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Patients' experiences of involvement at a clinical training ward: a qualitative interview study

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ABSTRACT
Interprofessional education aims to foster healthcare students' ability to collaborate in interprofessional teams with the patients at the center of care as active participants. However, little is known about how patients experience this collaboration. Therefore, this study aimed to explore patients' experiences of being involved in the interprofessional team of healthcare students at a clinical training ward in Sweden. A descriptive design with a qualitative approach was used. Data were collected through semi-structured individual interviews with 22 patients. Braun and Clarke's reflexive thematic analysis was used. The main finding was that patients were only included as passive participants. Although most patients wanted to be involved, they were hindered due to their health condition or excluded from care planning and decision-making. The patients needed family members' support to be involved. However, this need was not recognised by the interprofessional team of healthcare students. Patient involvement must be highlighted as an important component of interprofessional education initiatives. Further research is needed to explore family members' perspectives on involvement in interprofessional training ward settings.

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Collaboration; education; interprofessional; patient involvement; training ward

Introduction

Patients' involvement in their care has been associated with improved health outcomes (Bombard et al., 2018). Previous studies suggest that patient involvement is necessary to optimise patient care and to uphold patient satisfaction with care and medical decision-making (Bombard et al., 2018; Vahdat et al., 2014). However, several studies also stress that to enable patient involvement, patients must be regarded as team members in the interprofessional healthcare team, and healthcare professionals need to recognise how patients experience their involvement (Hewitt et al., 2015; Källén et al., 2021; Kvarnström et al., 2012). Research shows that interprofessional collaboration (IPC) is central to utilising all professional resources needed in patient care, ensuring patient safety, and facilitating patient involvement (Frenk et al., 2010; Källén et al., 2021; Wen et al., 2014). Interprofessional education (IPE) has been identified as a requirement to equip healthcare professionals with sufficient IPC practice skills (Frenk et al., 2010; Wen et al., 2014). However, additional research is needed to understand patients' experiences in terms of their involvement in the care process during IPE that, for example, can be organised in an interprofessional training ward (ITW) (Bombard et al., 2018).

Background

Patient involvement

Over the past decades, patients' position in healthcare has been strengthened by global recommendations leading to the implementation of patient involvement (World Health Organization [WHO], 2007). The World Health Organization (WHO, 2007) describes how patient involvement can promote patients' compliance to treatment as well as their satisfaction with received care. Additionally, it emphasises that patients and their families should be at the centre of all care to promote person- and family-centered care (World Health Organization [WHO], 2015). Patient involvement can be defined as increased shared decision-making that will enhance the care experience and ensure patient empowerment (Halabi et al., 2020). Patient involvement in healthcare considers patients' abilities, requests, and expectations to guide and individualise their care and treatment (Dent & Pahor, 2015). Additionally, it ensures that patients understand and agree with the advice provided by the healthcare team (Bombard et al., 2018).

Due to the international recognition of patient's unique knowledge and expertise of their illness, the involvement of patients in health professional education is increasing (Rowland et al., 2019). Highlighting patient involvement within IPE creates opportunities for healthcare students to understand patients' individual needs (Källén et al., 2021; Rowland & Kumagai, 2018; Shakhman et al., 2020). However, despite theoretical efforts to involve patients in interprofessional teams, recent studies reveal that care planning and decision-making are often made without direct patient involvement (Källén et al., 2021; Wolf et al., 2017).

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Interprofessional training wards

IPE can be exercised in a clinical setting and is often organised in interprofessional training wards (ITWs). The general structure of ITWs is that students from different healthcare educational programs work together with a high degree of clinical independence within patient care, including care planning and ward rounds. However, the students have continuous supervisor support to guide the work and promote reflection among the students (Brewer & Stewart-Wynne, 2013; Carlson et al., 2011). ITWs have been internationally recognised because of their positive impact on students' learning outcomes regarding IPC competencies regarding knowledge, skills, and attitudes (Mink et al., 2021; Oosterom et al., 2019). Furthermore, the ITW as an IPE initiative seems to have positive short- and long-term effects among healthcare students in terms of interprofessional socialization, cooperation, and coordination (Mink et al., 2021).

In Sweden, several healthcare programs offer compulsory training at an ITW (Carlson et al., 2011; Falk et al., 2013). Falk et al. (2013) described how all students in the interprofessional team shared the responsibility for caring for patients, which created openings to learn from and about other professions. When students work with patients as participants of the team, they establish a relationship that involves active listening and mutual dialogue to address patient concerns and preferences. In turn, patients can provide feedback that is valuable for students' professional development (Suikkala et al., 2021).

Recent studies have shown that IPE in hospital settings can be performed with adequate patient safety and that ITW is an appropriate context to practice IPC (Hallin et al., 2018; Jakobsen et al., 2021). Although patient involvement has been strengthened through laws and global strategies (Swedish Patient Act [SFS], 2014; WHO, 2015), few studies measure the impact of IPE on patient outcomes (Oosterom et al., 2019) or its contribution to patient involvement in the interprofessional team (Jensen et al., 2022b; Reeves et al., 2017; Rutherford-Hemming & Lioce, 2018). Jensen et al. (2022a), used an ethnographic approach to explore how interprofessional student teams and patients interacted in ITWs. Their results showed that even though the students did collaborate with the patient in focus, the patients did not always feel involved and heard. Nevertheless, after getting feedback from the patients, the students adjusted their approach. The study provides a good example of the benefits of patient involvement in IPE activities. Although the study included both students and patients as participants, it mainly focused on the student's perspective. Previous research within the IPE field rarely focuses on patient involvement from the patient's perspective. Therefore, little is known about the different views patients have on their role as interprofessional team members (Dahlke et al., 2020; Jensen et al., 2022b; Reeves et al., 2017; Rutherford-Hemming & Lioce, 2018).

Aim

This study aimed to explore patients' experiences of being involved in the interprofessional team of healthcare students at a clinical training ward in Sweden.

Method

Research design

This study used a descriptive research design with a qualitative approach. To ensure procedural rigor, the authors considered the Consolidated Criteria for Reporting Qualitative Research during the whole process (Tong et al., 2007). Data were collected through semi-structured individual interviews with patients admitted to an ITW.

Research setting

The study was performed at an ITW in Southern Sweden. Patients admitted to the ward needed general medical, nursing, and rehabilitation care. When patients were admitted to the ITW, they received verbal and written information about the IPE organisation and that they would be cared for by students.

At the ITW, medical, nursing, physiotherapy, and occupational therapy students engage in a two-week compulsory clinical placement. This occurs in the final year of the respective educational programs. The ITW is organised so that patients are cared for by student teams involving one or two medical students, three to four nursing students, and one physiotherapy and/or occupational therapy student. The students share all basic patient care in addition to their specific profession-related responsibilities. The student teams are supervised during the day shifts by senior supervisors from each profession. On evenings and weekend shifts, one registered nurse supervises the whole student team (Carlson et al., 2011). The clinical placement aims to provide opportunities for IPC while emphasising patient involvement in the care process.

Participants and sampling

A convenience sampling procedure was used based on patient accessibility during the data collection period, which took place between February and May 2022. Patients admitted to the ITW were eligible for inclusion if they were able to express themselves verbally in Swedish and had been admitted to the ward for at least 48 hours. Patients were recruited by the first author in consultation with gatekeepers at the ITW. Upon admission, all patients received written information about the study attached to the ward's welcome letter, distributed by the interprofessional team. Eligible patients were approached by the first author, who gave additional information and an opportunity to ask questions.

Data collection

Patients who agreed to participate were allowed to decide the time and place for the interview. Before the interviews started, the patients received information about the aim of the study one more time, had an additional opportunity to ask questions, and gave their written consent to participate. As per the patients' wishes, all interviews were conducted at the ward and took place in privacy with only the patient and the first author present. Each interview started with a brief conversation and gathering of background data, for example, age and former hospital experience. As recommended by Braun and Clarke (2013) a semi-structured interview guide was used to ensure that all questions of interest were covered. The interviews started with an open-ended question to get the conversation going: "Can you describe your experiences of being cared for in the interprofessional training ward?" Then, more directed questions were formulated, for example, "Can you describe how you want to be involved in care?" There were often follow-up questions, such as "Can you elaborate more about . . . ," to give patients the possibility to expand on their descriptions. All interviews were conducted by the first author, who had no relationship with the patients or clinical context. The interviews lasted between 19 and 49 minutes with an average of 35 minutes and were digitally recorded and transcribed verbatim by the first author.

Analysis

The interviews were recorded, transcribed, and analysed using reflexive thematic analysis according to Braun and Clarke (2006, 2019). Themes were generated through familiarisation with the data and coding. Braun and Clarke (2006, 2019) conceptualise themes as patterns of shared meanings, united by a core concept and not summaries of data. Coding refers to the process of labeling similar types of data with key features that might be relevant to the research question to make them more manageable. Braun and Clark have developed a 15-point checklist for good thematic analysis, which guided the researchers of this study during the whole analysis process to structure and increase the traceability and verification of the analysis (Braun & Clarke, 2006, 2013). The analysis took an inductive approach, searching for repeated patterns in the collected data and followed Braun & Clarke's (2006, 2013, 2019) principles of reflexive thematic analysis in the following six steps: The first step, familiarisation with the content, started already during data collection by taking field notes, writing down reflections, and transcribing the interviews. All transcribed interviews were then read numerous times for further acquaintance with the dataset. The second step was systematic data coding in which each interview and code were given equal attention in the process. The coding was on both a semantic and a latent level. In step three, all coded data relevant to the aim were thoroughly sorted to generate preliminary themes and subthemes using an inductive approach. In step four, the first and the last authors took a collaborative and reflexive approach, aiming to reach richer interpretations. To make sense of themes and subthemes, the first author discussed the preliminary analysis with all senior coauthors. Braun and Clarke's advice for researchers to be active was followed by going back and forth between coding and thematisation as part of the process of questioning and refining initial themes. Furthermore, the themes were checked by comparing them to the generated codes and by going back to the original data transcriptions (Braun & Clarke, 2006). All authors read the transcribed interviews and reviewed the coding and the themes. Afterward, the themes were reformulated and reorganise. In step five, the themes and subthemes were refined, and a story was formulated for each theme (Braun & Clarke, 2006, 2019).

Trustworthiness

To ensure credibility, recorded interviews were transcribed verbatim by the first author and reread multiple times during the analysis. The transcribed interviews were also reread after the analysis was finalised to make sure that the results were generated from the original data. To ensure confirmability, all authors were involved in the analytical process. Reflexivity was used to address and discuss the influence that authors might have had on the analysis and results related to preunderstanding (Grbich et al., 2008). All authors are registered nurses, which might have influenced the creation of interview questions and the subsequent analysis. However, none had experience with an ITW. For transparency, this was communicated to all patients, and the first author described her role and personal interests before the interviews were performed.

Reflexivity also refers to an awareness of the social setting and context that might influence patients' descriptions. Hence, the interviews were performed at the ward in accordance with the patients' wishes, which may have influenced how the patients responded as they were in constant need of care. To ensure the reliability of the results, every step of the data analysis was described.

Ethical considerations

This study adheres to the ethical standards of good research conduct as expressed in the Declaration of Helsinki (World Medical Association, 2013). The authors provided written and verbal information about patients' right to privacy and their right to decline participation or withdraw from the study at any time. Written contact information for all involved researchers was available in the information letters. In addition, when performing the interviews, the authors considered the participating patients' vulnerability due to their health status, especially about timing of the interviews. Therefore, the patients were recruited with support from and in consultation with gatekeepers at the ITW, and the interviews were performed when patients had improved their health status. Ethical approval was received from the Swedish Ethical Review Authority (No 2019–03761).

Results

A total of 28 patients were asked to participate; five patients declined, and one patient first agreed but had to withdraw due to poor health. Thus, the study included 22 patients,

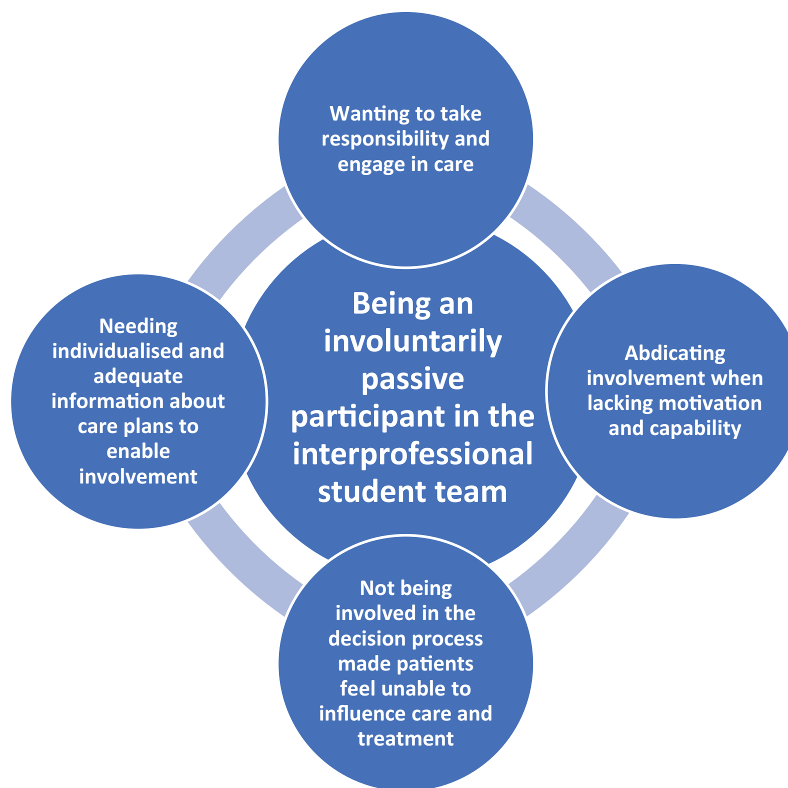

Figure 1. Main theme and related subthemes.

comprising 8 females and 14 males between 57 and 95 years old. Twelve patients had prior hospitalisation experience. The participating patients had been admitted to the ITW between 2 to 14 days and were close to being discharged from the ward when the interviews took place.

The analysis generated one main theme and four subthemes that together describe patients' experiences of being involved in the interprofessional team of healthcare students at a clinical training ward (Figure 1).

Being an involuntarily passive participant in the interprofessional student team

The patients experienced being ill, hospitalised, vulnerable, and reliant on the interprofessional team as being in a dependent and involuntary situation. Furthermore, the patients were aware of their responsibility in the care process and tried to engage. However, for most patients, the meaning and purpose of patient involvement were difficult to grasp and understand. Nevertheless, some patients wanted to be more engaged but were hindered by their health conditions; consequently, this decreased their motivation and capability to participate. Most patients did not see themselves as active members of the interprofessional team or believe that they could influence and be active in decisions concerning their treatment and care planning, describing being in the hands of the interprofessional team. Several patients also expressed pressure to report adequate information and news about their health status to relatives because they were not involved either.

Wanting to take responsibility and engage in care

Most patients emphasised the importance of their responsibility and engagement in care. Patients with former medical contacts and knowledge of their medical situation participated more actively in their care than less experienced patients. Furthermore, they experienced a need to keep track of their situation to be involved in treatment and decisions. The patients described feeling involved when they were given the chance to tell their stories. Most patients had experienced and appreciated that the interprofessional team took the time to talk to them. They also stated that a friendly attitude was an important motivator for involvement and health recovery. Several patients explained that involvement also meant being active themselves, for example, by asking about medicines and test results.

> Many people may think it is nice to avoid information, but I think that information is essential for you to be able to help yourself. I mean, if I don't know, how am I going to help? Because I'm the only one in charge of my life. (Patient number 21)

Some patients also felt obligated to motivate themselves and expressed that they wanted to take advantage of the good care and treatment that the interprofessional team offered. Several patients described wanting to follow the advice and directives given by the interprofessional team.

Most patients said that they perceived patient involvement as doing what the "doctor ordered" or doing their best to help the interprofessional team. Some patients even expressed that they had to do exactly as the interprofessional team recommended, arguing that they had to cooperate and not object or go against better knowledge. Some patients experienced being involved in

care as mentally taxing but also stressed their responsibility to minimise the workload for the interprofessional team, expressing concern for their burden. Consequently, the patients did not always ask for help when needed.

Abdicating involvement when lacking motivation and capability

Some patients expressed wanting to be more engaged but abdicated involvement for different reasons. One was related to illness: namely, some patients expressed not having the energy, and several patients argued that they were too old to be involved.

> I would say that in my case this has been a pretty tough ordeal, and I may not have had the energy and the opportunity to participate in any other way or more than I have. (Patient number 3)

Another reason for patients to abdicate involvement was that some did not want to be part of the team. Some patients expressed not wanting to interfere, and others just trusted and let the interprofessional team decide, arguing that they knew better. Several patients also explained that being involved in decision-making was difficult when lacking medical expertise.

> Care and decisions, how am I supposed to know? I don't know what it is. What they think is good, I think is good. (Patient number 22)

However, all patients expressed needing guidance, support, and motivation from the interprofessional team to be able to take a more active part and to be involved in care.

Not being involved in the decision process made patients feel unable to influence care and treatment

Most patients experienced not being able to control their care and treatment. The patients discussed how the rehabilitation plan was often presented without dialogue, and some patients expressed frustration over "poor" assessment instruments that were not suited for them. Furthermore, the rehabilitation was not always settled at the right level or adapted to their precise needs.

Most patients often experienced being excluded from decision-making or having any influence on decisions concerning their health, leading to uncertainty regarding illness conditions and care planning. In addition, this made patients dependent on physicians' decisions.

> No, it is the doctor who decides that. The decision is not mine. (Patient number 1)

Most patients described wanting to be more involved in discussions but were lacking a dialogue with physicians. Furthermore, patients with former healthcare experience expressed the need to be knowledgeable about their medicine and illness to be involved in discussions and decisions, and they argued that they had to speak up if they wanted to be involved; otherwise, they were not given that opportunity.

> If you're going to be very involved, then you have to scream. You have to be knowledgeable about your medicine and illness, then you have to speak up for them to sit down and discuss. Otherwise, there will be nothing. (Patient number 17)

All patients said that meetings and medical rounds took place without involving them. Instead, they experienced that decisions were made and merely communicated to them.

> You have nothing to decide; rather, they have had their meeting, and they have agreed. (Patient number 11)

This was sometimes problematic since some patients had also experienced that the interprofessional team lacked knowledge of their medical condition and physical ability. One patient described a situation when the interprofessional team came to him with "empty hands," not knowing why he was hospitalised and wanted to send him home. Furthermore, some patients were not content but felt they had to accept decisions made by the interprofessional team. Several patients expressed concerns about being sent home with short notice, before feeling that they had regained their health, and argued that healthcare must become more personalised.

Needing individualised and adequate information about care plans to enable involvement

Information was experienced as adequately conveyed, but sometimes the patients would have wanted the information sooner so they could mentally prepare. The patients often had to wait for the interprofessional team to share information. However, they did not want too many details because they did not have sufficient medical skills to be able to make sense of them. Moreover, several patients had experienced having a hard time remembering what had been said.

Some patients described situations where they perceived that they were not supposed to understand the information given, feeling as if some information was hidden or as if the interprofessional team was using a secret language and did not include them in the discussion. Several patients were disappointed in the contact with the responsible physicians, feeling that they did not take the time to provide information themselves.

> Today they are sending the nurses. They are their frontline soldiers. Nothing wrong with that, but there can be a lot of errors as well. (Patient number 16)

The personal dialogue with the responsible physician was important for all patients. They wanted to describe how they felt and where they had pain and to have the chance to ask questions. The physicians' absence made some patients worried that they were withholding information about their illnesses.

Most patients experienced that family involvement was important during their hospital stay. However, they also experienced that family members were passively involved in decisions concerning treatment and further care plans as they often received information through the patients themselves, not through dialogue with the interprofessional team. This was occasionally a problem, particularly when patients had trouble retelling the information, which led to stressful conversations with family members.

> When you're this old, it's very hard to take in all the information. I try my best because then my sons ask how I have it. I say I don't think I can take in all the information right now. (Patient number 9)

Most patients also expressed wanting some of their family members to be present when receiving important information because they needed their support to avoid forgetting or misunderstanding what had been said. One patient explained that she wanted her daughter to be present because she considered her questions to be important for care planning. Another patient said she was used to bringing her daughter when seeing healthcare professionals, but at the ITW, she had to cope on her own. This was problematic since she did not know Swedish very well.

Discussion

This study aimed to explore patients' experiences of being involved in the interprofessional team of healthcare students at a clinical training ward in Sweden. The main finding was that patients were often passively involved in the interprofessional team. Although most patients wanted to be involved, they were hindered due to their health condition or because they were excluded from care planning and decision-making. Furthermore, family members rarely had direct dialogue with the interprofessional team even though the patients needed them to be involved.

The patients in our study both emphasised the importance of being responsible in their care and displayed a more passive stance, relying on the healthcare professionals. Similar results were found by Wolf et al. (2017), where patients trusted professionals to have the expertise and competence to make healthcare planning and decisions. Furthermore, Wolf et al. (2017) described how patients seemed to value having a positive and personal interaction with healthcare professionals and being informed rather than taking an active part in care planning and decision-making. There seems to be an imbalance between, on the one hand, the intention of lawmakers and healthcare professionals to strive for patient involvement and, on the other hand, the patients' rejection of that opportunity because of a perceived lack of knowledge or experience in being a patient. Both Wolf et al. (2017) and our results correspond with the results of the Buljac-Samardzic et al. (2022) study, in which chronically ill patients described that their former healthcare experiences contributed to seeing the advantages of active involvement. Our results and those of previous research (Buljac-Samardzic et al., 2022; Wolf et al., 2017) in a way also indicate that it could be difficult for less experienced patients to be involved in their care. Furthermore, Hewitt et al. (2015) described how challenging it was for the interprofessional teams in their study to involve patients, mainly since patients did not seem to be interested in the processes of care, only in receiving the care they expected. Our results indicate that not all patients understand how to be involved, see the benefits of an active role, or know about their right to be involved in the interprofessional team. The reason for this could be that they were not actively and sufficiently invited by the care team. Suikkala et al. (2021) concluded that to promote healthcare students' ability to involve patients in a clinical learning environment, supervisors must encourage partnership with patients. Furthermore, our results also imply that a positive interaction between the patients and the interprofessional team enabled patient involvement, as also revealed in previous research (Wolf et al., 2017). Therefore, ITWs should focus even more on having a pedagogical strategy that promotes student-patient interaction and partnership so that the interprofessional team of students can learn about patients' capabilities, adapt to the individual patient, and train in how to promote patient involvement.

Some patients in our study abdicated involvement due to illness or, as they described, being too old, which affected their motivation and capacity to be involved. In contrast to our result, when studying patients' perspectives on factors that affected involvement in interprofessional teams, Buljac-Samardzic et al. (2022) revealed that the severity of the illness was seen as the most important contributor to active patient involvement. One reason for this difference in results could be that in the Buljac-Samardzic et al. (2022) study, the patients were not hospitalised and were not in an acute medical condition. Another reason could be that most of their patients had plenty of experiences with healthcare and could see the gains of being involved, as described earlier. The patients in our study sometimes described involvement as doing their best to help the interprofessional team. This was also shown in the Wolf et al. (2017) study, where patients described involvement more as participating as much as they felt able to physically. However, if the patients had been invited to decision-making, the meaning and purpose of being involved might have been easier for them to understand.

Nevertheless, there was a variation in opinions regarding involvement in care. Some patients chose to abdicate while others strived for involvement, especially being heard and seen. Regardless, previous research (Blanck et al., 2021; Buljac-Samardzic et al., 2022) has shown that an interaction between healthcare professionals and patients enables involvement. However, healthcare professionals need to be responsive to patients' capacity and willingness to be involved. Even though the patients in our study seemed to be content being in the hands of the interprofessional student team, patient involvement could achieve better outcomes for patients regarding compliance with treatment and satisfaction with care (WHO, 2007; Wolf et al., 2017). Our results and former research (Blanck et al., 2021; Buljac-Samardzic et al., 2022) also indicate that patients need to be recognised as individuals and depend on interprofessional teams' guidance and support to be active in care planning and decision-making. Most patients in our study expressed that they had no control over their care and treatment. Furthermore, they stated that ward rounds were organised without their presence and that decisions were delivered as a matter of fact. One reason for this could be that the ITW had more focus on the student's collaboration than on patient involvement. Similar circumstances were described by Jensen et al. (2022a), who

studied how interprofessional student teams interacted with patients in interprofessional clinical placements. The study showed that even though patients were at the centre of care, they were not always given the chance to ask questions or the opportunity to be heard in care planning. In the current study, this was sometimes problematic, especially if the patients felt that the interprofessional team lacked knowledge of their medical condition and physical ability or if they were not content with the decisions made. Several patients described that they did not have enough contact with physicians. One reason might be that when student teams were supervised by senior supervisors from each profession during dayshifts, they were mainly supervised by registered nurses on evenings and weekends. Therefore, the specific responsibilities of physicians in their profession may have been overlooked and become less apparent to the patients.

Our results can also be compared to the Källén et al. (2021) study, where the exclusion of direct patient involvement also led to the loss of important information in care planning and decision-making. When describing professionals' perspectives on IPC and patient-centered care, Dahlke et al. (2020) showed that daily rounds supported patient-centered care. Furthermore, in Jensen et al. (2022a) study, patient encounters were considered the most important aspect of IPE in learning to work with patient involvement. Additionally, our results suggest that patients need to be invited by the interprofessional team to support their involvement. Based on previous research (Dahlke et al., 2020; Källén et al., 2021) and our results, including the patients in the daily ward rounds might be the obvious and first-hand solution to enable patients' involvement at ITWs.

In the current study, the patients wanted their family members to be involved in care planning and decisions as well as when receiving important information. However, this was not recognised by the interprofessional team. Recent studies have shown that the inclusion of family members in hospital care improved the coordination of care and reduced the frequency and duration of rehospitalisation (Yildirim & Özlü, 2018). Moreover, Blanck et al. (2021) argued that patients received better quality and continuity in care when healthcare professionals involved the family and shared the decision-making with them. Similar results were identified by Buljac-Samardzic et al. (2022), who found that support from family members also appeared to enable patient involvement. In line with previous research, our results highlight the benefits of involving the family, such as supporting patients when receiving important information, in care planning, and especially in planning for homecoming. Moreover, the WHO has stated that patients and their families should be at the centre of IPC to promote person- and family-centered care (World Health Organization, 2010, 2015). Therefore, the interprofessional team must focus more on involving family members in patient care. This could be done by encouraging the student team to communicate with the family and promote their involvement by allowing them to be involved in discussions, treatment, and decisions related to patient care to make use of their potential contribution to the interprofessional team.

Limitations

The results were based on a limited convenience sample of patients from one single ITW. In addition, the patients were recruited in consultation with gatekeepers at the ITW, and there is a risk that more favourable patients were selected. Moreover, the ethical application did not cover the collection of patient's medical information, which might limit the generalisability of the results. The interviews were rather short. However, some patients did not have the energy for longer elaborations. Additionally, the interviews were performed at the ward and may have influenced how the patients responded. Further, as all authors were registered nurses this may have influenced both the construction of the interview questions and the subsequent analysis, thereby affecting reflexivity and rigor (Braun & Clarke, 2019; Grbich et al., 2008). Furthermore, the patients had to be able to express themselves verbally in Swedish. This, of course, led to the loss of important aspects and experiences from people who do not speak the native language. Moreover, in the current study, patients were sometimes unable to differentiate between students and supervisors. Additionally, the student´s learning objectives are different due to the specific professional program which was not considered in the study. These limitations might influence the transferability of the results (Grbich et al., 2008).

Conclusion

This study showed that the patients were passive participants even though they had the right to be involved. In conclusion, patients need to be invited by the interprofessional team to be involved in planning and decision-making. In turn, students need directions on inviting patients and their family members. It would be beneficial if supervisors took a more active role in guiding the interprofessional student team to involve patients. It may be favourable if all profession-specific supervisors were more available to student teams, as their presence seems to influence the students' priorities. This might assist the interprofessional student team in prioritising patient involvement and recognising the vital role of family members. IPE activities in ITWs should primarily focus on collaboration that includes patient involvement. Furthermore, including patients in the daily ward round might be one step forward toward enabling patients' involvement at ITWs. Since patients emphasised the importance of their family members' involvement, future research is needed to explore family members' experience of involvement in ITW settings to increase the usability of the results.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Malin Axelsson, RN, PhD is an associate professor and senior lecturer at the Department of Care Science, Malmö University. Her research is focused on among other things interprofessional learning.

Anna Carin Aho, RN, PhD is a senior lecturer at the Department of Care Science at Malmö University. Her research is about disability and person-centred care.

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Author's contribution

The first author was responsible for recruiting the patients, data sampling, transcribing the interviews, analysing the data, and writing the manuscript. The manuscript was written together with the last author. However, all authors have made substantial contributions to the study plan, research design, ethical application, analysis, and interpretation of data. Further, all authors have continuously given valuable intellectual contributions during the working process, and they have critically revised the manuscript. Moreover, all authors approved the final manuscript to be published and can be held accountable for all aspects of the study.

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