materials (e.g., videos, case studies, online learning modules) that focus on the experiences and perspectives of people living with pain that can be shared across programs. Strategic priority 4: Highlight the urgent need for improved pain education by advocating for the importance of pain management competencies and the essential role of physiotherapists in managing pain to (a) physiotherapy professionals, (b) other health professionals, and (c) the community at large. Key strategies :● Develop stakeholder consensus on core advocacy messages, desired media, and target audiences .● Partner with key stakeholders, special interest groups, professional associations, and health regulators that are well positioned to build awareness and support for effective pain management among each of the targeted groups.

Figure 2 portrays this relationship using an indirect arrow; though NPAG members are actively supported, their governance decisions are not directly within the scope of this strategic priority.

The two NPAG members that are more directly involved in regulation and accreditation opted to not participate in this process, whereas the two members that were involved in leadership and promotion of the PT programs and the profession did participate.

Other work in the area of U.S. medical education suggests similar challenges in integrating best evidence within their entry to practice examinations .29 It is likely that full integration of regulatory stakeholders will be a common challenge across professions and regions. Figure 2.

One challenge in implementing this plan will be to develop a pragmatic and feasible model for guiding these relationships.

The Patients as Partners framework may serve as a useful template that could be adapted to the context specific needs of PT pain education .32 Equitable engagement will also require adequate financial resources to support the work done by these partners, something that has been identified as a barrier in prior patient partnered initiatives ,33 further emphasizing the need for sustainable funding to ensure successful implementation of the plan. The fourth priority emphasizes advocacy, both within and outside of the PT profession, around the potential added value of Pts in effective pain management.

For instance, in 2017 the American and Canadian PT associations issued a joint statement that advocated for increasing the PT role within the non pharmacological management of pain in an effort to combat the opioid epidemic .35 Yet, despite this and related work, there are still important barriers within and outside the profession that may limit these efforts.

For instance, Pts often report low levels of confidence in managing patients with complex forms of chronic pain ,36–39 and patients seeking care report important barriers to engaging in non pharmacological treatments, such as restricted access or funding, reduced motivation for self management, and limited perceived efficacy of these interventions .40 These provider and patient barriers may have an interactive effect that further limits the availability and use of effective non pharmacological management options.

Future research in this area should explore the role that improved entry level education may play in mitigating these barriers .41 For instance, enhanced professional education may help new graduates become stronger advocates for non pharmacological management, which in turn may help limit some of the external barriers to care. The fifth and final priority focuses on the importance of research and evaluation of the effectiveness of any new curriculum, education, or training strategies .42 Evaluation is an important part of any rigorous implementation and or knowledge translation strategy .21,22 It should be targeted to optimize valid capture of important domains.

People living with pain, students and new graduates, and educators each provide unique and valuable insights into what change is needed, and engaging program administrators and national regulators is critical to facilitating implementation.

With this type of stakeholder engagement, the reported process could likely be tailored to fit the idiosyncratic needs of other training programs in different regions and across different professions. Readers are encouraged to also consider some of the limitations related to this work.

For instance, this project had apt centric focus that did not include other health professions.

This process and outcome may serve a useful template to facilitate improved pain education across other professions and geographic regions. Disclosure statement Timothy H. Wide man has received financial compensation for providing continuing education training on pain management for health professionals. David M. Walton has previously provided paid continuing professional development sessions for clinicians working in pain management, provides third party consultation, and has a small stake in a pain evaluation startup company (Ac tic A I Inc .) in London, Ontario; is co holder of a Canadian patent for a panel of blood markers intended for use in chronic pain risk and prognosis screening; and either currently or within the past 5 years has received grant funding from arm ’s length public fun der s, including the Ontario Ministry of Research and Innovation, the Canadian Pain Society, the Canadian Institutes for Health Research, and the Canadian Pain Network Chronic Pain Centre of Excellence; all such relationships existed prior to undertaking the current project and or will not be affected by the results described herein. Lisa Car les so has received honor aria from EPA Health and the Canadian Orthopaedic Foundation. All other authors have no conflicts of interest to report. Informed Consent Statement Informed written and verbal consent to participate in this project was obtained prior to the start of this study.

Hoe ger Be men t MK, St Marie BJ, Nor d st rom TM, Christensen N, Mong oven JM, Koebner IJ, Fish man SM, Sluka KA.

Pome y MP, Hi hath, Kh al if a M, Le bel P, Nér on A, Dumez V. Patient partnership in quality improvement of healthcare services: patients ’ inputs and challenges faced.

Syn not t A, O’ Keef fem, Bun zli S, Dank aerts W, O’ Sullivan P, O’ Sullivan K. Physiotherapists may stigmatise or feel unprepared to treat people with low back pain and psychosocial factors that influence recovery: a systematic review.

‘I need to do another course ’ Italian physiotherapists ’ knowledge and beliefs when assessing psychosocial factors in patients presenting with chronic low back pain.

(4) What are strategies are not of particular interest relevance to your stakeholder group ?a.

· Version 4( Final ): Engage people living with pain as partners in the design and implementation of curricula to ensure strong alignment with patient needs and priorities. Strategic priority 4: · Version 1: Build awareness of the importance of pain education for physiotherapists.

· Version 4( Final ): Highlight the urgent need for improved pain education by advocating for the importance of pain management competencies and the essential role of physiotherapists in managing pain to (a) physiotherapy professionals, (b) other health professionals, and (c) the community at large. Strategic priority 5: · Version 1: Set clear goals and assess outcomes.

THE PROCESS OF USING PARTICIPATORY ACTION RESEARCH WHEN TRYING OUT AN ICT SOLUTION IN HOME-BASED REHABILITATION.PDF

The Process of Using Participatory Action Research when Trying out an ICT Solution in Home Based Rehabilitation Regular Article International Journal of Qualitative Methods Volume 21: 1–8© The Author (s) 2022DOI: 10.117716094069221084791 journals. sage pub. com home ijq The Process of Using Participatory Action Research when Trying out an ICT Solution in Home Based Rehabilitation Anne lin y man 1, St in a Rut berg 1, Margaret a Lilja1, and Gun ill a I saks son 1 Abstract This article describes the process of using Par and discusses the strengths and challenges of adopting it as a methodology.

This pilot project aimed to explore how ICT solutions can create new ways to deliver home based rehabilitation that meet the needs of the organization, rehabilitation professionals, and older persons.

Our project stemmed from demographic and epidemiological trends in society viewed as a “ real life problem ” experienced on different levels in the organization of home based rehabilitation.

At the same time, Par was a challenging research method to use, as it was time consuming and required the commitment and contribution over time of the different participants involved.

There were also specific challenges that had to be considered regarding routines and regulations, as the pilot project was conducted in a healthcare context.

We propose that these guidelines can act as a tool to guide researchers in carrying out Par. Keywords action research, methods in qualitative inquiry, Par participatory, action research, mixed methods, community based research Introduction This paper describes experiences associated with the process of using participatory action research( Par) in a pilot project when trying out an ICT solution in home based rehabilitation. According to Frei re (1993), action can range from the rising of critical consciousness among individuals and communities about a shared concern to changes in practices.

Further, Frei re argues that the central tenet of Par is that it begins with a real life problem or need (s), rather than with the researcher ’s perception of those problems.

This pilot project was designed as a response to concerns accentuated by social services, responsible for community based healthcare, in a municipality in northern Sweden.

The rehabilitation professionals and stakeholders in social services experienced growing challenges in practice to uphold quality in home based rehabilitation, for example, continuity in intervention delivery and followups.

Further, they experienced challenges to provide accessibility to service, especially when older persons were living in rural areas, which involves time consuming travels. They stressed the need to develop new working methods in home based rehabilitation as an urgent and essential issue, which formed the basis for this pilot project.

Thus, new working solutions and methods need to be developed to effectively deliver rehabilitation. In this pilot project, working solutions, including the use of information and communication technologies (I Cts ), was designed to meet the need to develop effective working methods.

It values experimental knowledge that can be used to address real life problems and achieve positive social change( Park, 1999; Reason& Bradbury ,2008).

More specifically, in this pilot project, participants from social services in the municipality( see Table 1) were involved in identifying issues and participating in the process of shared dialogue and reflection to understand the issues of concern. This shared process was critical to further address actions needed to develop effective working methods in home based rehabilitation. Purpose of This Paper In this paper, we describe the process of using Par and discuss the strengths and challenges of adopting it as a methodology.

This pilot project aimed to explore how ICT solutions can create new ways to deliver rehabilitation that meet the needs of the organization, rehabilitation professionals, and older persons. Methodology To address the purpose and provide a description of the process when using Par, we applied a methodological approach involving six steps.

The six steps are (1) delineating the problem; (2) choosing action; (3) design and assessment; (4) engagement in action; (5) data collection; and (6) reflective knowledge. Design of the Pilot Project – “ The Rehabilitation Journey ” The pilot project employed a Par design and lasted over a period of eight months.

Different members involved in the rehabilitation process in the municipality( Table 1) were included and encouraged to identify needs, plan and try out solutions in their practice setting as well as make necessary changes during the project.

Using this method promoted the inclusion of different actors from social services in the municipality as co researchers in different phases of the project, including identifying and prioritizing the problem of importance to research, generating, and anal y zing data and disseminating results to inform change .2 International Journal of Qualitative Methods Study Setting The pilot project was carried out in a middle sized municipality with an area of 2000 square kilo meters and 78 000 residents in the northern part of Sweden.

The pilot project included researchers and participants with different levels of expertise and responsibilities regarding social services and rehabilitation in the municipality as well as those in need of rehabilitation, that is, key stakeholders, stakeholders responsible for rehabilitation, rehabilitation professionals, and older persons in need of rehabilitation.

An overall problematic situation was described by the key stakeholders concerning the increased responsibility for home based rehabilitation and the growing proportion of older people with rehabilitation needs in their homes.

They described an urgent need to find new effective working solutions and methods to deliver home based rehabilitation.

Delineating the problem Workshop.

Step one began with a workshop to outline the problems and needs regarding organizational concerns related to growing challenges to uphold quality in home based rehabilitation.

Different problems were identified in relation to effectively delivering and upholding quality in home based rehabilitation.

Illustration of Actions Taken and Participant Involvement in the Six Steps of the Par Method. The Six Steps of Par Actions Participant Involvement Step 1: Delineating the problem Workshop Stakeholders responsible for rehabilitation, rehabilitation professionals and all researchers Step 2: Choosing action Seminar – choosing ICT solution All researchers Workshop – test of ICT solution Stakeholders responsible for rehabilitation, rehabilitation professionals and all researchers Stakeholder consultation – presentation and discussion of ICT solution Key stakeholders and researchers (GI, SR) Step 3: Design and assessment Workshop – choosing approach for data collection and procedures Stakeholders for rehabilitation, rehabilitation professionals and all researchers Step 4: Engaging in action Trying out the ICT solution Rehabilitation professionals and older persons Workshops( three occasions) Rehabilitation professionals and all researchers Step 5: Data collection Field notes Researcher (GI, SR) Interviews with older persons Researcher (GI, SR) and older persons Step 6: Reflexive knowledge Workshop Stakeholders responsible for rehabilitation, rehabilitation professionals and all researchers Seminar – presentation of and reflections on results Stakeholders responsible for rehabilitation, rehabilitation professionals, researchers (GI, SR) and invited rehabilitation professionals from the municipality Note.

3 solutions, and methods affected possibilities to deliver rehabilitation to an extent that met the older persons ’ needs. Another problem was a lack of support for family caregivers and home help staff.

The discussions reflected frustration about the limited possibilities to deliver a high quality service in practice to meet the needs of older persons in their homes. From the discussions, the following requests were prioritized by the stakeholders responsible for rehabilitation and the rehabilitation professionals: (i) provide a more time efficient way to deliver home based rehabilitation using ICT, (ii) develop and try out new working methods using ICT to successfully provide home based rehabilitation, and( iii) provide solutions using ICT to support family caregivers and home help staff.

At this point, many ethical issues arose related to difficulties in handling information in a secure way when trying out ICT solutions in a health care context.

Consequently, many of the needs identified could not be managed within this project, and a shared decision was made to use an ICT solution for interaction and communication in real time but not record any data.

Step two began with a seminar where the researchers( see Table 1) discussed potential ICT solutions that could meet the identified problems to effectively deliver and uphold quality in home based rehabilitation and prioritized requests identified in step one.

More specifically, possibilities and challenges for social services to provide I Cts up port to rehabilitation professionals were emphasized.

In these discussions, benefits and challenges were identified from the perspective of the rehabilitation professional ’s and their ideas of how to meet older person ’s needs.

Furthermore, individual interviews were decided upon in favor of focus groups based on the experience of the rehabilitation professionals concerning older persons ’ various needs and challenges.

These discussions were important to capture experiences, benefits, and challenges from the perspective of rehabilitation professionals and older persons during the rehabilitation process.

In addition, to generate ideas on how the ICT solution could be further adopted to be more user friendly, that is, to meet the needs of all users( rehabilitation professionals and older persons ).

Another experience expressed by a not was how to instruct and assist a home helper in adjusting problems with an older person ’s wheelchair. These examples illustrate how collaboration can be developed, resulting in more effective use of time and rapid response to issues and problems that can occur in practice. Identified challenges with the ICT solution from the perspective of the rehabilitation professionals were associated with the technology and usability of the ICT solution.

A general problem was the internet connection, and the transmission of pictures and voice was interrupted or was of bad quality.

In addition, challenges were related to how to position the tablet to capture a situation.

For example, when the tablet was close enough for the older person to see the rehabilitation staff, he or she could not see the older person ’s arms or legs and make necessary corrections in the program.

Another example was coaching rising from a chair when there were problems with the older person ’s being either too close or not close enough to see the instructions. Step 5 Data collection In the pilot project, data collection involved both field notes and interviews with older persons. Field Notes.

During the entire pilot project, the researchers (GI,SR) generated data by documenting field notes at all workshops and seminars to note identified problems, reflections, ideas, and experiences of trying out the ICT solution.

The interviews were conducted in a manner to capture their stories and experienced benefits and challenges with trying out the ICT solution in their rehabilitation. The identified benefits and challenges of using the ICT solution from the perspective of the older persons were associated with usability.

Using the ICT solution created opportunities for the older persons to show problematic situations related to daily activities in the home environment as well as outdoors. Furthermore, the continuity and close followups during the rehabilitation process created a feeling of safety.

Difficulties that were expressed were related to handling the technique, which was experienced as stressful.

For example, some older persons had problems turning on the tablet or starting the Skype app.

They pressed the button either too long or not long enough to be able to start the program.

In these cases, support was needed from either a relative or a home helper.

It became evident that the ICT solution was not user friendly for all .Ny manet al.

The identified possibilities and challenges during the workshops in step four( during the period of trying out the ICT) were again highlighted and discussed between the researchers, rehabilitation professionals, and stakeholders responsible for rehabilitation( see Table 1).

Ideas for solutions were built upon the rehabilitation professionals ’ experiences of identified challenges in the project, such as being able to connect the tablet to an external camera or the television and to use a stand for better positioning of the tablet.

Yet, another idea was recording different exercises or activity performances in the older persons ’ environments to enable the rehabilitation professionals to monitor their progress and take part in how problems occur.

The discussions focused on the results from the project and identified benefits and challenges.

Furthermore, the discussions continued with the ideas and challenges that were identified in the last workshop with the rehabilitation professionals( step 6). Methodological Insights A fundamental premise of Par is that it embraces the concerns experienced by a group, community, or organization( Frei re, 1993; Park, 1999; Reason& Bradbury, 2008).

Our experience is that using Par as a research method in the pilot project had several strengths, as our project stemmed from demographic and epidemiological trends in society viewed as a “ real life problem ” experienced on different levels in the organization of home based rehabilitation.

At the same time, Par was a challenging research method to use, as it was time consuming and required the commitment and contribution over time of the different participants involved.

There were also specific challenges that had to be considered regarding routines and regulations, as the pilot project was conducted in a health care context.

Our methodological insights will be further discussed below in relation to the methodological approach applied. Strengths and Challenges of Adopting Participatory Action Research Delineating the Problem.

A strength of using Par when delineating the problem was that it was opened for knowledge translation from different areas of expertise and, therefore, enabled equitable relationships between participants and researchers.

As such, Par promoted the inclusion of participants as collaborators and co researchers in the identification of a problem that mattered to those involved and their community (cf.

During these discussions, the voice of the rehabilitation professionals became especially important to capture “ the real life problems ” they experienced.

However, the strength of capturing real life problems also became a challenge as the project had to consider routines and regulations within the organization as well as ethical issues.

These challenges influenced the decisions that had to be made, as the project was situated in a healthcare context. Choosing Action Steps The collaboration of individuals with diverse knowledge, skills, and expertise is described as a strength in Par, as it fosters the sharing of knowledge development( Macdonald ,2012).

For example, including key stakeholders in the discussion at this step made it clear that there could be problems related to ICT services because the social services It department could not provide support to the rehabilitation professionals during the pilot project.

(2015) arguments that collaborators should have a voice and that researchers do not have complete power over data interpretation. Engaging in Action Engaging in action was challenging because it was time consuming.

A strength of this step was the fact that it continued over an extended period of trying out the ICT solution and engaging in continual dialogues of sharing experiences during workshops. In this sense, problems and challenges were discussed, and new ideas were generated.

However, some of the identified difficulties, from the perspectives of both the rehabilitation professionals and the older persons, could not be resolved during the pilot project.

Although Par seeks to fully include all participants as co researchers( Reason& Bradbury, 2008), research highlights difficulties in involving all participants in all phases( Can las& K arp u dewan, 2020).

It can be considered a weakness that older persons were not involved as co researchers from the beginning of the project.

Therefore, Par was not utilized to its full potential.

Not involving older persons as co researchers is also highlighted and criticized in a review evaluating Par with older adults( Corr a do eta l., 2020). Nevertheless, we consider them active contributors to the research and knowledge generation, even though they did not participate in all steps (cf.

Mcdonald s, 2012). Reflexive Knowledge The final step in the Par process should stimulate a reflection — action — reflection cycle( Frei re, 1993) in which ongoing understanding of new problems and action to address those problems is facilitated by the generation of knowledge( Park, 1999).

A challenge identified for further implementation was that changes needed to be made within the organization to support the new working methods that were tried out in the pilot project.

Fletcher eta l., 2015). Conclusion To conclude, Par is an established method; however, it has been argued that Par studies do not articulate or fail to explicitly demonstrate the methodology used in the processes( Can las& K arp u dewan, 2020), and we agree with this critique.

Delineating the problem Workshop Step 2 Choosing action steps Seminar – Choosing an ICT Solution Workshop – Test of the ICT Solution Stakeholders ’ Consultation – Presentation and Discussion of the ICT Solution Step 3 Design and assessment Workshop – Choosing an Approach for Data Collection and Procedures Step 4 Engaging in action Trying Out the ICT Solution Workshops – Experiences of Using Skype Step 5 Data collection Field Notes Interviews with the Five Older Persons Step 6 Reflexive knowledge Workshop Seminar – Presentation of and Reflections on Results Methodological Insights Strengths and Challenges of Adopting Participatory Action Research Delineating the Problem Choosing Action Steps Design and Assessment Engaging in Action Data Collection Reflexive Knowledge Conclusion Acknowledgment s Declaration of conflict of interests Funding Or Cid id References