


How the current non-significant effects of person-centred care on nurses' outcomes could be abated by the WE-CARE roadmap enablers: A discursive paper

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Abstract

Aim: To describe the non-significant results in nurses' outcomes after the implementation of person-centred care (PCC) and discuss if and how enablers of the WE-CARE roadmap for implementing PCC could abate the non-significant results.

Design: In this paper, an innovative framework of enablers in the WE-CARE Roadmap is explained in relation to increased PCC and nurses' job satisfaction.

Method: Findings from a scoping review and published material provided how PCC and nurses' outcomes connect. The WE-CARE roadmap entails five enablers: Information technology, Quality measures, Infrastructure, Incentive systems and contracting strategies.

Results: The WE-CARE roadmap was described and each enabler in the WE-CARE roadmap is discussed concerning PCC and the nurses' job satisfaction. Thus far, the effects of PCC on nurses' outcomes have been non-significant. The WE-CARE roadmap enablers can be implemented to ensure an increased PCC implementation and higher nurses' job satisfaction.

KEYWORDS

enablers, job satisfaction, patient-centred care: nurses, person-centred care, WE-CARE roadmap

1 | INTRODUCTION

Person-centred care (PCC) has been widely promoted as an ethical and holistic approach to care to relieve some of the pressure on the healthcare system and has proven to be a cost-effective model that retains the quality of care (Ekman, Busse, van Ginneken, et al., 2016; Hansson et al., 2014). PCC emphasizes the partnership

between patients and healthcare professionals and customizes care and treatment to the individual based on their particular needs and resources (McCormack et al., 2015). The Institute of Medicine created six dimensions that stipulate what PCC (described as patient-centred care) entails: respectful to patients' values, preferences and expressed needs; coordinated and integrated; provide information, communication and education; ensure physical comfort;

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provide emotional support; involve family and friends (Institute of Medicine, 2001). The significance of PCC has been embraced by several European countries, and particularly the UK and Sweden (Britten et al., 2020). A European standard called *Patient involvement in health care—Minimum requirements for person-centred care to ensure quality improvement in person-centred care* (CEN, 2020) was created to specify the minimum requirements for characterizing health services as person centred. The standard aims to create beneficial structural conditions for PCC on a strategic level for quality assurance, quality improvement, educational and supervisory purposes (CEN, 2020). Application of this standard is expected to support wider implementation of PCC and can serve as a basis for nurses on how to co-create care in the form of a partnership between the patient (often with relatives) and the team of healthcare professionals. A phenomenological-hermeneutical study into the meaning of working in a person-centred way by Vassbø et al. (2019) showed how healthcare professionals experienced more energy and inspiration. The implementation of more PCC has the potential for the development of personal and professional growth leading to staff that is satisfied with their job (Vassbø et al., 2019). Working in a person-centred manner promotes an ethical awareness of the content of care, control over daily tasks and social cooperation (Ryan, 2022) which can influence nurses' perception of work experience and work-related health (van Diepen et al., 2020). Both job satisfaction and quality care depend on the work environment that should be altered by a person-centred approach. However, thus far, studies on the effects of PCC have shown no significant changes in nurses' outcomes.

Implementation of new ways of working in health care is a complex matter and measuring the implementation and its outcomes can be challenging. The lack of significant results can have multiple methodological reasons, to name a few: the degree of PCC implementation, the time to follow-up after implementation, staff turnover from baseline to follow-up, and participation rate or bias. Still, the lack of significant results is intriguing given the theoretical arguments in favour of an expected positive effect for nurses.

Although the implementation is decided and arranged on a macro level, most of the PCC practices can be found in the interactions between healthcare professionals and patients (and often their relatives). Within healthcare professionals, nurses are more accessible and deal with patients longer than doctors (Clark et al., 2009). Therefore, nurses form the core of the PCC implementation (La Grouw et al., 2019; Lloyd et al., 2020) and most studies in this area include at least the nurses in their samples. For nurses, working with PCC means their work shifting from caregiving to also engaging the patient in becoming part of the care team (Ahmad et al., 2014; Granström et al., 2020).

The PCC model is a specific care approach, but many interventions and models of care have similar elements in which the patient can participate such as shared decision-making (Charles et al., 1997) or Value-Based Health Care (Porter, 2008). PCC relies on ethical principles and is distinct from other models of care by emphasizing the importance of knowing the patient as a person, and the

establishment of a collaborative equalitarian partnership between healthcare professionals and patients (Ekman et al., 2011). Hence, PCC implies that both parties take responsibility; nurses as experts in care and treatment and patients as experts on their own lives, which means a stronger commitment rather than to "just participate." Despite this distinction, PCC is often used interchangeably with other models of care in the literature (Håkansson Eklund et al., 2019) indicating that researchers and nurses may not have the same understanding of PCC, which complicates its application in practice. Consequently, when implementing PCC, it may not be recognized and viewed as a new model of care, or at least feels like a comparable approach to care. Therefore, most nurses may feel that they already are providing PCC before the implementation (Alharbi et al., 2014; Jobe et al., 2020; Naldemirci et al., 2017).

With the implementation of (more) PCC, the hypothesis is that nurses should have more control over their work activities and can organize these to fit with their perception of providing high-quality care (Ryan, 2022). So far, there is no explicit support for the claim that PCC has beneficial effects for nurses. However, as indicated by cross-sectional studies in reviews (e.g., Rajamohan et al., 2019; van den Pol-Grevelink et al., 2012; van Diepen et al., 2020), reduced ethical stress and improved social relations between patients and staff could be hypothesized to improve job satisfaction among nurses.

According to the few reviews on this topic, the empirical evidence of the impact of implementing PCC on healthcare professionals is scarce and varies in design and quality (Barbosa et al., 2015; Rajamohan et al., 2019; van den Pol-Grevelink et al., 2012). These systematic reviews found an array of PCC implementations and outcomes, making it difficult to draw robust conclusions. In our scoping review (van Diepen et al., 2020), all included intervention ($n = 5$), or longitudinal ($n = 1$) studies showed no significant effect of implementing PCC on healthcare professional outcomes. A scoping review on facilitators of PCC by Ryan (2022) expressed that just focusing on the nurses' skills and competencies is not enough and that some facilitators should be searched among organizational and workplace factors.

Since PCC is a growing and promising approach to better health care with studies showing positive effects on patient outcomes, we want to describe the non-significant results in nurses' outcomes after implementation of PCC and discuss if and how enablers of the WE-CARE roadmap for implementing PCC (Ekman, Busse, van Ginneken, et al., 2016) could abate the non-significant results.

2 | BACKGROUND

There are many possible reasons why non-significant results are detected which are important to identify to change this in the future. Imperative in these longitudinal or intervention studies on PCC and nurses' outcomes is that there was no baseline in which the participating healthcare professionals were (completely) unexposed to PCC which most likely led to the perception of PCC not increasing significantly or with a minimal margin over time. When

the exposure variable does not change, one cannot expect a change in the outcomes. We detected in the empirical studies in our scoping review only a minimal increase in PCC. Alharbi et al. (2014) studied the normalization process of the PCC implementation. Rather than a sustainable level of PCC, the implementation lost momentum after six months and was back to starting level after a year, only with the nurses having a better understanding of what PCC entails and thereby considering the level of PCC in the workplace lower than before the implementation.

The lack of significant results over time can also be found in the floor and ceiling effects (Vassbø et al., 2020; Wolf et al., 2008). These effects arise when the scoring is already so high or low that an improvement is hardly possible. The perception of PCC among nurses is required to increase from baseline to follow-up also to see significant improvements in nurses' job satisfaction. If the perception is blurred due to nurses' thoughts of already providing PCC, the increase will be absent. As with any study, many other factors can influence this association. Therefore, the influence of PCC on nurses' outcomes needs to be distinct enough to measure.

The effective implementation of PCC needs to be governed from the top by the organization and management who understand the culture and context so that PCC can be applied in practice (McCormack et al., 2011). In a study on the PCC implementation from a managerial perspective, Alharbi et al. (2014) found that there was a lack of common strategy. Instead, each manager had their thoughts and understanding of how to implement and operate PCC (Alharbi et al., 2014). This is not beneficial as everyone working within the system need to apply the same approach to PCC (Jobe et al., 2020). The flexibility of the implementation is necessary as different healthcare settings have different challenges and opportunities that make some dimensions more critical than others (Berghout et al., 2015). Nevertheless, the flexibility creates uncertainty about the presence of PCC for nurses.

Similarly, PCC is measured differently in empirical studies. Our scoping review (van Diepen et al., 2020) inspected the PCC measurement on the inclusion of the six dimensions of PCC (Institute of Medicine, 2001). The type of PCC measure and whether it focused on all, or some dimensions did not matter in the results.

Nurses' outcomes vary in type and measurement and to showcase how the PCC implementation can affect nurses' outcomes, an indicator would be most effective. The review of Van den Pol-Grevelink et al. (2012) used job satisfaction as it is influenced by PCC. Job satisfaction has many components related to other work-related health outcomes, such as emotional exhaustion and ethical stress. A nurse's attitude and emotional response to the work in addition to physical and social conditions of the workplace are represented by job satisfaction (van der Meer et al., 2018). Increasing job satisfaction should have a knock-on effect on other elements of the work environment.

The level of job satisfaction among the healthcare professionals is found to be a precursor for absenteeism and turnover which affect the continuity of care and the safety of the patients (van der Meer et al., 2018). Therefore, job satisfaction is well-positioned as

an indicator for healthcare provider outcomes, especially in combination with PCC (Lu et al., 2019; Rajamohan et al., 2019; van den Pol-Grevelink et al., 2012). Job satisfaction forms an excellent indicator for healthcare provider outcomes as it can change easily when organizational changes occur (Lu et al., 2019). PCC has shown positive associations with job satisfaction, but this finding results from cross-sectional studies, which could not claim causality.

To increase the level of PCC regardless of the healthcare facility, focus can be placed on the enablers in the PCC implementation. A tool that can be applied is the WE-CARE roadmap (Ekman, Busse, van Ginneken, et al., 2016; Ekman, Busse, Van Hoof, et al., 2016; Lewandowski, 2020; Lewandowski et al., 2021; Lloyd et al., 2020; Swedberg et al., 2021). The roadmap was created to consider efficacy from clinical trials and community effectiveness, including the appropriateness of services provided and was developed to showcase enablers in the implementation of PCC to make a person-centred work environment sustainable (Ekman, Busse, van Ginneken, et al., 2016). Explicitly, with these enablers, the healthcare facility can continue the implementation independently of constant outside assistance. An absence of collective actions and reflexive monitoring during the implementation resulted in a non-stable and reclining PCC (Alharbi et al., 2014).

WE CARE is an EU Seventh Framework Programme consortium tasked to propose a research and development roadmap for innovative, cost-contained, quality care (Ekman, Busse, van Ginneken, et al., 2016). Key players among the pharmaceutical industry, technology sector, academic researchers and health professionals, together with patient representatives and politicians, were invited to participate and contribute to creating this model (Ekman, Busse, van Ginneken, et al., 2016). The stakeholders met to determine the key areas where interventions and policies are required to address the major challenges in health care during five workshops and a conference (Ekman, Busse, van Ginneken, et al., 2016).

These enablers should be applied whenever PCC is implemented and have shown great promise in cultural transferability (Lewandowski et al., 2021).

As shown in Figure 1, the model consists of five enablers that are highly interdependent: Information technology (IT), Quality measures, Infrastructure, Incentive systems and Contracting strategies

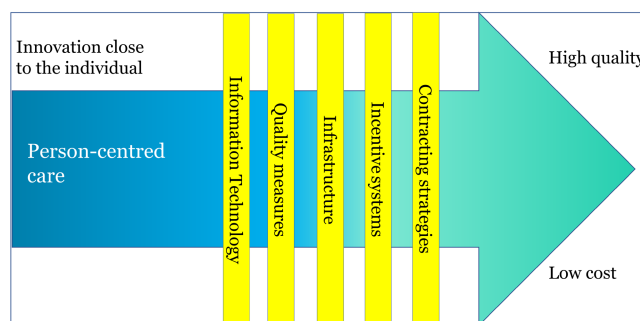


FIGURE 1 Interdependencies of the six themes adapted from Ekman, Busse, van Ginneken, et al. (2016); Ekman, Busse, Van Hoof, et al. (2016) and Swedberg et al. (2021)

(Ekman, Busse, Van Hoof, et al., 2016; Lewandowski, 2020; Lloyd et al., 2020). With the enablers, the implementation is not restrained to medical quality and cost and includes the functioning of the PCC processes itself (Lewandowski, 2020). A short explanation of the enablers is copied from Lewandowski et al. (2021), pp. 3–4.

1. Information Technology might include IT solutions for communication or wearable devices for monitoring.
2. Quality measurement systems to capture all necessary aspects of the implementation process and its outcome.
3. Infrastructure relates to the necessary resources and structures empowering the delivery of PCC (e.g. hospital organization, home care and their interaction).
4. Incentive systems include all conceivable means which could motivate both patients and professionals to engage in behaviours congruent with PCC.
5. Contracting strategies include financial solutions and mutual agreements regulating commitments and deliverables.

The five enablers are connected to different stages in the implementation process. Lewandowski (2020) described in his paper where and how the enablers are attached to the PCC implementation. The two enablers that should be used for the implementation design are “contracting strategies” and “incentives,” as these enablers need to be present before starting the implementation. Then during the implementation process, the enablers, “infrastructure” and “information technology,” are most relevant as they support the implementation and are more focused on the work environment becoming equipped to provide PCC. The last enabler of “quality measures” ensures that the PCC is measurable with the quality and costs evaluation. Important for this paper is that the roadmap enablers are created to be implemented on a macro or organizational level, with large structures supporting the enablers and the PCC implementation overall and are not intended for nurses to change by themselves. However, the inclusion of the enablers in the PCC implementation will plausibly affect how nurses comprehend PCC and their job satisfaction.

Nurses are essential for a sustainable intervention and are directly and indirectly involved with the enablers. The main goal of using the enablers as a tool in the PCC implementation process means that the enablers offer comprehensive coverage of important aspects from the nurses' perspective in the complex area of health care. Job satisfaction is ideally positioned to represent the nurses' work-related outcomes as a way to connect the WE-CARE roadmap enablers to the (as yet) non-significant results.

3 | DESIGN

Because of the importance of these enablers in the sustainability of the PCC implementation and the role of nurses within the implementation, a pragmatic analysis of the enablers and the connection to nurses' job satisfaction is applied. The findings are based on

a combination of our scoping review (van Diepen et al., 2020), the published material on the WE-CARE roadmap (Ekman, Busse, Van Hoof, et al., 2016; Lewandowski, 2020; Lewandowski et al., 2021; Lloyd et al., 2020) and additional material to describe and explain the benefit of employing the roadmap to improve the impact of PCC on nurses' job satisfaction. Lloyd et al. (2020) applied Programme Theories to describe the “if-then statements” that arise in the inclusion of enablers in the PCC implementation. However, the enablers described in the WE-CARE roadmap are not necessarily new to the healthcare workplace and this paper focused on how these enablers are and can be used so that they benefit the PCC implementation and by extension the job satisfaction of the nurses working with PCC.

3.1 | Discursive method

A discursive method includes the discussion of the issue of non-significant effects of PCC on nurses' outcomes and arguments for the inclusion of enablers to the PCC implementation. The methods used for this discursive paper were, first, to describe the enablers and how they enable the PCC implementation. Second, to describe and discuss if these enablers could affect nurses' job satisfaction based on literature. This way, the existing structure is strengthened with the efficient use of the enablers which can significantly impact the work environment.

3.2 | Ethics

Ethical approval was not required for this discussion paper.

4 | RESULTS

The discussion describes the enablers and the different types of involvement for nurses. The enablers are executed on an organizational level, but the nurses should be affected by macro decisions on their work.

4.1 | Information technology

The Information Technology (IT) enabler has been the driver for many current innovations in PCC provision. IT extends beyond the information flow regarding Electronic Health Record (EHR) and supports collecting information, applying incentive systems and contracting strategies (Lewandowski, 2020). By ensuring an IT presence, communication streams can be established and become more efficient (Lewandowski, 2020). Specifically, the presence of IT can help with the communication of the specifics of the PCC intervention, thereby guaranteeing attention to the implementation. This information stream makes certain that nurses are aware of changes in their organization and the new duties that come with PCC.

This enabler is fluent and can be adjusted in its application to PCC. Important here is the availability of a so-called “toolbox” in which a partnership can be created between patients and professionals in which they can choose their required type of IT communication (Barenfeld et al., 2020). Notably, there needs to be an IT solution that allows, tailors and facilitates PCC. Moreover, it needs to be understandable for the persons using the application and the IT may be easier to implement in some healthcare facilities than in others. This toolbox can also be updated and innovated when the situation requires it (Granström et al., 2020). There is no one size fits all solution to providing PCC, but the enablers can assist.

This enabler directly affects how nurses work. The IT enabler to benefit PCC is mainly driven by professionals who encourage patients to use the application (to keep a health diary, ask questions and look at records and meetings; Wolf et al., 2016), thereby increasing the effort made by nurses to make the eHealth successful. IT also contains rewards for nurses as they can now easily message, reflect and concur with colleagues before contacting the patient through the same platform (Granström et al., 2020). Through the presence of IT as an enabler for PCC, nurses can work more efficiently. Findings from a cross-sectional study showed nurses who used IT services experienced more satisfaction with their job (Atinga et al., 2020).

Information technology seems to be quite challenging to implement and may need to be more developed and tailored together with nurses and patients (Barenfeld et al., 2020; Wildevuur & Simonse, 2015). This enabler, when applied effectively, can increase the entire healthcare provision and quality. Particularly, the elements that are essential in PCC such as the person's needs and resources, the health plan and the opportunity for co-creation of care can be realized with a well-functioning (and for both nurses and patients understandable) IT service.

4.2 | Quality measures

This enabler includes the provided quality of care and the costs attached to the implementation (Lewandowski, 2020). Accurate measurement of quality of care and costs in a proper time scope is one of the most essential conditions for improving health care (Porter, 2010). A pre- and post-comparison of costs associated with PCC quality processes analysed against quality measure scores would assess effectiveness (Lloyd et al., 2020). However, according to a systematic review by Jessup et al. (2020), healthcare professional outcomes are not prioritized in studies on new models of care as only 13% of the included studies looked at healthcare professionals. The nurses doing the PCC work are often forgotten in analysing the success or failure of the intervention (Jessup et al., 2020).

This enabler is generally already part of an intervention as it is vital for scientific research. However, as mentioned in the introduction, thus far, the quality measures have shown no significant effects in peer-review publications. The different constructs to measure PCC are not the same and focus on different aspects of PCC. Likewise, our scoping review counted 10 different constructs to measure job

satisfaction in 14 articles (van Diepen et al., 2020). Added to the quality measures of quality of care and cost-effectiveness, there is a need for a unified PCC measure to be able to assess the level of implemented PCC.

Although this enabler is important for the topic at hand and policy that can arise from the results of the quality measures, it does not increase the PCC implementation. The quality measures only make it possible to measure accurately. According to the literature review by Lu et al. (2019), quality measures were not among the predictors or mediators to nurses' job satisfaction.

If quality measures affect PCC or nurses' job satisfaction remains unclear, but the connection between both variables can be measured more proficiently which would enable a better understanding of connections between PCC and nurses' job satisfaction.

4.3 | Infrastructure

An infrastructure to perform PCC needs to be present in the healthcare facility. Infrastructure could be understood, very broadly, as all physical and non-physical environments within which health services are delivered and indicate all aspects not mentioned in the other enablers (Lewandowski, 2020). Within the infrastructure, access to understandable and credible information about PCC and the changes they entail for healthcare professionals and patients is vital (Lloyd et al., 2020). A healthcare workplace, that can accommodate PCC, improves the psychosocial work environment for nurses as they feel more supported and empowered (Hunter et al., 2016). Creating an environment of physical comfort may positively affect job satisfaction and well-being as nurses have fewer obstacles in providing PCC (Lehuluante et al., 2012).

Ensuring that the infrastructure to PCC is present can make the implementation more efficient and, in some cases, possible. Through good physical infrastructure, the nurses will have more ways to interact with patients, which can be beneficial in avoiding routine-like, procedure-led work (Wolf et al., 2017). PCC practices are not limited to interpersonal relations but extend to institutions. Health care is about activities and practices involving moral judgement and nurses often face great uncertainty in these situations. In other words, conviction and critical reflections on these convictions, which are the main components in PCC, may positively influence the quality of care and nurses' job satisfaction.

This is a challenging enabler to include. If the healthcare organization is not equipped to provide the infrastructure necessary for PCC, this can come at a great financial cost. However, the infrastructure can be altered in a positive direction towards PCC during the implementation process, considering that professional bodies have long endorsed PCC as one of a set of core competencies needed to meet the complex challenges of today's healthcare systems (Britten et al., 2020). Like IT, an efficiently functioning infrastructure is beneficial for the quality of care but can be tweaked to better fit a PCC environment when effectively managed (Lloyd et al., 2020) by including, for example, suitable examination and meeting rooms.

4.4 | Incentive systems

A system of incentives should create motivation for both healthcare professionals and patients to work according to PCC principles (Lewandowski, 2020). Often, incentives are not well aligned with PCC, leading to incentives that make health system actors perform in a way that may conflict with the broader goals of a given health system and lead to fragmentation in the provided care through the emphasis on efficiency and competition (Ekman, Busse, Van Hoof, et al., 2016). On a macro-level, the decisions are made that will affect the ability of nurses to provide integrated care as specified in PCC dimensions.

Thus far, nurses have little incentive to provide PCC: They may think they are already giving PCC (Alharbi et al., 2014; Naldemirci et al., 2017) or see too many barriers and fall back into traditional care (Carlström & Olsson, 2014; Jobe et al., 2020; Moore et al., 2017). However, many nurses experience the move to more PCC as a professional development (Boström et al., 2020) which is an intrinsic motivational incentive to provide PCC. The incentive system should be a combination of financial and non-financial rewards in increasing the PCC provision (Lloyd et al., 2020), and positively affect nurses' job satisfaction (Lu et al., 2019). It is difficult to identify an individual contribution (Lloyd et al., 2020), and these incentives should be arranged on a departmental level to induce the PCC cornerstones of teamwork and communication. This enabler is quite essential, but financial resources and a uniform incentive system from the organization are stumbling blocks.

4.5 | Contracting strategies

Contracting strategies are methods of financing medical services (Lewandowski, 2020). As there are many different healthcare systems, there are many ways in which contracting strategies can assist in cost containment with quality of care in a PCC work environment. This is not specific to nurses' care services but shows how their financing can be changed to enable PCC within their contracts. Hence, contracting strategies should reward nurses' activities related to PCC, such as listening thoroughly to patients' narratives and identifying patients' resources and personal goals, co-creation of treatment and care plans and improvement in patient self-efficacy (Lewandowski, 2020). Contracts tied to PCC could foster trust and productivity (Lloyd et al., 2020), but this enabler lies at an organizational level and should acknowledge that transparency about the model of care in the facility is vital for the sustainability of the PCC environment.

Moreover, it provides nurses clarity on which tasks are part of the PCC model and which they will need to perform to meet expectations. The role of nurses shifted to becoming more of a coach, encouraging patients to become part of the team and use the provided IT (Granström et al., 2020). This role change needs to be communicated and administrated promptly. In the long run, role clarity will keep nurses longer in their position in the

healthcare organization as they know what they are getting into and what the responsibilities are (Rajamohan et al., 2019). Still, the nurses' job satisfaction could be worsened with this enabler as the contracting strategies focus on the increase and clarity of PCC rather than the parts of the job description that are important for nurses, such as career management and organizational and administrative support (Lu et al., 2019). Moreover, when applying this enabler to the PCC implementation, it may lead to an increase in un-reflected mechanical tasks (e.g. number of health plans created) and would miss the ethical base of PCC. When the quality of care is surmised to quantifiable tasks, job satisfaction is likely to decrease (Rajamohan et al., 2019).

Person-centred care has been picked up by many European countries and the health ministries have designed PCC guidelines as the way forward for health care (Britten et al., 2020; CEN, 2020). Therefore, the pressure is now on the healthcare organizations to arrange their contracts to fit with a PCC model of care (Lewandowski, 2020). This is a bureaucratic enabler and might be difficult to incorporate into practice.

5 | RELEVANCE TO CLINICAL PRACTICE

In this paper, we described that nurses in co-creation with patients are at the centre of the PCC implementation and that sustainable PCC, supported by enablers in the implementation of PCC will (indirectly) benefit nurses' outcomes. The main goal of using the enablers as a tool in the process of implementing more PCC is that they offer comprehensive coverage of important aspects from a healthcare professional perspective in the complex area of health care.

This paper proposes applying the WE-CARE roadmap enablers to increase not only the sustainability of the PCC implementation but also affect the nurses' job satisfaction through a change in the work environment, either through the PCC implementation or directly as the enabler. The enablers are not new but need to be adjusted to fit a PCC work environment and considered at what costs these can be implemented. The WE-CARE roadmap was designed for the implementation of more PCC but is not in variance with other models of nursing care and the enablers could be considered for other implementations.

6 | CONCLUSION

This paper showed the current state of knowledge on the impact of PCC on nurses' outcomes and thereby emphasized the necessity of improving the PCC implementation to assure a significant impact for nurses. An innovative WE-CARE roadmap was described and discussed to illustrate how the five enablers could be applied here. The roadmap guides how to apply enablers in the implementation to improve PCC and (indirectly) nurses' job satisfaction. This approach to the PCC implementation overreaches to different contexts and types of PCC.

The addition of the enablers as core components to an increased PCC implementation could make nurses experience a change in their work which, based on the literature described here, would affect job satisfaction. With the quality measure enabler in place, this will also be better measurable and thereby abate non-significant results in this type of research.

Most importantly, there needs to be a change in approach to expect a change in results. This paper suggests implementing the WE-CARE Roadmap enablers on an organizational level so that the impact of PCC can be measured at the level of the nurses. The description of the WE-CARE roadmap enablers is presented as one solution. PCC as a model of care is designed to be beneficial for all actors involved and the studies should reflect that.

AUTHOR CONTRIBUTIONS

The authors developed and conceived the discursive paper together. CvD and GH created the objective. CvD drafted the first version of the manuscript with feedback from all authors. The manuscript was then revised in different steps by AF, MA, IE, MB and GH, with CvD taking the main responsibility for writing. All authors approved the final version of the study.

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (<http://www.icmje.org/recommendations/>)]:

- substantial contributions to conception and design, acquisition of data or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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CONFLICT OF INTEREST

The authors have declared no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

PATIENT CONSENT

No patient consent was needed as this discursive paper only includes previously published material.

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