Aspects of nursing with evidence-base when nursing frail older adults: a phenomenographic analysis of interviews with nurses in municipal care

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Introduction: In earlier research as well as in political discussion and documents, the topic of evidence has been highlighted as one of the most important concerns in nursing care. This study focuses on understanding what lies behind nurses’ ways of acting regarding evidence-based nursing through an illumination of the way they perceive the phenomena.

Aim: The aim was to identify and describe the different ways municipal care nurses perceive aspects of working with evidence when nursing frail older adults.

Methods: An explorative design with a phenomenographic approach based on interviews with nurses working with home-based care within the municipality was used in order to gain understanding of nurse’s perceptions of the phenomena.

Results: Findings revealed that the nurses perceived a variety of aspects when working with evidence when nursing frail older people. Aspects with a spectra of different perceptions shown in the analysis were as follows: Evidence-based nursing as a desired intention/mission, lack of practical supporting structures to apply evidence, lack of confidence in own capacity to apply evidence and a belief that it will work anyway.

Conclusions: Findings reveal that it is a challenge to implement research both on an individual as well as on an organisational level. Understanding the contextual perceptions of evidence by nurses can cast light on the barriers as well as the prerequisites of working with evidence while caring for frail older adults in municipal care.

Keywords: evidence, frail older adults, municipal care, nursing, phenomenographic analysis.

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Introduction

Nursing is shifting focus from a traditional institution-oriented paradigm to nursing practice in patients’ homes (1). Healthcare resources are, and probably will continue to be, scarce. Top-level managers and politicians agree upon the future limitations regarding financial funding, staff and time for caring. By improving the municipal care, specialised healthcare within hospitals can be avoided and the number of emergency department visits and readmissions reduced (2). As a result of recent deinstitutionalisation, the number of older people remaining at home with extensive and complex needs is growing. There is a need for nurses and other carers not only to focus on diagnoses but also acknowledge older persons’ values, histories and social worlds (3, 4). With scarce resources, the implication of doing the “right thing” is even more important. Person-centred care is advocated where accurate interventions according to physical condition or health status are acknowledged and older peoples’ values are integrated in evidence-based nursing (5–7). In meeting the demands of the future, increased competence of nurses working in municipal care and a care of frail older adults that is based on evidence are needed. Sharing evidence between academia and the professionals caring for frail older adults in the municipality means that mutual knowledge and competence can be generated. This study tries to understand what lies behind Registered Nurses’ (RNs) ways of acting in regard to evidence through an illumination of the way they perceive the phenomena.

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**Background**

Chronic diseases and long term health conditions in ageing populations are major global challenges for the future. Sweden, like most countries, wants to reduce reliance on tertiary healthcare (2). More of the care of frail older adults with comorbidity is organised by municipalities. Frailty is considered common in old age and can be related to high risk for falls, disability, hospitalisation and mortality (8). As advanced healthcare and nursing is given in the older adults’ homes, RNs working in community municipal care require a considerable knowledge and a range of nursing skills in order to perform accurate assessments and correct clinical interventions (9). In the Nordic countries, the balance between the changes in demographic distribution, that is, the rise of elderly needing care, the questions with gerontological focus as well as training in research use is unsatisfactory (10). Many researchers claim that there is an urgent need for interventions and implementations that aim to increase research use in nursing (11–13). Highly developed evidence-based nursing can raise nurses’ status in multiprofessional teams (14), but organisational support is needed and also exposure to professional journals and research-based information (1) as well as a confidence and growth, which contributes to nurses’ professional identity (6, 15). In past decades, healthcare has been impacted by substantial financial cutbacks, which have made employers’ financial contributions to RNs’ continuing training poor. Few have paid leave of absence during continuing training and are not compensated economically for the time and effort. The majority of RNs in municipal care have no supervision, and they have requested a better organisation for competence development (10, 16). Dogherty, Harrison and Graham (16) acknowledge facilitation within existing roles in nursing settings and team work as promising ways of supporting research utilisation and evidence-based nursing without increasing resources. Through a tighter collaboration between researchers at universities, the RNs and managers in municipal elderly care, the competence development of nurses might be secured.

The concept of evidence in a healthcare context can be understood as ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’ (17). Such a wide definition can be used by many healthcare professionals belonging to or trained in different scientific and theoretical paradigms. Evidence-based nursing can be defined as a more distinct concept focused on nurses’ area of interest (18). Evidence-based nursing (EBN) differs from evidence-based medicine (EBM) and evidence-based practice (EBP) by, for example, accepting qualitative research as evidence and the importance of a theoretical foundation and values based in caring/nursing for decision-making in nursing (19). One assumption of evidence in this field is that an original core of caring forms the basis of EBN. To see, realise the real and unveil the truth constitutes the concept of evidence in a caring perspective. Working with evidence can, according to this assumption, be explained by five different phases: envisioning, seeing, knowing, attesting and revising (20). Melnyk and Fineout-Overholt (21) explain the evidence-based nursing process in a more concrete form: (i) formulating a problem in clinic praxis (ii) systematic search for gathering the most relevant information about the topic (iii) critical examination of the information sources that were found regarding validity, relevance and feasibility (iv) integrating evidence from research with clinical experience, the patient’s needs and values (v) assessing and evaluating outcomes.

Nurses in municipal care are encouraged or even required to base their work on evidence. Rycroft-Malone et al. (22) explain that in many contexts, evidence is interpreted as research and sometimes perceived as something far away from reality of clinical practice. But what is nursing with an evidence-base in nurses’ own perspectives? The aim of this study is to identify and describe the different ways nurses in municipal care perceive aspects of working with evidence-base when nursing frail older adults.

**Methods**

A qualitative explorative approach with a phenomenographic method was used, based on interviews with community nurses working in home-based care within the municipality. The empirical research question was about describing the different ways community nurses in municipal care experience, understand and use the concept of evidence as they nurse frail older adults.

Phenomenography is a method that aims to describe qualitatively different ways people experience or think about something, that is, phenomena in their world. A phenomenon like evidence can, according to phenomenography, be understood qualitatively in different ways (2), which have two aspects: structural and referential. The structural aspect focuses on the fact that when people experience something, they distinguish its part from the whole and how the parts are related to each other. The referential aspects are the overall attributes of the whole (23). As this method focuses on various ways people perceive the world, it also illuminates effects on in individual decision-making processes and thereby on how people act (24). The phenomena of interest here are working with evidence. This study’s type of research question is typical within the field of phenomenography (25).
Data collection and settings

RNs working with the care of frail older adults in the municipalities were asked to participate in the study. Information about the project was sent to three different kinds of community care departments in two nearby municipalities in Sweden. The nurses were briefly informed about the study at a work conference by their nurse-in-charge. After this, every nurse in the two municipalities received a missive letter which included more information about the study and an invitation to participate. They were all informed that participation was voluntary and that everyone would be guaranteed confidentiality in relation to nurses-in-charge, employers and the public. From the two municipalities, 35 RNs, primarily working with care and promotion of health for frail older adults, agreed to participate in the study. The nurses represented, according to the phenomenographic tradition, a diverse group in regard to previous work experience, gender, age and employment time.

One individual interview ranged from 35 to 65 minutes with each nurse was carried out in spring 2012, in quiet rooms connected to the nurses’ working place by the research group. The questions asked during the interview were semi-structured, open-ended and started with the question: *How do you perceive evidence in your daily work?* This was followed by the question: *What is evidence for you?* And after that were questions that encouraged the informants to narrate about the topic. All interviews were digitally recorded and transcribed verbatim.

Data analysis

The analysis of the data was conducted according to the phenomenographic tradition described by Dahlgren and Fallsberg (23). The transcribed interviews were read and analysed in seven steps starting with step (i) *Familiarisation*, where the text was read a number of times. Step (ii) *Condensation* related to identification of the most significant statements that represented the nurses’ conceptions of the phenomenon (in this case, the concept ‘evidence’), which could provide an answer to the overall research question: What are nurses’ perceptions of nursing with evidence when working with frail older adults? Next came step (iii) *Comparison*, where significant statements were compared to see how they illuminated the variation or the coherence of the nurses’ conceptions about the phenomenon. In step (iv) *Grouping*, the data that had similarities were grouped together. By step (v) *Articulating*, a preliminary description of the essence of similarity in the different groups found in step four was created. In step (vi) *Labelling*, the groups were analysed and labelled in relation to essence, that is, the referential aspects which can be understood as the meaning derived from an internal horizon of the phenomena and to structural aspects that derived from the external horizon of the phenomena. In the last step (vii) *Contrasting*, the aspects were compared according to similarities and different variations of aspects (Table 1). The seven steps above were repeated several times and discussed between the researchers before the analysis was deemed satisfactory (23).

Ethical considerations

The nurses were informed that participation was voluntary and that the data collected would be handled with confidentiality. The nurses invited to participate in the study were not in any way dependent on or related to the researchers. Further ethical aspects were considered based on the World Medical Association Declaration of Helsinki (26, 27).

Result

The analysis revealed four major referential aspects of working with evidence when nursing frail older adults: EBN as a desired intention and mission, Lack of practical supporting structures to apply evidence, Lack of confidence in own capacity to apply evidence, A belief it will work anyway Table 2.

EBN, as an expected and desired intention and mission, was described by many of the nurses. In this referential aspect, there was a focus on evidence-based nursing both as a moral mission and a desired intention from themselves. They also expressed the belief that there was a demand or expectation from others,

<table>
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<th>Table 1 Demographic characteristics for nurses involved in the study</th>
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<td>RN+ postgraduate course in elderly nursing</td>
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employers, patients, their next of kin, that the work they performed was based on evidence. The structural aspects found referring to this were: Expectations from themselves; Expectations from employer and; Expectations from patients.

**Expectations from themselves**

Many nurses perceived evidence as a necessity in their profession and something they wanted to be included in their work. Even though they saw difficulties implementing platforms supporting this, many had a daily ambition to make it part of their care of the patients. This nurse expressed a personal responsibility to suggest and take action on what kind of evidence-based knowledge she needed:

‘I have to say that it’s very much up to me, my responsibility to keep updated with new evidence. One cannot just sit and wait for these things to be served.’ (I:20) Here, it is shown that some of the nurses understood the demand for evidence, not as something that is a responsibility of others to distribute to them, but as something they as professionals have to update themselves with. In some descriptions, working with evidence was viewed as a natural part of being a nurse. ‘Everything we do within healthcare should be evidence-based. When we take care of a wound, it should be according to latest research in the area, we know that.’ (I:12)

**Expectations from employer**

Within this structural aspect, the conceptions varied with a range from thinking it was expected of them to be informed about recent research findings, to that, it was up to the employer to take the initiative by giving them opportunities to get updated.

Some nurses considered that the employer took for granted that the work they performed was according to the latest evidence, it was a prerequisite in the employment.

‘Of course they expect us to not just make up things by ourselves, but do what is scientifically proven and approved. My boss is not forcing me into further education or supplementary training regarding different issues, but I do it. (I:7)

On the other hand, some of the nurses expressed that it was the employer’s responsibility to ensure that nurses received necessary knowledge about recent research findings and evidence. Here, the perceptions varied from viewing the head nurse as responsible for spreading new evidence among colleagues at the workplace to viewing the head nurse only as someone who helps make circumstances possible to adopt new evidence. ‘X, the head nurse, sends us to courses or lectures about a topic we nag about; she then wants us to share it with the rest of our colleagues.’ (I:17)

**Expectations from patients**

This aspect included perceptions by nurses that patients expected them to work with advanced EBN. They perceived that patients acknowledged them as highly educated intellectuals, respecting their nursing skills. Nurses also expressed that patients had a right to have high expectations, as living in a developed society implied receiving care based on research and latest evidence. ‘Patients expect us to nurse them with latest available knowledge. I think they would be very surprised if they found out that wasn’t the case. In that area, they trust Swedish healthcare.’ (I:28)

This aspect was also described in encounters with patients’ next of kin. When differing or discordant perspectives and arguments arose between the nurses and patients or nurses and the patient’s family about nursing issues, it was essential to discuss and refer to evidence to manage keeping their choices trustworthy. ‘Sometimes patients and their next of kin wonder really what I am doing. These times, it is important to state evident arguments. One cannot just say that you have made it up.’ (I:28)

**Table 2** The aspects of working with evidence nursing frail older people

<table>
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<th>Referential aspects</th>
<th>Structural aspects</th>
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<td>EBN as an expected and desired intention/mission</td>
<td>Focus on how nurses experience different kinds of demands regarding EBN. Aspects derived: expectations from themselves, expectations from employer expectations from policy documents, expectations from patients.</td>
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<td>Lack of practical supporting structures to apply evidence</td>
<td>Focus on nurses’ expressed need of prerequisites to work/nurse with evidence. Aspects derived: support in form of given time, support in form of availability, increased knowledge to search evidence, forum to exchange evidence.</td>
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<td>Lack of confidence in own capacity to apply evidence</td>
<td>Focus on nurses’ judgment of their own capacity of using evidence in daily work. Aspects derived: perceiving others much more competent, lack of education in the area, isolated from the centre of where it is happening.</td>
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<td>A belief it will work anyway</td>
<td>Focus on a ‘diss-need’ of evidence base in daily work. Aspects derived: a safety in doing as usual, believing true evidence only comes from the patient, trusting physicians or other experts to take care of the evidence ‘thing’.</td>
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In the referential aspect, lack of practical supporting structures the nurses focused on the supporting and facilitating prerequisites they needed for working with evidence. In relation to research use and best practice facilitation, nurses acknowledged lack of support structures in their clinical settings. The structural aspects found were as follows: Lack of support in form of given time and; Lack of support in form of availability.

Within the structural aspect, lack of support in form of given time, the nurses described that there was no time available for getting updated on research during working hours, even if they had the intention and wish to nurse according to evidence. They expressed a perception of having to sacrifice time from their private life to fulfil the intention of nursing with evidence.

This was experienced as stressful as family and other private life obligations could become neglected if they prioritised work. ‘There is no time for searching for evidence in working hours. If something should be done, it has to be at home in my free time.’ (I:20)

The nurses did not only find themselves split between searching for evidence and living their private life, but many nurses also expressed a situation where they were torn between evidence-based nursing and being able to see to their patients. ‘We have so many meetings, so if we sit down more, we lack time together with our patients.’ (I:4) A common perception among the nurses was a need of time exclusively for this matter that did not compete with patients’ needs and attention. ‘I think we need time defined for this. It is hard while working with our patients to set time for searching for the newest evidence for something.’ (I:21)

Lack of support in form of availability

Nurses were positive about being updated on research findings in terms of technology development. Smart phones, iPads and internet have made evidence in nursing easily accessible. But the nurses acknowledged their work was still very traditional. ‘I am not exactly bringing my computer home to the patients.’ (I:30) Several of the informants also expressed that it would be better to have someone at their workplace that assisted them in searching for evidence connected to their nursing. The latest research could then be continuously delivered to them from a specialist in reviewing research articles.

‘I would like someone to come to us and serve us with evidence. I mean someone who can screen and review the news flow so that we can have the things of importance more available for us. It’s impossible as it is now. It would take my full working hours reading everything I should.’ (I:21)

This specialist in evidence-based nursing could, according to the nurses, be someone from the university or municipal research centre who was involved with the nurses’ daily topics of interest. The nurses expressed the need for a forum where they could exchange new ideas and evidence which would enhance their work. ‘When I have learned something new, I feel that I really want to share it with my colleagues and to the nursing assistants. But it is hard to know how, and when.’ (I:22) In the current situation, there was neither time nor place set aside to exchange evidence in nursing.

In the referential aspect, lack of confidence in own capacity to apply evidence, the nurses’ judgment of their own capacity of using evidence in daily work was in focus. They expressed experiences of perceiving others as much more competent and perceived themselves as far from central.

In the structural aspect, perceiving others as much more competent, there was an apparent perception among older nurses that evidence-based nursing was easier and more natural for younger nurses who had recently used this in their training.

Older nurses experienced a lack of own capacity conditionally based on how long ago they graduated from nursing school. ‘Probably, they have talked a lot about this during their training, while they were students. But I am old in the field. I have been a nurse for 30 years. Back in those times, it didn’t exist.’ (I:17) In this apprehension, the informants did not discuss further education or in-service training but basic nurse training that in some cases was three decades ago. Some nurses tried to find evidence for their nursing, but felt a lack of confidence in doing the search in a way that they thought would be sufficient or correct. ‘I think one is out there and trying to make some kind of quality in this, about why one does what we do…but I don’t know.’ (I:21) They seemed to have a disproportionate image about the complexity of evidence-based nursing. In some descriptions, it was viewed as something unreachable, complicated and something only researchers were dealing with, not nurses in their daily work. ‘Evidence is nothing I am involved with, I would never be able to manage it myself.’ (I:32)

Isolated from the centre of where it is happening

There was a widespread apprehension that the organisation of municipal care made the nurses isolated from the news flow within healthcare and nursing research.

This was experienced both by those who had moved their employment from hospital-centred care to municipal care, as well as by those who had their first and only employment as a nurse in municipal care. ‘I don’t feel in the middle of things here. Maybe one becomes more up-dated at the hospital.’ (I:2) The perception the nurses had was that, in this type of organisation, they were excluded from where things happened and where they
were expected to be updated on science. ‘When working in the hospital, it was easier to work like that. Here in municipal care, it’s harder to get information, you work alone and have to trust your own judgment.’(I:2) Some nurses regarded this as a relief but many of them found these circumstances unsatisfactory.

The referential aspect, a belief it will work anyway, expresses a lack of the need of evidence base in daily work. As there were three different ways of describing this, Safety in doing as usual, Believing true evidence only comes from the patient and, Trusting physicians or other experts to take care of the evidence ‘thing’, those were the structural aspects derived.

Safety in doing as one is used to

The nurses claimed the perception that it was safest to continue doing as usual. When they did not try new things, they need not worry about what could happen. The new and unknown somehow seemed to be scary and uncertain. It was easier to ensure safety by performing nursing activities where they knew the outcome and were sure they could handle it. ‘I use my own knowledge, what I know I can use on this patient and what I know I can handle.’ (I:7) Some of the nurses had the opinion that once trained in the profession of nursing you can handle the care of the patient. ‘I still think you use the things you learned in school (20 years ago), then you have to modify them a little after your own experience.’ (I:2) Some nurses did not feel a need for continuous replenishment of evidence during their professional life. ‘But we are trained, we work in line with our training and we don’t need or do a lot of other stuff.’ (I:28) To review their knowledge from nursing school and the lectures they participated in seemed enough. By adding personal experience to their first knowledge about nursing, they could handle patients in different situations.

Believing true evidence only comes from the patient

The idea that evidence should be confirmed by patients was shown: ‘One has to think about how to prioritise work. In my eyes, I think it is the patient I shall prioritise. It’s my most important job to have the patient in focus.’ (I:6) The main priority of many nurses was to listen to what the patients asked for and use the patients’ perception as a source of evidence and evaluation. There was also mistrust in EBN interactions in the way the nurses described their patients as unique, with individual needs that no other patient could experience in the exact same way. They therefore argued that research could not be transferred from others, for example, from a study group’s context to their unique patient’s context. They perceived that they had to deal with multidimensional problems and that research was too coarse a tool to help them solve these nursing issues. ‘People are so different. One cannot be nor do the same to everyone. What you do or how you approach one patient may not work with another patient.’ (I:10)

Trusting physicians or other experts to take care of the evidence ‘thing’

There were perceptions by some of the nurses that it was someone else’s duty to keep the care of patients evident. These nurses frequently mentioned physicians as the most suited people in the team around the patients to take this responsibility. ‘I don’t think I ponder so much by myself. Most often, we are guided by the physician’s prescriptions.’ (I:3) By saying this, these interviewed nurses seemed satisfied being passive in their role, leaving evidence in nursing to another profession to solve. Some nurses also expressed a perception about having physicians as security, to lean on if they didn’t know what to do, or what decision to make. ‘If something is not working, one can always back off and get in contact with a physician, and then one is expecting that they know what they are talking about.’ (I:16) This perception included nurses leaving the decision to someone else. There was a feeling of freedom from responsibility over interventions and a quality of care being guaranteed by others. ‘One doesn’t think so much when one is working, I don’t wonder if something is evident or not. We just do... unfortunately.’ (I:3)

Discussion

The results show EBN as an overall desired demand wanted from different directions. Even though all the nurses seemed to understand it that way, it is notable that there was a spectrum of perceptions about their intention or mission to fulfil that wish/demand. For some nurses, we could recognise what Rycroft- Malones et al. (22) show, that EBN is sometimes perceived as something far away from the reality of clinical practice. Findings reveal that it is a challenge to implement research both on an individual and organisational level. There are similar barriers for implementing EBN: a lack of confidence or critical appraisal skills, insufficient clinical directions, no given time, lack of support, restricted access and a lack of technical support, which is also shown in earlier studies (15, 28–31). In the findings, perceptions pointing out nurses’ vulnerability when being alone with complex decisions were evident. In municipal care of the elderly, nurses work independently, often having to make decisions on their own without the possibility of contacting physicians or other professionals about their concerns. This contradicts the nurses’ statements in the structural aspect about being isolated and not being central and might reflect the view that it is the responsibility of others to bring evidence
into nursing care. This is also shown by Forsman et al. (32), where nurses working in elderly care scored higher on items related to the application of research use compared with nurses in other clinical settings. One can ask if these findings are a result of what Eizenberg (1) describes as the paradigm shifting towards a nursing practice in patients’ homes. If we presume that is the case, a lot of effort has to be made to compensate for this gap to perceive good qualitative home care. A recurring theme throughout the result is the nurses’ disbelief in their own ability to apply evidence in caring/nursing. This is frequently illustrated, for example, in ‘Lack of support in form of availability’, where it became apparent that evidence was seen as something external, something which was supplied to the nurses in their work, as opposed to an internal approach integrated into their nursing. The results show that nurses believe themselves as lacking the skills required to seek for evidence and therefore doubt that new knowledge will be correct or sufficient. Among the nurses, one can also recognise a misguided perception that if they do not explore or try something new, this will equate to not doing anything wrong. A reason for this is suggested under the theme ‘lack of confidence in own capacity to apply evidence’, where nurses expressed insufficient confidence in their own knowledge of applying the ‘right’ method in their search for evidence. Earlier studies also show that many nurses prefer oral communication with more experienced nurses over searching for evidence in research papers/articles (30, 33). This lack of confidence has even made them turn to other professions for advice in nursing matters. Taking this perception further, it could strongly affect the nurses’ role to become an assistant to other professions, whom she perceived as more qualified, for dealing with patients’ problems or needs. This perception created a barrier for nurses, as Tod et al. (14) claim, to raise their status in multiprofessional teams. Recent research (32) also shows that individuals who experienced work as less challenging were more likely to be low research users. This also contributes to the risk of undermining nurses’ status and even more importantly, lowering care quality and risking patients’ lives. We can see here, in the result, a risk in the nurses’ ambition to apply all evidence from the patient as an ethical ambition in order to perceive patients’ autonomy, as the responsibility demands that the patients know themselves what options and complications follow different solutions. This problem is also shown in earlier research by Brownie and Nancarrow as a nursing practice and attitude (34), something that motivates many nurses’ decision-making.

Methodological issues

The considerations about validity and credibility in this study have been guided by Marton (35) as well as Sjöström and Dahlgren (25). As phenomenography focuses on different ways in which people perceive phenomena in their world (24), the method had high applicability to our aim of identifying different ways nurses in municipal care perceive aspects of working with evidence when nursing frail older adults. In phenomenographic studies, participants are often strategically selected (23). In this study, all 35 nurses in the two communities were RNs working in the municipal units where the organisation’s management had agreed to participate in the study. In this sense, the participants can be seen as a total population as all nurses that worked in those units agreed to participate. We have to stress though, that all RNs were informed about their voluntary participation both orally and in the missive letter. We also guaranteed confidentiality in their eventual participation related to nurses in charge and employers. One can discuss whether nurses’ perceptions, which were revealed in the findings about evidence as an expected and desired intention/mission, played a role in deciding whether or not to participate. The findings of this study provide different variations of experiencing and thinking of the phenomena evidence where age, sex, length of experience working as a nurse and further education could possibly be interacting factors, although these demographic differences were not a focus in this study. Sjöström and Dahlgren (25) claim the importance of showing that the chosen way of describing differences and similarities is well supported by the empirical material. Many quotations were used to support the aspects derived. For accuracy in the description of the variances in nurses’ descriptions, the quotations were translated from Swedish to English as carefully and exactly as possible by a professional translator/reviewer. We have to accept this problem if non-English speaking contexts are researched. Sjöström and Dahlgren (25) supported by Marton (35) also claim that once a structure has been found, one has to be able to find some sort of intersubjective agreement. To ensure this in the process of analysis, the authors repeatedly considered and reconsidered the referential aspects and structural aspects that emerged.

Conclusion and relevance to clinical practice

There are a growing number of studies in the last decades describing the problem of implementing EBN. What this study adds to this knowledge are aspects connected to the specific context of working with frail older adults in municipal care. The identified different ways the nurses perceive aspects of working with evidence when nursing frail older adults is described as an expected and desired intention/mission, but nurses additionally report that there is a lack of practical supporting structures to apply evidence. There are also, unfortunately, some nurses who believe it will work anyway, that their nursing is good enough without continuously seeking new
evidence. What is obvious is that nurses have a lack of confidence in their own capacity to search for and apply evidence. For further development of clinical practice in this context, it is important that each and every nurse who wants to make a difference in patient outcomes takes personal responsibility for identifying the evidence and finding ways to adopt its use in clinical practice. To be able to take this responsibility, it is important that management and those responsible for the organisation of patient care provide time and tools making it possible for nurses to nurse with appropriate evidence.

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Study design: Lena-Karin Gustafsson, Åsa Snöljung, Karin Mattsson, Kerstin Dubbelman; data collection: Lena-Karin Gustafsson, Karin Mattsson, Kerstin Dubbelman; analysis: Lena-Karin Gustafsson; manuscript preparation: Lena-Karin Gustafsson, Karin Mattsson and Åsa Snöljung.

Ethical approval

Since nothing of the topics that is labeled as ethical sensitive topics is current in this study according to Swedish law (2003:460) about ethical approval, it is not covered by ethics committee’s aim and purpose.

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