Oncology Nurses and the Lived Experience of Participation in an Evidence-Based Practice Project

by

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Abstract

ONCOLOGY NURSES AND THE LIVED EXPERIENCE OF PARTICIPATING IN AN EVIDENCE-BASED PRACTICE PROJECT

by

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Nursing practice based on evidence is linked to improved patient outcomes. Barriers to evidence-based practice (EBP) in nursing have been identified at the individual nurse level, but recently increased attention has been paid to barriers at the organizational system and contextual level, and recommendations for organizational-level changes have been made and in some cases implemented. A gap in the EBP implementation literature is the qualitative study of the experiences of nurses who have engaged in EBP and is herein proposed as a prerequisite to the design of intervention studies. This paper presents a qualitative study using the phenomenological approach of M. Van Manen (1990) with the underlying philosophy developed by E. Husserl (1931). This study uncovered the lived experience of nurses' participation in an EBP project and drew from the experiences of nurses who had participated in an EBP project within an oncology academic hospital-based nursing setting that contains an organizational infrastructure of EBP. The Power as Knowing Participation in Change theory was found to be applicable to the findings.

Keywords: Implementation science, Evidence-Based Practice, Qualitative, Phenomenology, Barrett's theory of power

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Thanks to my mother, Eileen Carcaterra, for teaching me intelligent caring, and for knowingly directing me into nursing. Thanks to my father, Jack O'Grady for teaching me to be inquisitive through his career as a journalist and in his everyday interactions. I believe these qualities live on in my daughters, Leah Pilossoph and Laura Pilossoph, caring and powerful intellectuals who are soon to be doctorally prepared themselves.

This endeavor would not have been possible if not for Dr. Keville Frederickson, who persistently pursued the idea of public doctoral education for nurses, and then collegially and lovingly co-created it with her students. My sponsor, my teacher, my friend, my "doula", I thank you.

Thanks to my committee members, Drs. Nancy Kline, Violet Malinski, Martha Whetsall and Barbara Montero. I truly hope you see some of your many teachings in these pages. Each of you represents what was most meaningful to me on this path.

Thanks to the nurses with whom I've worked who inspired this study. A special thanks to the nurses who participated in it. Thank you for sharing your experiences with me and permitting me to share your experiences with others.

"A thousand hearings isn't worth one seeing, and a thousand seeings isn't worth one doing."
-Vietnamese village elder

Dedication

This dissertation is dedicated lovingly to my husband, Yuri Fridman, who embodies the concept of caring in the most consistent and loving way, day to day, year to year. You are a gift! You encouraged me to take this path. You then, quite literally, carried me through it. I thank you deeply. This work is dedicated wholeheartedly to you.

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Chapter I: Aim of the Study

The registered nurse was very concerned. A patient who had received chemotherapy as part of her cancer treatment came in with a fever and was found to have neutropenia, a dangerously low count of the infection-fighting part of the blood. The nurse knew that neutropenia was a common side effect in patients who had received chemotherapy, and many of her patients experienced neutropenia, but when it occurred with a fever it could be fatal. The nurse sent the patient to the emergency room for immediate attention.

The nurse knew that neutrophils are a form of white blood cell the body needs to prevent and fight infections, and neutropenia is a dangerously low neutrophil count in the blood. However, the nurse was confused about neutropenia management in her oncology practice because the regimen for prevention of neutropenia and neutropenia-related infection was not practiced consistently on her unit, and she didn't understand why. She started to wonder if there was a way to protect patients from this potentially life-threatening complication of chemotherapy.

Later that week she received a call from the hospital nurse. She was shocked to learn that her patient had died from complications of a neutropenia-related infection. The nurse was very upset about this death. This was a patient for whom she had been caring through several of the patient's important life events: a daughter's marriage, a son's high school graduation, and the birth of a grandchild. The nurse had been happy that the chemotherapy treatment for her patient's cancer was working, and she had hoped it would continue to keep the cancer at bay for as long as possible. The patient's death was especially upsetting because this death was caused by the *treatment* for the cancer, a

treatment the nurse herself had administered, not from the cancer itself. She wondered, could this hospitalization and resultant death have been prevented? Several of her patients in the past had also died from their neutropenia-related infections. What was the best way to manage chemotherapy-induced neutropenia?

The nursing unit had an evidence-based practice (EBP) project team composed of nurses in her department, and she considered approaching the team about studying her clinical question about neutropenia. She hesitated because she was concerned about where she would find the time to participate in an EBP project. She worried about how she would learn everything there is to know about neutropenia and was unsure whether the team would provide the direction she would need. If the nurses found out that their oncology team needed to change current practice, she couldn't see how they would have enough influence to actually do so. The nurses' voices about clinical problems were often not heard on her unit, so this project could be a frustrating waste of her time and energy. There were many reasons why she was thinking of not getting involved in starting this EBP project.

On the other hand, the nurse knew she could learn something from the project and possibly contribute to an important practice change, one that could help improve the lives of patients receiving chemotherapy. She decided to put her misgivings aside and approach the EBP project team with her clinical question.

The nurse in the above vignette is about to embark on an EBP project in nursing. Although there are a variety of definitions of EBP across healthcare disciplines, they all essentially define EBP as a practice based on the most current knowledge available combined with the expertise of the practitioner, the patient's values, and the patient's

preferences in care (Institute of Medicine [IOM], 2001; Melnyk & Fineout-Overholt, 2010; Sackett, Rosenberg, & Gray, 1996). EBP is in contrast to practice that is based on tradition, routine, personal preference, or opinion (Rutledge, 2002).

Applying the most current knowledge to healthcare practice has been shown to improve patient outcomes and the quality of care. Therefore, increasing EBP has become an important focus for improving healthcare quality in the United States (IOM, 2001). Developing EBP teams and EBP projects are common methods used to increase EBP in nursing (Melnyk & Fineout-Overholt, 2010).

Unfortunately, most nurses report that they do not employ EBP, nor are they familiar with EBP (Kitson, 2007). The nursing literature has identified many barriers to applying EBP, including some of the concerns expressed by the nurse in the above vignette: lack of time, lack of knowledge, and lack of support (Titler, Kleiber, & Steelman, 1994). The literature also repeatedly reports the barriers to the use of evidence in nursing practice, and nurse researchers continue to collect data documenting these barriers (Carlson & Plonczynski, 2008).

Much energy in nursing has been devoted to actualizing the ideal of EBP in the nursing workplace (Carlson & Plonczynski, 2008; Stetler & Caramanica, 2007; Wallin, 2008) because of its promise to improve the quality of care. In spite of the widespread commitment to EBP and the increasing implementation of EBP in the nursing profession, challenges and barriers remain, and nursing leaders describe EBP as an unmet goal (McCorkle, 2009).

Barriers and obstacles in this process have been identified, but nursing research has not yet explored the experience of nurses who have been engaged in EBP, and what

meaning the experience of participating in an EBP project has for nurses. The voices of nurses *not* engaged in EBP have been heard loudly, clearly, and repeatedly. The purpose of this study is to understand the experiences of nurses who *have* engaged in the practice of employing evidence to improve their nursing care and patient outcomes.

The aim of this study was to uncover the lived experiences of nurses' participation in an EBP project in an oncology nursing setting. The descriptive phenomenological approach was the specific method of qualitative research used for this study and is discussed in detail in the *Methodology* section.

The Phenomenon of Interest

The phenomenon of interest in this study is nurses' participation in an EBP project. EBP can be practiced in a variety of disciplines such as nursing, medicine, psychology, social work, and policymaking, and the nomenclature can be adjusted to the professional context, such as evidence-based nursing (EBN) and evidence-based medicine (EBM). Each profession has articulated its own definition, with the most commonly referenced definition of EBP being the following: "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996, p. 71). Sigma Theta Tau International (2005), the international honor society of nursing, defines EBN as "an integration of the best evidence available, nursing expertise, and the values and preferences of the individuals, families and communities who are served" (para. 4). The essentials of a practice that aims to reduce the knowledge-to-practice gap in healthcare for improved patient outcomes underlies the universally applied and interchangeably used term *EBP*.

Suzanne Murray 3/15/11 11:05 AM
Comment: **Hi Mary**, APA recommends that an abbreviation not be included unless it will be used three or more times in the text, so I've deleted STTI since it's not.

An EBP project in nursing is a group endeavor in a health care setting examining actual current nursing practice in a given nursing workplace, in light of what the current knowledge and literature is related to that practice (Melnyk & Overholt-Fineout, 2010). The intent of EBP projects is to update nursing practice according to current knowledge and evidence. Practice change may or may not result, depending on the current findings vis-à-vis the current practice. A practice change may be identified as not necessary, or a practice change, although identified as desirable, may not be implemented.

Within the EBP-related nursing literature there is confusion with the terminology used. The term *research utilization*, often used interchangeably with the term *EBP*, is actually a subset of EBP. The specific focus of research utilization is the uptake of research findings in the clinical setting (Estabrooks, Midodzi, Cummings, & Wallin, 2007; Graham & Tetroe, 2007). In EBP in nursing, other sources of evidence, in addition to research, are valued (Melnyk & Overholt-Fineout, 2010). Therefore, the term *research utilization* is more limited than *EBP*. In nursing, EBP represents the combined application of research (research utilization), sources of knowledge in addition to research, practitioner expertise, and consideration of patient values and preferences. All of these factors are employed in EBP and clinical decision-making (LoBiondo-Wood & Haber, 2010; Melnyk & Fineout-Overholt, 2010).

Suzanne Murray 3/16/11 2:18 PM
Comment: **Hi Mary**, I've changed spelling of first author to match that in the reference list and that which I found online using a Google search. OK?

Rutledge and Bookbinder (2002) make a distinction between the study of EBP as a process or as an outcome. As a process, "EBP requires a systematic series of activities to locate, critique, synthesize, translate, and evaluate evidence" (p. 1). When a practice change occurs as a result of the EBP process, the practice change is the product of EBP, the product being the knowledge translated into practice.

In this study, it is the process of EBP and the meaning for nurses participating in the EBP process through an EBP project that will be studied. The phenomenon of interest is the lived experience of nurses' participation in an evidence-based, hospital-based oncology nursing practice project.

Justification for the Study of the Phenomenon of Choice

Improving patient outcomes has been identified as an urgent goal and measure of the quality of care. The IOM was charged with assessing the quality of the American health care system and with providing a prescription for the improvement of patient outcomes. The quality of care in the United States has been identified as uneven and sub-par (IOM, 2001); thus, improved quality of care in the United States has become a national priority.

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The IOM (2001) report, *Crossing the Quality Chasm* states that currently "the American health care system is not delivering on the investments of thirty years of clinical research and development. Americans are not reaping the full benefit of these investments" (p. 145). The knowledge-to-practice gap in health care has been estimated at 15 to 20 years (Balas & Boren, 2000), and even when the evidence reaches the clinical setting, "adherence of clinical practice to the evidence is highly uneven" (IOM, 2001, p. 145).

There is a relationship between decreased quality of care, or poor patient outcomes, and decreased use of evidence in practice (IOM, 2001). Research studies have demonstrated that health care practice based on the best current evidence, EBP, yields improved patient outcomes, such as decreased mortality and decreased hospitalization rates (IOM, 2001). The IOM cites EBP as playing a major part in improving the quality

of health care in this country in the portion of its report aptly entitled, “Applying Evidence to Health Care Delivery” (2001). Logic dictates, and evidence supports, that nursing practice that is based on the best knowledge available will produce superior outcomes for patients. For a better health care system, health care delivery must be based on evidence (Kitson, 2007).

The IOM report resulted in the specific statement that EBP is part of the solution to improving health care in the United States for the 21st century (IOM, 2001). In fact, the need for evidence-based decision-making is one of the 10 new rules the IOM lists. In addition, one of the 13 IOM recommendations is that the Department of Health and Human Services (DHHS) be responsible for “a comprehensive program aimed at making scientific evidence more useful and accessible to clinicians and patients” (p. 146). Professional practice based on current evidence has been identified as an essential, but lacking, component of quality care in the United States.

The nursing profession is important to the quality of health care in this country. In the report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, the IOM identified the nursing workforce, the largest part of the health care workforce, as playing a critical role in the U.S. health care system (IOM, 2004). The full engagement of the nursing profession in the improvement of the nation’s health care will be required if we are to have “a new health system for the 21st century” (IOM, 2001). The use of evidence-based guidelines in practice is seen as critical for improved patient outcomes (Glasziou & Haynes, 2005). Nursing practice based on evidence is critical to a new and improved health system.

Making EBP a reality in nursing has been a challenge. EBP-related nursing

research has helped to describe the obstacles to the implementation of EBP. Most of the research in nursing related to EBP has been focused on the research utilization aspect of EBP. As described earlier, research utilization is a subset of EBP whose focus is the use of research findings in practice; it has been a focus of nursing research since the 1970s. The term *research utilization* was in use before the EBP movement began in the 1990s, when the term *EBP* became more common and began to replace the term research utilization.

A bibliometric analysis of research utilization publications in nursing traced publications in the field to the 1970's with a steady increase since the 1990s (Estabrooks, Winther, & Derkson, 2004). The authors concluded that it is an underdeveloped field, based on the low incidence of citations of actual research articles (4%) and repeated use of the same references.

Early studies of research utilization in nursing identified several common barriers to its use in nursing practice. Nurses surveyed reported that they didn't know about research findings, didn't believe the findings, didn't know how to use the findings, and were not allowed to use the findings in practice (Kitson, 2007). Other barriers cited include lack of value for research findings and the lack of ability to access research through the means available to them (Pravikoff, Tanner, & Pierce, 2005), with the authors concluding that nurses in the United States are not ready for evidence-based practice "because of the gaps in their information literacy and computer skills, their limited access to high-quality information resources, and above all, their attitudes toward research" (p. 50).

The BARRIERS Scale is a survey tool commonly used in nursing to determine the attitudes of nurses towards using research in their practice. An integrative review of studies using the BARRIERS Scale showed that 45 studies had repeatedly identified the same barriers to nurses' research use in data collected over a 15-year period, from 1991 to 2006 (Carlson & Plonczynski, 2008). The recurrent findings were that nurses do not have the time, the information-seeking skills, the access to information, the skills to critically evaluate the literature, the autonomy to change care, or a supportive work environment. Findings are similar internationally where the BARRIERS Scale has been used, in countries such as in Australia, Finland, Ireland, Sweden, and England (Gerrish et al., 2007). There has been little change in the findings over a 30-year history of EBP-related research (Estabrooks et al., 2004). For many nurse leaders the conclusion is that survey research in this field is saturated (Carlson & Plonczynski, 2008; Titler, Adams, & Everett, 2007). Subsequently, research trends in research utilization in nursing reveal a shift in focus from individual characteristics of the nurse as barriers to research use to organizational contextual variables at the unit and organization level (Kitson, 2007). EBP nurse researchers, having identified the importance of the organizational contextual variables in the uptake of EBP, call for action from the practice sector to address organizational barriers (Titler et al., 2007).

Work environments with a culture of scholarship and an infrastructure of EBP have been recommended and implemented in many settings (Foxcroft & Cole, 2009; Rycroft-Malone, 2004; Stetler & Caramanica, 2007). However, intervention studies have not been done to test the efficacy of the implementation of EBP infrastructures in nursing

organizations (Cummings, Estabrooks, Midodzi, Wallin, & Hayduk, 2007; Foxcroft & Cole, 2009).

The nursing research community and policy leaders call for intervention studies demonstrating the impact of EBP on patient outcomes (Glasziou & Haynes, 2005; Phillips & King, 2009). Intervention studies will be an important step in the growth and development of the young field of implementation science. However, I think that design of intervention studies would be hindered at this time due to the lack of qualitative research findings reporting on the experience of those in nursing who have engaged in EBP.

Understanding a situation in which nurses have engaged in EBP will shed light on the phenomenon of the experience of nurses implementing EBP. No studies were identified that specifically addressed the experiences of nurses in a system-wide implementation of EBP. Further insight into this experience for a select group of nurses is needed. To achieve EBP in the nursing workplace, the focus needs to shift from identifying the barriers to EBP in nursing to examining situations where the barriers have been overcome and to giving voice to the meaning of those experiences for nurses.

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Comment: Nice insight!

Phenomenon Discussed Within the Context of Oncology Nursing Practice

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EBP is important to the delivery of quality oncology nursing care. Despite increased funding for cancer research since the enactment of the National Cancer Act of 1971, and a resultant increase in the knowledge base related to cancer care, that new knowledge has not been widely disseminated or applied in practice (Phillips & King, 2009). In response to this gap, increasing the transfer of knowledge to practice has been identified as one of the three goals of the Oncology Nursing Society's (ONS) 2009-2012

strategic plan in its mission to "promote excellence in oncology nursing and quality cancer care" (ONS, 2009, para. 2).

The Oncology Nursing Society has a sustained record of developing research on oncology practice. In addition, this effort has also translated to the use of research and EBP. One of the first to identify research priorities in cancer nursing in 1978, ONS has reassessed identified priorities approximately every 4 years since 1980 (Phillips & King, 2009) through surveying its members. Oncology Nursing Society research priorities are used to develop the organization's research agenda, determine funding priorities for grants and corporate donations, select specific clinical issues for educational program development, distribute research priorities, and give expert testimony to federal, professional, and health-related funding agencies (Phillips & King, 2009). The Oncology Nursing Society's recently published book, *Advanced Oncology Nursing Science*, provides a state of the science record of the Society's research and EBP-related activities, which "translates the evolving knowledge base to professional practice and facilitates shaping health policy "(Hinshaw, 2009, p. xiii). This new publication is yet another example of the leadership of the Oncology Nursing Society in the development, implementation, and dissemination of oncology nursing research, which serves as a foundation for EBP in oncology nursing.

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In accordance with the ONS mission and strategic plan, project teams have identified patient outcomes that can be influenced by nursing interventions, as "nursing-sensitive patient outcomes" (Phillips & King, 2009, p. 299). The "Putting Evidence into Practice" project, which produced pocket-sized evidence-based practice resources on several identified nursing-sensitive patient outcomes, has delivered these resources to

nurses at the bedside (Phillips & King, 2009). This initiative and others have also delivered the message of EBP as an essential component of oncology nursing professional values to its over 37,000 members (ONS, 2010).

The oncology nurse in the vignette described earlier is working within an organizational structure that supports EBP. She had an EBP team to turn to with her clinical question; a similar context was used in this study of nurses' experiences of participation in an EBP project.

The specific context of this study is an oncology nursing setting, inpatient and outpatient, where patients are receiving cancer care. To support oncology nursing as the context for implementation of EBP, the study took place in an oncology-focused academic medical center with an EBP infrastructure in place. Nurses recruited for this study were nurses who had completed participation in an EBP project in an oncology nursing setting.

Justification for Using Qualitative Research

Qualitative research is important in studying the complexity of EBP implementation strategies. Survey research in nursing regarding EBP has reached its saturation point (Titler et al., 2007). Many researchers call for a move from descriptive quantitative survey research to intervention research (Titler et al., 2004; Wallin, 2008), but challenges exist. Our medical colleagues who have conducted much of the intervention research in EBP have identified these challenges. Medical researchers have found it difficult to control for and isolate those factors that contribute to the success of EBP intervention strategies, given the multifactorial complexity of the EBP process and the multiple contextual and human dynamic variables involved. Inconclusive findings in

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guideline implementation in medicine have been attributed to these complexities (Grimshaw et al., 2006).

Some researchers state that randomized control trials, the gold standard of medicine, are not appropriate for interventions strategies related to EBP (Walshe, 2007). Others in the medical literature propose that quantitative measures alone are not sufficient and should be supplemented with qualitative measures of the complex dynamics of processes and outcomes at play in EBP (Wallin, 2008). The nursing literature has also called for the use of qualitative research methods to research EBP: "Observational and phenomenological rather than self-report methods could be used to identify more appropriate and compelling variables" (Carlson & Plonczynski, 2008, p. 331). Qualitative research is recognized, within and outside of nursing, as a necessary and important part of a program of research in EBP (Estabrooks et al., 2007; Straus, Richardson, Glasziou, & Haynes, 2005.)

There is a precedent in nursing for the role and value of qualitative research in EBP research. Studying successes in nursing as a basis for replicating those successes is the proposed fit of this research study in the EBP program of nursing research. Qualitative research has served this role before in the body of research on the development and standardization of magnet hospitals.

Magnet designation for hospitals that demonstrated the ability to retain their nurses and to provide quality patient care is based on 14 "forces of magnetism" identified in the original 1983 American Academy of Nursing study (Kramer, 1988; McClure, Poulin, Sovie, & Wandeh, 1983). These criteria were created by identifying 41 hospitals that were successful in retaining nurses and providing high-quality care. Individual nurses

at these successful workplaces were interviewed, not surveyed, in order to elicit these forces of magnetism (Kramer & Schmalenberg, 2002).

In 1991 the American Nurses Association, through the Credentialing Center (ANCC), developed the Magnet Recognition Program based on the original magnet research. Since that time, ongoing qualitative research in magnet-designated hospitals has identified, through in-depth interviews and grounded theory, eight “essentials of magnetism” (Urden & Monarch, 2002). The magnet movement can claim qualitative research and the voices of nurses in magnet institutions as foundational in the development of magnet programs of success that have been and continue to be replicated across the country. Identifying EBP projects in nursing and interviewing the nurses involved could lead to similar success in the EBP movement in nursing.

What are the “essentials of evidence-based nursing practice”? The model of magnet nursing research can be used in our attempts to close the gap between knowledge and practice. Identification of nurses involved in EBP, then interviewing them to discover their experiences, may lead to defining the “essentials of evidence-based practice.” The voices of these nurses, as the voices of those in the magnet program studies, may be foundational in establishing a successful, sustainable, and replicable template for EBP in nursing.

It has been said that phenomenology is the “science of examples” (Munhall, 2007, p. 163). Examples of the lived experience of participation in EBP are needed in order to understand the nature of the EBP process as the nurses themselves experience it. As Husserl (1931, as cited in Polifroni & Welch, 1999) directed, we must go back to “the

things themselves" ("zu den Sachen selbst"; p. 236) as we seek understanding and knowledge in science.

Descriptive phenomenology is an appropriate method for exploring nurses' experience of participation in an EBP project because this experience has not been described before within the context of a qualitative research study. The clear unfettered voices of the nurses themselves can best be heard using the descriptive phenomenological approach. The structure of the EBP experience and its meaning for nurses involved in that process is described by the nurses themselves and reported in this descriptive phenomenological study, informing the discipline of nursing.

Biases and Assumptions Related to the Study

EBP projects that I have participated in through my nursing career have been positive experiences for me. My bias is that EBP is rewarding and valuable for nurses and patients. I expect that nurses interviewed will express an overall positive and meaningful experience from their EBP activity. In a pilot interview that I conducted for a qualitative research course, I knew I had to put this bias aside to conduct an effective interview. I learned, from just this one interview, that I really don't know what the meaning of anyone else's experience is until they share it with me. In the pilot interview, the nurse described aspects of the experience that I had expected, but there were also negatives related to the EBP experience that I had not considered. The pilot interview experience helped to reduce my bias somewhat, but my passion and justification for conducting the study indicate that my bias in favor of EBP is still there.

Summary

Evidence-based health care professional practice has become the “Holy Grail” for the health care professions. Logic dictates, and EBP research demonstrates, that new knowledge, when applied judiciously in the practice of patient care, improves patient outcomes (IOM, 2001). Nurses play a critical role in health care, contributing to improved patient outcomes by applying new knowledge.

Nursing has a mandate to provide care for society that is safe, effective, and humane. We can best meet that mandate by incorporating identified best practices. An EBP project may be a nurse’s entrée into the use of evidence. This experience may act as a foundation for practice and may change the tide from resistance and barriers to receptiveness and actualization of the EBP ideal.

EBP is important not only for nursing, but the entire health care system to ensure safety and quality. To date, nursing research has not demonstrated consistent implementation of EBP in the nursing workplace. The recurrent theme in nursing research in EBP is that nurses do not engage in EBP and feel that there are many obstacles to their doing so. A gap in the EBP literature in nursing is a description of the lived experience of nurses who have engaged in EBP so that we may learn from these experiences and their meanings. Without hearing these voices, attempts to proceed with intervention studies will be premature.

It is hoped that the findings from this study, produced within a context of discovery, will add to the knowledge of the EBP experience as it is occurring in clinical practice. Efforts to increase sustainability of such projects will be enhanced by a better understanding of the essences of the experience of EBP as revealed by the nurses

themselves who have been engaged in the process. It is hoped this work will contribute to the foundation of knowledge translation research in nursing, and form the basis for development of appropriate EBP intervention studies.

Chapter II: Evolution of Study

Historical Context

Drs. Archie Cochrane and David Sackett are both credited with initiating the EBP movement in the field of medicine in the 1970s. EBM grew out of the concern for the wide variation in medical practice, dependence on tradition and experience, and the need to remodel medical education with a more scientific, evidence-based approach. Nursing also based much of its decision-making on tradition, institutional policy, experience, and intuition (Rutledge, 2002).

Cochrane, a British epidemiologist, was disappointed in the lack of use of evidence in medicine for clinical decision making. His work inspired an international collaborative enterprise, the Cochrane Collaboration, which produces systematic reviews of medical intervention research (Cochrane Collaboration, 2010).

Sackett, a Canadian physician who transferred his EBM work to Oxford, England, originally coined the term *evidence-based medicine* (EBM Working Group, 1992). Sackett created a medical education and practice model based on his group's newly developed EBM paradigm (Sackett et al., 1996; Straus et al., 2005). The original definition of EBM was "the conscientious use of current best evidence in making decisions about patient care" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000).

Evidence-based medicine drew wide acceptance, although it also drew criticism for what some saw as its limited scope. Debate in the EBP field, from nursing and others, centered on the overemphasis on research as the sole factor in decision making, to the exclusion of patient preferences and values. Some thought that not only the patient was excluded in this new paradigm, but the clinician as well. Without the use of practitioner

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Comment: **Hi Mary**, The first half of the sentence seems at odds with the second half. If acceptance was wide, wouldn't it only have drawn criticism from "some" rather than "many"?

clinical judgment, the practice of EBM appeared to some to be simply "cookbook medicine." These criticisms, which persist to this day, prompted this response from Sackett et al. (1996), in an editorial in the *Journal of the American Medical Association*:

> Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. (p. 71)

Clinical expertise and patients' values and preferences, given their personal circumstances, were addressed in Sackett et al.'s (1996) expanded definition above, if not in the practice of teaching EBM. However, a debate continues about what type of research is considered the best research evidence, and what, besides research, can be considered as evidence.

The development of hierarchies of evidence, with the randomized control trial seated at the top, continues to heat the debate. Sackett defended his position that randomized, controlled clinical trials (RCTs) are the "gold standard" of research (Sackett et al., 1996). Opposition remains from those who think that the RCT, so revered in medicine, should not be excessively valued to the exclusion of other sources of

knowledge, such as qualitative research sources. These authors, most often outside of medicine, state that EBM promotes quantitative research studies in general, and RCTs in particular, as having hegemony as the only sources of good evidence (Holmes, Perron, & O'Byrne, 2006; Isaac & Franceschi, 2008). A variety of hierarchies of evidence have been developed in response to this concern, in both medicine and nursing (Mantzoukas, 2008; Merlin, Weston, & Tooher, 2009), although nursing is more likely to include qualitative research study sources in published hierarchies of evidence (Melnyk & Fineout-Overholt, 2005).

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Comment: Hi Mary, I added 2nd & 3rd authors to match reference list. Accurate?

Many criticize the overemphasis on research as the sole source of evidence or knowledge for nursing practice (Holmes et al., 2006; Isaac & Franceschi, 2008; Mitchell, 1999). EBN includes the utilization of research findings, but also includes a variety of sources of evidence (Melnyk & Fineout-Overholt, 2008), such as aesthetic, ethical, and personal, to name a few (Chinn & Kramer, 2008).

The debate about what qualifies as appropriate "evidence" or legitimate knowledge coincides with a movement in philosophy of science to expand the epistemological base beyond the limits of logical positivism, directing science to explore other ways of knowing beyond empirical research, such as aesthetic sources of knowledge (Chinn & Kramer, 2008; Holmes et al., 2006; Polifroni & Welch, 1999). Nursing and other human sciences have begun to move away from the purely empirical, rationalist approaches of the positivist era (Polifroni & Welch, 1999).

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What is agreed on in the EBP field is that practice based on evidence improves patient outcomes and thus the quality of care (IOM, 2004). This logical connection has come to the attention of policymakers, especially in countries like Australia and England

where health care is provided by the government (Melnyk & Fineout-Overholt, 2005) and in the United States, where the recent passage of the Health Care Reform Act presages an increased role of government in policy-making for health care.

Policy Context

There is an important interplay between policy development and EBP. An exemplar is the adoption of core quality measures adopted by the Joint Commission on Accreditation of Healthcare Organizations in 1999, which was refined, unified, and adopted by Congress in 2003 and is used as the basis for reimbursement. Outcome measures were developed based on evidence, policy has mandated their use for reimbursement determinations, and, as a result, the use of EBP to improve on these outcome measures is incentivized (Frederickson & Nickitas, 2010). Policy has established a role in encouraging the use of evidence in practice.

Another example of the relationship between policy and EBP is the national goal to reduce health care disparities. The reduction of health care disparities is one of the two overarching goals for improving the health of the nation identified in *Healthy People 2010* (U.S. DHHS, 2000). This goal is based on the belief that “every person in every community” of our diverse nation is entitled to access to quality and culturally competent health care (p. 16). Access to care is identified as a major obstacle to achieving equity in quality care delivery in this country (U.S. DHHS, 2000). Without the transfer of knowledge into practice, patients do not have access to the best care.

Cultural differences between practitioner and patient have been identified as one of the causes of health care disparities and decreased access to care. Attention to patient’s values and preferences in clinical decision-making, as directed by EBP, can lead to

increased focus in research and practice on the development of cultural competency. Recent quality measures instituted by policy leaders have shown that the disparities gap continues. This evidence could be the basis of the formation of policy to fund new research and new programs to narrow the health care disparities gap.

Policy has a role in the *creation* of new evidence to base practice on through the regular funding of clinical and health services research (Talsma, Grady, Feetham, Heinrich, & Steinwachs, 2008). Policy itself is created through the use of good evidence for policy decision-making, justifying the funding of health services research to provide that evidence. In both of these ways, the evidence-based movement has moved into the policy arena. In addition, policy developments have mandated and incentivized data monitoring and reporting systems as a means to measure the quality and impact of initiatives.

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Technology has eased the collection, retrieval, and storage of this information. Nursing data for measuring nursing outcomes are difficult to retrieve, if present at all (Talsma et al., 2008). Funding and reimbursement for nursing services will become dependent on the ability of nursing to demonstrate success of interventions with measurable nursing outcomes. Technology has the capacity to expedite this process.

Nurses' lack of information literacy and use of technology has been identified as one of the many barriers to EBP, with a call to action to recognize and address this deficiency so as to capitalize on all the benefits technology can bring to patient care (Bakken & McArthur, 2001; Shorten, Wallace, & Crookes, 2001). Pravikoff et al. (2005) stated that nurses in the United States are not ready for EBP due in part to their information illiteracy. In addition, nurses prefer information from interpersonal

communication, according to some (Estabrooks, O'Leary, Ricker, & Humphrey, 2003; Rutledge, 2002).

Conceptual/Theoretical Context

By using the qualitative method, these data can be used to support or add to existing EBP models or to develop new models related to EBP implementation. Multiple nursing EBP models have been developed (Rycroft-Malone & Bucknall, 2010; Stetler, 1994, 2001; Titler et al., 2001) but are not yet used consistently to direct research (Estabrooks et al., 2007). Rogers' (2003) model of the diffusion of innovations is frequently used as a theoretical base for EBP research. Rogers identifies five steps in the process of translating an innovation (new knowledge) into practice (adoption):

1. awareness or knowledge of the new information
2. being persuaded as to the benefits and usefulness of the new information
3. making the decision that the new information is useful and should be adopted
4. doing so (implementation)
5. either continuing or discarding the new practice (confirmation).

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Rogers' original work was in the diffusion of innovations in the agricultural industry. His interest in developing a model for the diffusion of innovations that would have general applicability to other disciplines has been realized in its wide applicability to research in a variety of disciplines, including nursing (Rogers, 2003).

Experiential Context

As a newly graduated nurse I was shocked to discover a big difference between what I learned in school and what was done in the "real world." The first time I changed jobs I also learned that what was a required, safe nursing practice in one workplace was

not a required practice in another workplace. What was the basis for all the variations in nursing care? I could often find no good answer, and the same is true today. This knowledge-to-practice gap has engaged my curiosity throughout my nursing career.

Several roles in my nursing career have involved me directly in EBP projects. As a nurse practitioner in oncology, I initiated an evidence-based system for effectively managing oncology patients on long-term anticoagulation and witnessed the benefits in both process and outcome. I have been a nurse educator in the biotechnology/pharmaceutical industry in the NYC area for the past 8 years, teaching nurses the Federal Drug Administration-approved, evidence-based use of pharmacotherapy for managing the symptoms induced by cancer chemotherapy and for treating cancer. In this role, my interaction with nurses from a variety of cancer treatment centers in the New York metropolitan area exposed me once again to the variations in nursing practice, including the variations in knowledge of and adherence to national practice guidelines. I encouraged many nurses to evaluate if adherence to national guidelines made a difference for their patients through EBP projects in their settings. Despite all the focus in the literature on EBP, I have found that focus is often not matched in the clinical settings in oncology that I have frequented.

Summary

The movement to translate knowledge into practice began in medicine and quickly followed in other health care professions, especially nursing. Discussion and debate about the definition of EBP and its actualization centers around the perceived overemphasis on the RCT as the sole source of meaningful evidence for practice. Evolving philosophies and evolving human science disciplines are challenging the

hegemony of the RCT and adding to it other ways of knowing, including other types of research approaches.

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Comment: **Hi Mary**, Perhaps "gathering knowledge" is more precise and accurate here?

The increasing role of policy in health care has increased the implementation of EBP and will continue to do so as measurable system and patient outcomes provide evidence for policy. The developments in the field of technology have accelerated the development of EBP resources that are brought closer to the practitioner, bringing EBP in the health care arena closer to a reality.

Challenges remain as disciplines, including nursing, struggle with a definition of EBP that is inclusive and embraces the mission of the respective discipline. Nursing continues to face the challenges of incorporating both technology use and policy development into nursing so as to maximize the benefits of each for nursing and for the public it serves.

Chapter III: The Methodology of Phenomenology

As Van Manen (1997) described, there is a difference between research method and research methodology. The term *methodology* refers to the philosophical basis and assumptions underlying the approach to the study of the phenomenon of interest. The term *method* refers to the actual technique used to perform the research and embraces its philosophic underpinnings. This chapter will discuss the methodology of phenomenology as developed by Husserl and expounded by Merleau-Ponty. The method, or the way the research is done, as outlined by Van Manen, is discussed in Chapter IV.

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Philosophy of Phenomenology

Human science has been described as "a knowledge-acquiring enterprise that uses an approach and method that is faithful to the unique qualities of human beings" and that is "radically non-reductionist" (Giorgi, 2005). Husserl (1931) developed the phenomenological approach to epistemology in the early 1900s. Its approach changed the focus of philosophy and science from objects in nature to consciousness itself and from the quantitative analytic approach to one that embraces the qualitative aspect of the human experience. In phenomenology, consciousness is the object of study as it contributes to meaning that humans attach to their everyday experiences (Munhall, 2007).

Edmund Husserl

The context of Husserl's initiation of the phenomenology movement in philosophy was the over industrialization and perceived mechanization of humans' interactions with the world, with each other, and with the epistemological approach of the natural sciences (Polifroni & Welch, 1999). Phenomenology represents a restoration of the focus on our human-ness, and with its systematic emphasis on human consciousness,

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it reflects the aspiration for the elevation of the discipline of philosophy to a science (Munhall, 2007). Giorgi (2005) describes phenomenology as a modern movement in philosophy that has human subjectivity as its focus, and this stands in stark relief to the claims of the logical positivists to completely have eliminated subjectivity from the research process. The truth of this claim has been argued by some philosophers of science and has been strengthened by the identification of subjectivity even in the revered scientific field of physics (Bohm, 1996). The restriction on subjectivity for the positivist approach to research is removed as an obstacle in the phenomenological approach; it is accepted and addressed. The phenomenological approach is seen not only as the "safeguarding of the subjective point of view" (Denzin & Lincoln, 1996, p. 263) but as "treating subjectivity as a topic for investigation in its own right, not as a methodological taboo" (Denzin & Lincoln, 1996, p. 264).

Husserl (1931) developed phenomenology as the study of the essences of humans' experiences within their life-world. The nature of the experience with an emphasis on its attendant meaning for the individual is the phenomenon under inquiry, not the cognitive aspects of an experience, or steps conducted during an experience. It is the human-ness that is emphasized, so that a person's lived experience is explored within the context of its meaning for the human being. Phenomenology seeks to reveal what it means to be human (Polifroni & Welch, 1999).

Concepts and Terms

As a completely original approach comprising a new worldview, phenomenology developed its own language that can be difficult to describe and to understand. Husserl (1931) produced his philosophical works in the German language, his native tongue. In

thanking an English translator of one of his works, Husserl (1931) admitted that the language is "so difficult, even for Germans" (p. 22). Its distinct vocabulary includes concepts and terms that must be described here to aid with the discussion. The *essence* of an experience is the meaning of an experience in a particular context for an individual. The essences of *lived experiences* are presented to our consciousness as objects of consciousness, which are considered to already have meaning attached in that they can be recalled at all (Drew, 1999).

The *natural attitude* in phenomenology refers to one's experience in the life-world as framed by one's preconceptions, assumptions, and prior learning, and which contribute to the meaning of the experience for the individual (Munhall, 2007). This natural attitude is considered an aspect of our consciousness. When two people have, in some part, a shared perception of reality in the natural attitude, this shared reality is referred to as *intersubjectivity (*Drew, 1999). Communication and understanding can be affected by our separate subjectivities in our life-worlds, especially when we are engaging with another person through the colored lens of our own natural attitude. In conducting nursing research from a phenomenological perspective, the practice of *decentering* is to come to a place of *unknowing* by placing aside these preconceptions of the natural attitude that influence our experience of reality. *Decentering* is said to aid in the ability of the researcher to perceive what is really there in the process of discovery (Munhall, 2007).

Husserl introduced the concept of the phenomenological reduction early in his writings on phenomenology. Husserl developed, as he described, a new science that required a new way of looking at the world: "a new way of looking at things is necessary,

one that contrasts at every point with the natural attitude of experience and thought" (Husserl, 1931, p. 39).

> We shall start from the standpoint of everyday life, from the world as it confronts us, from consciousness as it presents itself in psychological experience, and shall lay bare the presuppositions essential to this viewpoint. We shall then develop a method of "phenomenological reductions," according to which we may set aside the limitations to knowledge essentially involved in every nature-directed form of investigation, deflecting the restricted line of vision proper to it, until we have eventually before us the free outlook upon "transcendentally" purified phenomena, and therewith the field of phenomenology in our own special sense of the term. (Husserl, 1931, p. 39)

With its acceptance of subjectivity as part and parcel of human existence, human interaction, human science, and scientific research, qualitative research employs methods to deal with subjectivity in the qualitative research process. The specific technique of *bracketing* to achieve the phenomenological reduction is discussed in the next chapter.

Meaning of experiences in phenomenological terms means to understand that a person's experience occurs within their *situated context.* Meanings can vary across different contexts, so it is important in phenomenology to account for the person's particular *life-world.* The life-world is described as having four existential domains: *spatial, temporal, corporeal,* and *relational*. Human experience occurs within a specific space (place; environment), and time (point in history; phase of life), each of which can vary and alter the impact of the meaning of an experience. *Corporeality,* best understood as the person's experience of their embodiment, can also impact the nature of an

experience. *Relationality* addresses a person's relationships with others in his or her life-world and can deeply affect the meaning an experience may have for an individual. Knowledge of the different dimensions of a person's life-world assists the phenomenological nurse researcher in coming to a deeper understanding of the contexts of the individual's experience (Munhall, 2007).

Merleau-Ponty

Merleau-Ponty (1962) defined *consciousness* as "a sensory awareness of and response to the environment" (as cited in Munhall, 2007, p. 160). This phenomenological definition recognizes mind and body as one in the process of consciousness and defines this intertwining of conscious awareness and both the experience of and the perception and connection to this world as *embodiment* (Merleau-Ponty, 1962*)*. Expanding on the work of Husserl in phenomenology, Merleau-Ponty focused more on the perception aspect of consciousness as it occurs through the body, embodiment, and its role in experience. As described by Munhall, "*experience* and *perception* are our original modes of consciousness" (2007, p. 161).

Hermeneutic Phenomenology

The word *hermeneutic* is derived from the Greek and means interpretive, just as the Greek god Hermes interpreted communication between the gods and mere mortals (Van Manen, 1997). Having defined earlier that phenomenology is the study of things as they appear, without presuppositions, one might see hermeneutics as a violation of the phenomenological approach. However, as Van Manen (1997) explained, there is no such thing as an uninterpreted phenomenon, as the meaning that an experience has for an individual is achieved by the individual's interpretation of the phenomenon. In addition,

we capture experiences and meanings as they are expressed by the individual experiencing them, which involves the use of language, and language requires interpretation. This interpretation, or hermeneutics, is inextricably bound within the phenomenon, thus, hermeneutic phenomenology. The aim of hermeneutic phenomenology is to interpret the meaning that lived experiences represent for individuals.

Summary

In this chapter the philosophy of phenomenology, developed by Husserl and expanded upon by Merleau-Ponty, was described. Phenomenology is concerned with the essences of the meanings of lived experience. It is separate and distinct from the objective, natural sciences; it is a subjective human science. Concepts and terms unique to the study of phenomenology were defined.

The important distinction made in phenomenology, and critical to nursing practice, is the difference between reality as viewed by an outside observer versus the reality of an experience for the individual. Hermeneutic phenomenology attempts to interpret the meanings of lived experience for individuals from the individuals' unique perception (Munhall, 2007).

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Chapter IV: Methodology Applied

This chapter will discuss the phenomenological method of research applied to uncovering the lived experiences of nurses' participation in an EBP project. The specific method to be used is outlined by Van Manen (1997) in the six research activities described in the sections below.

Van Manen Research Activities

Van Manen's (1997) six research activities include turning to a phenomenon that seriously interests and commits us to the world, investigating experience as we live it rather than as we conceptualize it, reflecting on the essential themes that characterize the phenomenon, describing the phenomenon through the art of writing and rewriting, and maintaining a strong and oriented pedagogical relation to the phenomenon. Each is discussed as it relates to the present study.

Turning to a Phenomenon That Seriously Interests Us and Commits Us to the World

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Comment: Hi Mary, FYI - I've formatted this and other activities as Level 2 headings, per APA style.

The phenomenologic method of research requires the full attention of the researcher to the phenomenon of interest, which is a lived experience. "So phenomenological research is a being-given-over to some quest, a true task, a deep questioning of something that restores an original sense of what it means to be a thinker, a researcher, a theorist" (van Manen, 1997, p. 31). In this study I have turned to the phenomenon of nurses' participation in an EBP project in an oncology setting.

Investigating Experience as We Live It Rather Than as We Conceptualize It

As Husserl (1931) described, a requirement of phenomenology is to be able to exclude presuppositions and thought: to be present for the lived experience. For this

study, I selected nurses who have been involved with first-hand experience in an EBP project in oncology.

Reflecting on the Essential Themes That Characterize the Phenomenon

Uncovering the hidden nature of a lived experience reveals its essences, that which expressly describes the phenomenon. Following data collection, I had the recordings transcribed into a written transcript. In the first review I read the transcripts as a whole. Then I took each participant's transcript and read it while I listened to the audiotape. This second read along with the audio provided me with the experience of hearing the participants' own words as I read them.

Describing the Phenomenon Through the Art of Writing and Rewriting

Part of the research process is writing. Van Manen (1997) highlighted the process of writing—putting into language—the uncovered and interpreted essences of lived experience. For this study, I first identified categories of meaning, then themes and subthemes and then essences based on the transcript through writing and rewriting.

Maintaining a Strong and Oriented Pedagogical Relation to the Phenomenon

There is no distanced objective attitude in phenomenological research; the researcher is deeply and subjectively involved in the phenomenon while bracketing assumptions and biases (oriented). The researcher must not lose focus of the phenomenon being studied, nor be distracted (strong). For this study I continued to focus on the experience as relayed by the participants as I dwelled with their words. I asked the participants to read the transcript to be sure that their words reflected their experience.

Balancing the Research Context by Considering Parts and Whole

The hermeneutic circle describes the moving from the part to the whole and back to the parts as the researcher tries to maintain a holistic perspective of the phenomenon under study (Polifroni & Welch, 1999). As themes and essences were identified and described, I sought out five of the participants and asked them to validate the findings.

Bracketing

The *phenomenological reduction* is achieved by *bracketing* and *withholding existential claims*. Bracketing is the recognition and setting aside on the part of the researcher of preconceptions, assumptions, and biases that could interfere with the researcher's perception of the experience as actually presented by the participant so that it is not influenced by what the researcher *expects* to hear. Withholding existential claims refers back to the idea that the phenomenon being studied is not the objective reality of an event, such as "it is cold" as reflected by a thermometer or other persons present, but the experience of the individual who may instead state "it is hot." Whether or not it is hot or cold is not relevant in the phenomenological reduction; the meaning of the experience for the individual, of the phenomenon, is the focus of the phenomenological inquiry, not some externally defined "true" reality or existential claim of a situation. This study was bracketed first through the identification of my biases, then through my experiential context, and finally, by my keeping a journal to write about my experiences, thoughts, and ideas following each interview.

Protection of Human Subjects

The study plan was approved by the Institutional Review Boards at both the university and the study site. The study site required and provided a research assistant.

Confidentiality is a main concern in the conduct of research. It was required that the interview be taped. Thus, to facilitate recruitment of volunteers, potential participants were assured that their comments would be shared only with the doctoral student and her professor as an educational exercise. The power relations in the organization must not influence the manner of recruitment of volunteers, so through confidentiality, no nurse would feel coerced to participate. The participant's identity was kept separate from the transcript content and confidential between the participant, the doctoral student, a research site representative, and the sponsor. If the participant chooses to share her participation with others, she is free to do so.

Lack of knowledge of the experience of a focused interview may have left the participant unprepared for the reality of the interview experience so participants were assured at frequent junctures that he or she may reconsider consenting to participate with no untoward response or sequelae for the participant. Each participant was told as part of the consent process that counseling was available if any undue stress was experienced during, or as a result of, the interview. None of the participants requested counseling.

An informed consent was designed to address all of the above concerns (see Appendix A). The unique aspect of "process consent" is included in the consent and was articulated verbally with the participants. Process consenting involves the verbal review at regular intervals with the participant of their continued consent to participate, which serves to remind them of their right to withdraw from the study at any time in the study process (Munhall, 2007). This was done via email prior to the interview and at the time of signing the consent.

Setting

The study setting is an academic hospital oncology nursing setting with an established EBP infrastructure that has been in place for several years. The department was initiated by the creation of a position of director of nursing research and evidence-based Practice. Two employees in the department currently report to the person holding the director position: a non-nurse research associate who has been with the program since its inception and a recently appointed part-time nurse researcher. The director of the department developed two main arteries for the department: the EBP committee structure and the Nursing Research Fellowship.

The EBP hospital-wide nursing council consists of eight departmental subcommittee chairs from a variety of clinical care areas. Committee members were led through a series of workshops enabling them to consume and create nursing studies of both a performance improvement and research nature. The groups meet at the divisional level in an ongoing manner and their representatives meet once monthly in the larger group to discuss ongoing projects across the department. This ensures cross-pollination of ideas and findings as well as consistency and collaboration in the direction of the nursing department in its mission and values.

The second major artery of the EBP model at the study site is a Nursing Research Fellowship. Nurses at all levels are invited to apply to the program and, as yet, no nurse has been rejected. Nursing Research Fellows receive release time to attend classes and conduct their research or EBP-related work. The Fellowship curriculum is geared to enable nurses to pursue their clinical research questions from the idea stage to the review of the literature, to study design, to data collection, to statistical analysis, and finally to

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Comment: **Hi Mary**, I have inserted the comma before “and” in a series of three or more items, here and throughout, per APA style.

results interpretation and dissemination to the larger nursing community. Nurses in the Research Fellowship are encouraged and assisted to write grants for funding and create posters for presentation at national professional meetings.

Nurses drawn from this setting were interviewed for this qualitative study of nurses' lived experience of participation in EBP. It is hoped that the findings of this study will contribute important knowledge to the EBP research field by capturing the experiences of nurses who have experienced EBP, within all of its complexity. These nurses' experiences can contribute to the meaningful, rational, and evidence-based design and testing of sustainable EBP programs for the improvement of patient outcomes. Without the contribution of their voices, EBP intervention testing is premature.

Sample Selection

A convenience sample from a pool of nurses at one institution who had engaged in an EBP oncology project was selected. This was done initially through announcement made by the Director of Research and Evidence-Based Practice at the monthly meeting and via email. Additional participants were recruited through snowball technique, as needed. Interested nurses responded to the research assistant, and the research assistant scheduled the interviews. Inclusion criteria were registered nurses who had completed one project as a participant in the EBP program.

Data Collection

Potential participants contacted the research assistant through email. Recruitment continued until 12 nurses had been interviewed. Once data saturation had been obtained, meaning that no new information or themes came forward, data collection was stopped.

The concrete descriptions were obtained through unstructured interviews, allowing the participants to describe their experiences and attendant meanings without being unduly led in the discussion by a structured series of questions. Van Manen (1997) has described the subject or participant as a collaborator in the study, and as such he or she must be consulted as to the researcher's interpretation of the meaning of the interview text. In this vein, I returned the identified themes to five of the participants to elicit their feedback.

Data Storage Procedures

Confidentiality of participants was maintained by exclusive control of taped interview by student researcher and faculty member. The tapes of the interviews were destroyed upon study completion. Until that time the tape was safeguarded in the personal possession of the student in a locked file. This information was provided in the informed consent.

Data Analysis

The interview transcripts were read while still maintaining the attitude of phenomenological reduction, so that I as the researcher was as open as possible to what was being presented. At first, the interview was read as a whole, and then the interview was broken down into categories of meaning, sections identified as conveying a singular meaning, which in some cases were as short as one sentence and in others as long as many paragraphs. Several statements in different parts of the interview applied to the same defined category of meaning: statements that were repeated at different times and in different ways, but were interpreted as still conveying the same meaning.

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Comment: Hi Mary, There was some ambiguity here. Meaning retained with this revision?

Once the categories of meaning were identified and integrated, each category of meaning underwent a process called *free imaginative variation.* Employing the *eidetic reduction*, with the help of imaginative variation, one "plays" with the meaning by adding and removing parts of it, until it becomes clear what is the essential part of the meaning required for it to actually represent that meaning, like purifying a chemical to its absolute essential structure by removing "extraneous" matter. A nursing attitude is required, as some sense of the discipline being practiced has to be applied to the philosophical procedures articulated by Husserl (1931) to guide the analysis. The essential meanings were identified from the interview; they were used to create a structure of the essential meanings as presented by the participants. Each of the essential meanings is illustrated in the *Findings* section with several examples from the participants themselves in the form of exact quotes. This will show how these categories of meaning have been interpreted as presented. Some meaning units seen as not relevant to the phenomenon of interest were excluded from the structure. The elicited structure was checked against the raw data to confirm the findings, dwelled upon with the written description, with constant analysis for any bias that may have inadvertently seeped into the analysis. This is part of the qualitative researcher's critical analysis of the work, where the researcher self-evaluates the rigor of the method.

Reliability and Validity Considerations

Reliability and validity were established through the unique criteria for rigor in qualitative research: credibility, auditability, and fittingness (LoBiondo-Wood & Haber, 2010).

Credibility

Credibility, “the truth of the findings as judged by participants and others within the discipline” (LoBiondo-Wood & Haber, 2010, p. 119), was met in this study by returning to the participants to review the transcription to confirm its accuracy and to make corrections that the participants identified as needed. As it turned out, no corrections were needed. Validity, often referred to as credibility in the qualitative research field, is achieved by having the participants read the descriptions and interpretations of the researcher (Creswell, 2007; Van Manen, 1997). Credibility is achieved when the participants themselves concur with the researcher’s themes, or opportunity is given to correct any misinterpretations. Part of the consent form included the participant’s agreement to review the transcribed material and to correct the transcribed interview content. This was done with five of the participants.

Reliability is often addressed in qualitative research in terms of how multiple coders of transcriptions agree on their interpretations of text (Creswell, 2007). I turned to three doctorally prepared qualitative researchers to verify coding, themes, subthemes, and essences that I interpreted from the transcripts.

The commitment to staying true to the data can be more closely achieved by bracketing out personal biases. To assist in identifying personal biases I first responded to the interview question myself and recorded it, so as to raise any prereflective unidentified biases associated with the research question. In addition, I maintained a personal journal throughout the course of the interviews, documenting any personal bias experienced with the material prior to transcription, coding, and interpretation.

Auditability

In the *Findings* section I present the information required to allow the reader to follow the steps I took from the raw data, through analysis, to the interpretation of the findings. Explicit examples are provided to allow for the reasoning of the interpretation to be clearly followed by the reader. In this study I conducted all of the coding of transcripts but sought an external check from a doctoral-student peer who was familiar with the focus and method of this study. Two doctoral colleagues reviewed the transcripts and three doctoral colleagues validated the identified themes.

Fittingness

Fittingness is achieved when there is "faithfulness to everyday reality of the participants, described in enough detail so that others in the discipline can evaluate importance for their own practice, research, and theory" (LoBiondo-Wood & Haber, 2010). Readers should experience the phenomenological nod (Husserl, 1931) that accompanies a reading that "rings true" (LoBiondo-Wood & Haber, 2010), and this occurred with the doctoral peer readers employed during the analysis, as well as the five study participants who reviewed the themes.

Research Question

The aim of this study was to uncover the lived experience for nurses who have participated in an EBP project. The guiding question for the study participants was, "Tell me, what was it like to participate in an evidence-based practice project in nursing?"

Chapter Summary

This chapter reviewed the Van Manen (1997) applied method of research employing the phenomenological approach. The specific research activities were

delineated and defined, including the method for obtaining the sample; collecting, storing, and analyzing data; and taking steps to ensure the protection of human subjects. The specific research question posed to the participants was presented.

CHAPTER V

Findings

This chapter describes the study sample and the research findings. This study revealed the experience of the oncology nurse's participation in an evidence-based practice project. The participants were nurses who work in an oncology setting with an established infrastructure of EBP. Each nurse had at least one experience of group EBP work. The participants were interviewed and data were analyzed following the six steps of the Van Manen method of applied phenomenological research as outlined in his seminal text, *Researching Lived Experience* (1997).

Study Sample

Twelve oncology nurses participated in this study through purposive sampling and snowball technique. As intended by the study purpose, the nurses were invited to participate in the study if they had been involved in an EBP project in their oncology practice setting. All the participants were women between the ages of 27 and 58. Their involvement in EBP projects ranged from 5 years ago to the present time. Demographic data were collected during the interview. The roles of the nurses included staff nurses, advanced practice nurses and charge nurses. All of the nurses work full time.

The confidentiality of participant comments was protected in this manner, as well as through using an encrypted website for uploading of audiotapes for transcription. In addition, pseudonyms for each participant were used in the transcription of audio taped interview data and for reporting the findings. Participants were asked for their personal email addresses rather than their institutional address for any communications required for the study, including the review of their interview transcriptions for accuracy.

Participant confidentiality was of paramount importance since the study had the approval of the organization that employs them.

Descriptions of the Participants

Alice

Alice came into the conference room for the interview with a big smile on her face. She had an air of authority about her. Alice is an advanced practice nurse and has worked at the institution for many years. She also had an air of "duty" about her, that she was here to do her "duty" to participate or assist with this nursing research study, and an air of seriousness; a readiness to start being interviewed with no apparent reservation about the tape recorder or the interview itself. She asked about confidentiality before I had a chance to address it, and she was assured of the confidentiality of her interview. I then explained that she would be asked to review the transcript of the interview so that she could correct any errors or add anything that she might have left out. And so we began.

> It was – evidence-based is a very long process. It's a very tedious process. It's fun, 'cause along the way while you're searching, you know, you get to know, "Ahh! I didn't know that. I didn't know this." These things – things popped out as you're searching.

Alice often went back and forth from the "fun" of being involved in EBP projects and the difficulties:

> You know, and – But overall, I think it's a – I enjoy evidence-based practice. My only barrier – one barrier is we need time…the time to do it, because it requires a lot of time and, you know, off-work hours. 'Cause during clinic hours, it's just so

> hard to concentrate on doing an evidence-based search. Totally get distracted from one thing, you know. It doesn't have, like, the full hour to do it – phone calls and all that stuff. So time is my – is the enemy of this, but then, you know, like I what I said, the fun part is the one that motivates me to keep going and surfing in the net.

Alice was so expressive while she spoke, I could almost feel her sweating, as she described the literature review process as she experienced it.

> It is a struggle. I actually feel it. [Laughs] You know? Like sweat coming out, like "OK. OK, what is this search engine again? What happens?"

Beth

Beth entered the room at her appointed time. She had a tight-lipped smile on her face and a look that seemed to question, "What do you want me to do?" with maybe a little apprehension attached. When I explained the purpose of the study and how it would be recorded and transcribed, and reviewed the confidentiality that would be maintained, she sat down and folded her hands in her lap, still with a shy smile and maybe even a little blush, and said, "OK" and looked at me for the sign to begin.

Beth described her apprehensions when first becoming involved in her EBP project:

> I mean, that was exciting for me because it was something I never did before with school. And – and then it was hard to critique it because – you know, I looked back, actually, on my transcript, and I did take a research course, but I don't remember any – it was nothing like what we had done with the group. So it was like a whole new learning curve for me.

Carol

Carol came after work and was only 5-10 minutes late, but was very apologetic for having detained us. She seemed very energetic and eager to be interviewed. When I thanked her for coming to participate in the study she was effusive in thanking me for including her and that she was happy to participate. Once settled in the conference room for the interview, she seemed very focused and reflective about her experience with EBP projects, and had much to share. "Um, I've been here at [workplace] for, [clears throat] next month it'll be [many] years". Carol seemed proud to share this, to want to discuss the reasons behind this, so I asked what contributed to her staying for so long.

> I think there's just always been a tremendous amount of support for – and I've been a bedside nurse the whole time. But being a bedside nurse, I think the support was to, you know, develop your skills in whatever expertise you seem to lean towards, whether that be leadership in a charge-nurse position or education. You know, and I just – a lot of mentoring is always available. Maybe you wanted to pursue something that you feel you have a strength in. Um, certainly, the department of nursing education fostered and reached out for people to advance in school, whether it be to go from an Associate to a Bachelor's and up and onwards. Um, the hospital has always engaged in whatever's available – financial support.

When the interview shifted to the EBP experience that Carol had, she continued on a similar tack:

> So there was again that support and resources just there for the asking, and that's what made the difference. Because to sit all day and absorb all that material and then have to go back there and make it work, you know, is not very easy. And we

> had a large committee because it was two units, so it was a little bit of a challenge to get people together, but we did, because…we knew if we made the effort to get together, the payoff was huge, because we got so much help for the project.

Donna

Donna came into the room and we instantly exchanged warm greetings. She was wearing a long sweater on this cold and rainy day. She asked right away, “How’s it going, are people volunteering to come?” She seemed interested in participating in the study and informed me that she had encouraged other nurses whom she worked with to volunteer as well. When asked about her experience of participating in EBP, she said initially it was completely new to her, although she had already been a nurse for several years.

> I don’t remember anything like evidence-based, you know. You know, I don’t recall ever hearing anything about it.

Some of the initial challenges of EBP for Donna still linger:

> I felt pretty confident. Yeah, the only thing that I don’t still feel confident – and I say that – like, is the lit review. I don’t know why. Just, you know, reading the articles and saying, “Is this really a good article?” Um, I also think, um, a lot of the, like, statistical part of it, like, um, the p value and “Is this statistically significant?” – that’s stuff I still kind of struggle with because that’s not what I went to school for and so, um – though I did take statistics for nursing, but that was, again, [a while back]… [Laughs].

Eileen

Eileen entered the library conference room for the interview early in the morning, with coat and rain gear in tow, and a large cup of Dunkin' Donuts coffee in her hand. When thanked for her time she explained that in her advanced practice role she had a flexible schedule, so she was able to carve out the time to be interviewed. Eileen talked about her EBP experience as on-the-job training:

> So at first it was a little intimidating because a lot of people that are in this job are younger than me and went to grad school since evidence-based practice was kind of the new thing, but when I went to grad school, it wasn't as much a focus, so I didn't learn it in school; I learned it at work. So that was just a little bit intimidating, …

Fiona

Fiona entered the conference room briskly. She would occasionally look at her beeper or phone to see if she was being called, apologizing, but in spite of this she was very energetically engaged in the interview. She spoke with a strong loud voice, each word clearly enunciated, leaning forward with intensity. She knitted her brow frequently when thinking back on her experiences being involved in her EBP group project.

> So it's been – out of one question [laughs] has come… a lot's come out of it. Yeah, so it's been –Yes. And, you know, it's so funny –….. [Laughs] I said it's gonna be on my tombstone: "[name of project]" [both laugh] No. And it's funny because, you know, you just – it just blew up into a million different things.

Gladys

Gladys came into the room with a lot of energy and enthusiasm. “Are people signing up, is it going OK?” She explained that when she got the email she forwarded it to a group of nurses who had been involved in an EBP project with her. As an advanced practice nurse, she was very much in “professional mode” as the interview began, and spoke in more distant terms about her personal experience of EBP.

> It was this huge study, called the [name of study], that clearly, clearly showed that [improved outcomes]. ……I would love to have one of the nurses go back to the doctor and say, “Well you know the [name of study] trial, like, why is he on [name of drug]?” or “Is there some, you know, some risk factor I don’t know?” *That’s* evidence-based practice.

Hope

Hope walked into the room slowly and tentatively, frowning and expressing her concern that she really didn’t have that much to offer, she had only been involved in one EBP project, she wasn’t sure she could be helpful to the study. Once assured that her experience was important to me and to the study, she sat down at the table with a look of disbelief that I would still want to interview her. Her frown stayed with her during most of the interview, even when expressing positive sentiments, which she seemed to brush off as “no big deal.” She reminded me several times during the interview that she had a limited experience with EBP.

> I know very little about evidence-based practice, so I—but I was asked to be a part of this group. Initially I was really intimidated because I thought all these people know how to do it, they all appear to have been involved in other projects,

> and I thought, you know, they're going to realize that I've been doing this a long time but I don't know what in the world we're talking about, but that's actually, you know, not what happened, so I felt better that way. They were fine, they didn't, no one did anything to make me feel that way.

Inez

Inez had a large smile when she introduced herself and the first thing she said was, "I hope I'm the right person for your study, what do you need?" I explained to her that if she was a nurse and had been involved in an EBP project, that she was definitely right for the study. She smiled and relaxed, sitting down at the table, saying, "Oh, OK."

> I think for the most part I think nurses have, like, this bad connotation or association with research. I think they think it's, like, very cumbersome and that, "Oh, we're not gonna" – you know, "I'm not interested in this. It's boring." I think that may be kind of the mindset. But I think once you're actually put into one of these groups and you start the project, you realize it's actually – if you break it down into different steps, it's actually fairly simple and very educational. Plus the fact that it's – plus the fact that it's, um – you know, we're going forward. This is, like, the future of our profession, and so why not, you know, dive into this? I know – I mean, at least in my unit, um, people are fairly excited about doing evidence-based practice, you know.

Jeanne

Jeanne came bouncing into the appointed interview room with a lot of energy. She expressed her interest and excitement to participate in a research study about nursing and

had a lot of quick questions, “Oh, you want to tape it? OK. Is it a qualitative study? Have you interviewed many people so far?” She spoke animatedly during the interview.

> I’ve been a nurse for about [many] years, and when I first started practicing, I just didn’t really hear a lot about evidence-based practice. I don’t know if maybe I was just – I don’t know. Maybe I just wasn’t hearing bout it – until I came to [name of facility], and everything is evidence-based, evidence-based practice. I don’t know. I don’t know. In your experience, how long has it really – it’s probably been this way for years, but I just didn’t hear about it when I was a new nurse.

Keville

Keville was all business-like and brisk. She couldn’t come to the designated interview room, a conference room away from her unit, because time was tight for her at work. She invited me instead to come to an empty room on her unit. Keville has been a nurse for many years. She spoke very quickly, with great energy.

> Well, it was a little, I would have to say a little scary at the beginning, only because, um, not that I’m not, um, I really embrace change, and challenges, but when it’s something that you’ve never done before, at this level, you’re thinking, “wow, can I do it?”

Lynn Marie

Lynn Marie was also very busy on the interview day, so I met her in the cafeteria near her unit. She was wearing a big smile that stayed on her face during the whole interview.

> I think I got that confidence once I started to see that if you present it in the right way, and you have the right documentation, you have your facts straight and you know what you're talking about, you can really bring that to somebody and, um, sort of win them over.

Her passion was energizing, and she seemed to build up into a crescendo as the interview progressed, even as the afternoon was fading:

> And I think also the general public doesn't realize that. I think they really—have a high—very high regard and respect for nurses, but I'm not so sure that they know that we're also scientists.

Data Analysis

This section will describe the detailed steps taken in the analysis of the data according to van Manen's hermeneutic method of phenomenology (1997). The first research activity is *turning to the nature of the lived experience*. "The lived experience is to the soul what breath is to the body. Lived experience is the breathing of meaning" (p. 36). I turned to the meaning of the nurses' experience of participating in EBP projects.

The second research activity, *investigating experience as we live it*, is the gathering of experiential accounts, formed by reflection, of the phenomenon of interest (van Manen, 1997). I gathered the accounts of the 12 participants through in-depth interviewing under the guidance of three doctoral level qualitative researchers. The first was an internationally known qualitative researcher and academician of more than 30 years, the second a qualitative researcher with 20 years of experience with interview techniques and the third, a qualitative researcher with experience in educational research. Each contributed in unique ways. For example, one expert was available to review

transcripts immediately following an interview, thereby preparing me for the next interview with new insights into the method. The interviews were audiotaped, transcribed to written text, and reviewed. A transcription service was used in which all transcribers were CITI certified and were able to return transcriptions, through an encrypted website, within one to two days. This facilitated review by the outside expert and interview modifications for the next participant.

The third activity, *reflecting on essential themes,* is the process of engaging in hermeneutic phenomenological reflection. This was a lengthy repetitive process that included reviewing and re-reviewing the textual descriptions, reviewing the transcripts while listening to the tapes, sharing the transcripts with the three doctorally prepared qualitative nurse researchers, validating the transcripts with the participants, extraction of categories of meaning, synthesis of categories into themes and sub-themes and distillation of themes and sub-themes into the essences.

I sought validation of the accuracy of the textual transcription of the audiotaped interviews from each participant. I also asked them to add any reflections that they felt they might have omitted upon review of the transcript. Respondents made no corrections or additions to the interview material. One participant corrected the pseudonym and replaced it with her real name, thinking it was a transcription error. I explained to her that the pseudonym was used for confidentiality purposes and that to maintain her anonymity I would use the pseudonym instead of her real name.

First Iteration of Data Analysis

I immersed myself in the stories told by the nurses. I read the transcripts to get a holistic sense of each individual interview. I concentrated on putting aside preconceived

assumptions and biases before analyzing the data. Next, with pen and highlighter in hand, I analyzed each sentence as a meaning unit and assigned a phrase to capture its meaning. Upon completion of this approach to the first transcript, I felt uncomfortable with the technique; it felt too reductionist to break down the interview sentence by sentence. I felt that I was missing the "forest through the trees". I recorded my feelings in my journal and consulted with my qualitative nurse research consultants. I was encouraged to follow my instinct to capture units of meaning, as they were presented, not necessarily sentence by sentence. In some cases one sentence did convey a meaning that needed to be captured, but often a meaning was conveyed in several sentences, or by the telling of a story as an example of the meaning the nurse was trying to express. I highlighted the meanings I identified by highlighting each category of meaning with a different color. I did so without rigidly naming the categories, but allowing my initial response to the meaning to direct the color assignment. Later, I named the categories according to the commonalities I had perceived. The categories identified and their sub-categories in this first iteration were:

- Initial apprehension/anxiety towards EBP participation
- Knowledge deficit/struggle
- Support received (or not)
    - Organizational context
    - EBP team support
    - Nursing leadership
- Positive aspects of experience
    - Fun to learn new things

Exposure beyond my unit

Exposure beyond my hospital

Feeling empowered

Recognition/acknowledgement

Making a difference in patient care

New way of thinking about everything

Presentations/outside exposure

Writing up abstracts, learning power point

Writing articles

Working in teams

Second Iteration of Data Analysis

Once again, I conferred with my qualitative nurse research consultants to seek other perspectives. The data that I had assigned to the category "presentations/outside exposure", upon further analysis revealed activities that actually represented stages of professional development. Data organized under what I had initially labeled "positive aspects of the experience" were too voluminous and varied, so the category needed to be re-examined. Upon deeper reflection, this category seemed to reveal the nurse's experience of empowerment through the process, and the satisfaction this created, as well as the experience of making a difference by improving patient care. In discussion with my collaborators, I decided to go back to the transcripts again, and see how I might re-group the data analysis. I reviewed the transcripts a third and fourth time, now completely immersed and dwelling in the data in the attempt to "hear" the meanings expressed. At the time, I recorded in my journal my concern that the bias of my knowledge of EBP

research and EBP models might unconsciously direct my interpretation. The aspects of the nurses' concrete experiences that aligned with that prior knowledge might interfere with my "hearing" the meanings expressed by the nurses. In other words, I did not want to fall to any pre-existing categories that exist in the literature, such as "barriers," a term used often in describing EBP in the nursing literature, but not often used by the participants.

During this second iteration, I listened to the audiotapes again in conjunction with the reading of the text during the analysis, at the suggestion of my experienced qualitative research consultant. In so doing, I was reminded of a strong feeling that I had entered in my journal during the interviewing process. As I received the transcripts and read the texts the first time, I felt the limitation of the written text in communicating the holistic experience of the interview: the passion the nurses expressed was diminished, or lost, in the translation of audio to text. During many of the interviews I became emotionally involved with the reflective experience of the nurses. Their stories were often told with passion and there was a deep, personal sharing that was moving: several times I had become teary during the interview. Each time I did, I received an affirming smile or nod from the nurse that seemed to communicate, "Yeah, you get it." In trying to capture the passion diminished through transcription, during this second iteration I also kept a separate list of adjectives and phrases used by the participants in the telling of their stories. A sample of some of these words/phrases is below:

I feel like I made a difference

It was exciting!

Awe-inspiring

Uplifting

I felt heard, valued

Confidence

Pride

Really cool

Feeling of “yes!” (While fist pumping)

Very empowering

Struggle

Not easy

Rewarding

Fun

Tedious

Long

Life-changing

Uphill good thing

The categories that emerged during this second iteration were:

Category I: Supports

Protected time

Nursing librarian

EBP team

Nursing management

Administration/Medical Director

Ongoing educational support

Working in a group

Encouragement of professional development

Presentation practices, review of posters, etc

Category II: Challenges

Initial Knowledge deficit

Anxiety related to above

Anxiety, initial and ongoing, about lit searches and critiques

Category III: Transformation

New way of thinking about everything

Exposure outside the unit, the hospital, the state, the country

EBP is no more just a "school" thing, it's in everything we do

Critical thinking integrated and spills over to personal life

Category IV: Discovery

Fun part of learning

Learned so much

Self-confidence: I can do it!

Pride

Exposure outside the unit, the hospital, the state, the country

Category V: Empowerment

I make a difference

Challenging status quo now: "why are we doing this"

Making change

Impacting patient care

I am heard

Recognition/acknowledgement

Pride

Category VI: Evolutionary journey

Over a long time

Multiple leanings

Feeling changed by the experience

Category VII: Professional development

Inclusive of all levels of staff

Conflict resolution

Assertiveness

Public speaking

Writing skills; Power point skills

Mastering group work from member to leader

Collegial collaboration with MD and other disciplines

Becoming an EBP mentor

Conducting research

Category VIII: Improvement in patient care

"The bottom line" is that it's for pt care

Helps me be better at what I do for patients every day

More edgy, expert care giver and consultant in patient care

Third Iteration of Data Analysis

In discussing these categories with the qualitative researchers working with me, I decided to combine categories that seemed to be descriptive of a broader common theme. I shared the identified themes with several of the study participants. One nurse participant recommended collapsing categories: "I'm assuming transformation is linked with professional development?" The participants agreed with the identified themes with the following comments: "Love empowerment." "Perfect, exactly." "You captured it all!" Another nurse asked, "The themes all ring true to me. I would add that the experience opened doors to other disciplines, e.g. in our team's experience we developed an ongoing collegial relationship with the [department outside of nursing] that continues to be useful to this day". When I responded "Right now I have those things under "discovery"- how you expanded your exposure beyond your unit, to other disciplines and departments, all the way to international arenas. What do you think? Maybe I should rename that theme?" The nurse's response was "The way you have it sounds perfect". The themes were re-categorized into four essential themes and are described in the next section.

This ended the third research activity. Up until this point, the final themes and sub-themes were still a work in progress. Moving to the fourth research activity, writing and re-writing was when the themes and sub-themes were finalized as essential themes and the essences extracted from the essential themes.

The fourth research activity, according to van Manen (1997) is the art of writing and rewriting. Writing is the way we bring thought to speech: "So phenomenology is the application of logos (language and thoughtfulness) to a phenomenon (an aspect of lived experience), to what shows itself precisely as it shows itself" (p. 33). During the analysis

I kept in mind van Manen's fifth and sixth research activities: maintaining a strong and oriented relation to the phenomenon being studied and balancing the research context by considering parts and whole. Both these research activities serve to keep the researcher "on track": focusing and refocusing, writing sentences (parts) with an awareness of how it expresses the whole. Writing during the analysis in forming the words to articulate the themes and in describing them, contributed to the iterative process of analysis. In addition, I also turned to the writings in my journal to incorporate reflections from the interviewing process. Based on the responses from the participants and the qualitative research experts, I began to write. In the writing, I present the essential themes, the themes contained within them and the thematic support from the interviews.

Essential Themes and the Themes Contained Within Them

The essential theme of *support* includes the sub-themes of *organizational context*, *EBP structures and processes*, and *EBP work group context*. The essential theme of *challenges* includes the sub-themes of *knowledge, time,* and *resistance to change.* It is important to note that challenges as an essential theme included both those challenges that the nurses described as ongoing and successfully supported and those that were ongoing with varying degrees of support. The essential theme of *evolution* includes discovery, transformation/expanding boundaries, and professional development. The essential theme of *empowerment* includes challenging the status quo and making a difference in patient care. The development of categories was a challenge because many of the themes and sub-themes are interrelated, and could be arranged in different ways. Again, I focused on the nurses and their experiences, and the manner in which they shared them. The final categories reflect my attempt to be true to the nurses' stories in

both content and emphasis. For example, professional development certainly contributes to empowerment, yet I kept it under the theme of *evolution* because of how the nurses described their experience of changing and growing in the mastering of new skills. Many of the nurses used the terms "discovery" and "fun" to describe this process. None of the nurses used the term "professional development", the theme under which I categorized many of these "fun" "discoveries."

Essential Theme I: Support

Had I done a word count, the word 'support' would probably have been used with the highest frequency. Support was described as coming from the organization at large, the EBP department within nursing and the nursing management. The nurses talked about their workplace in general as one of support and a shared mission, coming from both inside and outside the nursing department.

Organizational Context

Beth:

> I – you know, I believe that, you know, the – the administration sets the tone for high standards for people to work here, and you know, through all the years, you know, nurses who don't want to work to that high standard, you know, are – you know, either leave on their own or are encouraged to leave. And I think it makes the people who are here really want to be here, really want to help the patients that we have and, um, do the best job they can. And it shows when you work with people like that.

Keville

And she's [referring to the EBP Director] really brought a culture of, to this institution, where we're really thinking outside the box. And thinking about, how can we improve our practice? Not that we're doing things wrong, but can we do it better?

Carol:

Evidence-based practice is running through the pipes in this place.

The [EBP] kickoff meeting. [The medical director] was the speaker. [The EBP Director] had him come. This is coming from the chief of medicine. This is coming from the medical board. This is not nursing's little latest project, so it was center wide. Evidence-based practice. You know, this whole paradigm of looking at systems, looking at systems, looking at things that we do and why we do it that way. And we have to look at, you know, is that way the best? And if not, you know, benchmarking and just changing practice based on the evidence-based practice. So, you know, it came – you know, and that was important for her, to make sure that, you know, it was hospital wide. In other words, no one could refuse, "No, we don't do that" or "well, you're invited to participate." This is the paradigm. This is how we're gonna work."

Alice

You know, I had support from one or two doctors who really made a difference. Um…who – I had support from two doctors, I would say, that stood out – Or three doctors who stood out, to say, "Maybe you should do it this way. Maybe

> this," who gave me confidence along the way to say "Keep going." So who didn't doubt me, you know, just like, "Keep going. Maybe it's not your evidence-based. It's the design. It's this." Who gave me a lit of positive, uh, and constructive feedback, you know.

EBP Structure and Processes

The EBP structure included those in the EBP Department in nursing: the Director, her Research Associate, and the medical librarian in the hospital library who was assigned to support nursing. The participants described the great role these individuals played in their EBP project.

Keville

> And in the process, of course, [name], who's our director of research here, spent a lot of time with us with [EBP research associate] sort of structuring the group and getting us on a platform where we could be more autonomous. And then we'd come to them when we needed to have a little bit more direction or we hit a brick wall, so to speak, and, um. So it was very interesting because they brought to the table all the experience that they had, especially [Director of EBP], doing evidence-based practice.

> We did all the lit searches, we worked very closely with [name] who's a librarian here at Sloan-Kettering. And we have the privilege of having a library that's fully stocked, and fully staffed, and we have one librarian who's dedicated to nursing, and evidence-based practice, who's [name]. And so when we are unable to find articles on our own, she does a lit search for us, so she helps us with it. And, you

know, it's all about the little, uh, choices of words that you put in to make your lit search a little more specific. And she's been able to, you know, really help us with that. She does, she does an in-service in the library with the new evidence-based practice groups to introduce them to what it is to actually do a good lit search. So, and she's available all the time.

Fiona

Um…and, uh, tons of education. Um, and [Director of EBP] was amazing. She was so helpful. [Director of EBP] and [Research Associate] were very helpful in anything that we needed help with. They were great, you know, and I said, like, any time I've had any projects with them, they've been fabulous, because they kind of, like, just put the polish on it [chuckles] when we get it all together, and they've really helped us pull things together. Um –

Carol

Um, and then it just continued. I mean, she's [Director of EBP] amazing. It just continued with monthly meetings, with individualized meetings at the unit level. If we were stuck on something or we felt we needed a little bit more help, say, with critiquing the literature, [Director of EBP] and [Research Associate] would set up a time with us, come and just really work on our own project with them. So there was again that support and resources just there for the asking, and that's what made the difference. Because to sit all day and absorb all that material and then have to go back there and make it work, you know, is not very easy.

EBP workgroup

The nurses spoke often about what a support it was to be working in a group, learning together, and sharing those learnings with each other.

Alice

Right, it's, it's, uh… but it's – you know, I'm only humbled by people who have worked me – worked with me. It's really a community of nurses who have contributed a lot. It's really not – it's really not my work alone. I mean, truly, if you understand evidence-based, it's not one person's work. It's a lot of people's work, and the more it encourages me to say, "I can't just drop this now." Because [laughs] a lot of people put their heart and soul into it, too, you know. So, um…you know, it's – it's – it's, um…it's interesting in that way.

Donna

And, um, so I felt good working with them because I felt like they knew what they were doing. So, like, even if I was kind of on the fence about things, they were still reviewing – we were working as a team, so it was nice, you know. And they came from different areas, so it wasn't – um, I didn't know [name] before I started working with her. So that was nice, you know.

Essential Theme II: Challenges

The nurses talked about some of the challenges they had to overcome in order to participate and succeed in their EBP project. One of these challenges was their initial "apprehension" about participating because they didn't have the knowledge necessary, often adding that they had not learned EBP in school.

Knowledge

Hope

> So we decided to look at those guidelines, and I'm not a graduate student, I have a bachelor's but I have no, I've never done any graduate work, I know very little about evidence-based practice, so

Eileen

> Um, well, about maybe four years ago, when [EBP Director] came to [name of organization], we first had a workshop that we were all kind of asked to attend – the CNS's – I'm a clinical nurse specialists here – and the nurse leaders from inpatient and outpatient. Um, and that's really where I learned initially about how to do evidence-based practice and what was involved in it.

Inez

> Um, and…and just getting accustomed to using, like, our library. Like, you know, I haven't been in school in forever, so I'm like, you know, "Wait. How do I do this again?" But, um…you know, everything's on the internet now, so you're like – it's just a different process. But now it's actually very easy to get articles, and, you know, doing your keywords, like all that whole process of a lit review, but, um… So that – it was just like getting accustomed to doing that.

Alice

> Or if they changed your face – your – you know, the website or the…It's like someone just arranged my furniture, you know. [both laugh] I guess I'm a creature of, uh, habit, you know. Like someone just arranged the furnitures. OK, I bumped myself on the edge of the table. So I total describe it to the way I do the

search engines. You know, "OK, where did they put this search – this box again?" You know, "Did they put it on the side? Did they put it right there in front of your eyes, or it's hidden?" You know, it's not as obvious as a librarian would be doing it. So that's a struggle, and, you know,

Time

Time was mentioned by the participants in a variety of ways. The nurses discussed the challenges of getting time off of work to attend group meetings and to do assigned work. Most nurses talked about this aspect of time as a support provided by nursing administration and sometimes facilitated by the EBP Director. Only one nurse mentioned that time off from direct care responsibilities was not sufficiently available to her. Many of the nurses talked about time in terms of how long completing the project actually took, adding that the supports they received helped them to see it through to completion.

Gladys

Yes. And how am I going to find time to do this, I'm working, I've got X, Y, and Z, I'm taking this clinic, I'm doing this, and, um, it was much more daunting. Um. Although we did make a point to try to get nurse leaders to get paid nurses time, you know, they still needed time to do this, you know, from work.

Fiona

I think the only issue was that for the – like, people in my role, as far as clinical nurse specialist, they would tend to go to the meetings a lot, but it was a little bit harder for the staff nurses, the clinical nurses, 'cause some of – due to scheduling issues, they might not have been there every meeting. So I think for, um – you

know, just for some of the staff nurses, it may have been a little bit harder because they weren't able to go every meeting or, you know, consistently.

Carol

And [EBP Director] – again, if, you know, there was trouble getting time, she would talk to the nurse leaders, you know? And discuss with them, you know, what she could do to – to help, uh, get us some time. We never really had to – I mean, our nurse leader always supported… you know.

Alice

And one barrier really is the – is the time. Clinic hours – very disruptive. There's no one protected time, you know, to say, "OK, you have half a day to do it." There's – You know, on paper, they said they have – admin would give you a, uh, protected time. It's not protected time. Someone calls in sick, there you go. This is least priority. Your priority is clinic. So that's – The inconsistency of the support is a barrier. Of, like, protecting the time is so – it's not there, you know? Because when you're being called to the clinic, someone calls in sick, you cannot sit in your office and say, "I'm sorry. I can't go there because I have my protected time doing my journal, my research, my evidence, researching my evidence." You cannot say that. And in all conscience, I have to get up and do it. So a lot of times, really, to get things done is to get it off clinic hours.

Eileen

So, um, I think what was the hardest about it is just how long it takes and trying to get enough time to do the work, but it was really rewarding in the end because we

did a little research project as part of it, and we were able to roll out a new, um….new [practice guideline] that the whole hospital uses now.

Resistance to change

Many nurses talked about the challenge of getting a consensus on practice changes, or once consensus had been achieved, the challenge of successfully implementing the change. Beth spoke about some of the typical responses she received when trying to change practice:

Yeah, I mean, for years, you know, "Well, that's the way we've always done it." Well, why? You know? Well, nobody really knew why. ….Yeah, so, it was a long process, but it was good because, you know, we saw all our hard work, you know, have a change in our practice that was based on evidence.

Eileen

I think in other projects, one thing that's been hard is we did, um – in our inpatient group we did this project … which took a long time to get people to agree to 'cause there were so many people interested in it, like physician groups from different areas. So we finally came up with a consensus of what should be done, just the logistics of implementing it. It's still not fully implemented like two years later. And I think what we found is that although a nurse might lead the project, it might be really helpful to have, like, an implementation team actually implement the work after we finish.

Inez

Um, but yeah, I think the biggest drawbacks of these – of evidence-based practice is people not accepting it as what they want to go forward with, that they're

resistant to change. Um…and that's a big problem, because then if you're gonna do all this research, what's the point if no one's going to adopt it? So you really have to have, like, leadership, you know, on board.

Carol

So, we had to go through a few hoops to get it approved to be used in the main hospital.

Essential Theme III: Evolution

Discovery learning

Alice

The fun part is like when you discover – you read something and you think, "I didn't know this." And it just gives me – settles my mind, too, like, "Oh, OK." It validates what I know and – or just teaches me a new thing, like, "Oh, OK, this is a new way of looking at it." You know? So that's a fun—that satisfaction of, you know, knowing more, you know. And just gives – you know, gives me more edge over a subject topic. Like, "Oh, I think I know this." Rather than not knowing it and not knowing what I'm doing with my patients. So it's – And being able to talk to my – you know, uh, to the colleagues, doctors [unintelligible] to say, "OK, I know what you're talking about." So that's a fun part.

Transformation/Expanding boundaries

Beth

Yeah, the other staff that are in the hospital. And it was good to, you know, meet them and get to know them and work with them and, you know, the knowledge that they have that we could share together and work together. It was very good.

Keville

You know, and um, you get to meet people from other departments and then you end up sitting on different committees and next thing you know you're like, you know, having contact with nurses in the ICU, nurses that work on the floor, nurse practitioners, you know, nurses that work on the floor, nurse practitioners, you know, clinical nurse specialists in the ambulatory setting, from the other off-sites, who all come together-

Donna

It was a life changing experience.

Hope

I think differently now about everything….The experience was learning and just looking at things, and then I started to look at things more on my own, you know, just little things people would say or look at research people would do—like someone recently said at [medical meeting], a paper was presented, ………… So I looked at that—maybe they're right, but it was a very small sample, it was just one thing, so I don't know, maybe those people were in the low-risk group anyway for other reasons. It just made me think more a lot about all that I read and what people say. You know, just thinking, it just made me think more about what I hear, you know, rather than—

Professional development

Through their participation in EBP projects the nurses engaged in many professional development activities, often for the first time, from presenting their findings to their local group, to presenting to an international nursing audience. The nurses share

that they have completed or are in the process of completing written abstracts of their findings, articles for publication of their findings, and some have written research studies to be conducted as a result of finding gaps in the research literature.

Alice

> Because of that, of the evidence-based, that led me to say, "I don't want to do this anymore. I'm tired of telling patients doing these things because I don't think I would do it." So that led to a study. So that's a fun part of it. You do find the gaps, and you do, you know, um – and there was even international guidelines supporting what we're doing, so I felt like the whole world really is doing the same that what we're doing, and I just didn't believe that that was it. There must be a better way of doing it, you know? But that led to a study, the study that's gonna help improve or say, "OK, this is it. Sorry. We tried."

Carol

> Um, evidence-based practice has generated two projects that have gone everywhere. They've gone to ONS, to [other nursing organization]. A year ago this month, I was [out of state] presenting the work yet again to the [international nursing organization], …... Um, so we have gotten so much mileage out of that.

> Well, I worked on the – the evidence-based practice and the posters. I only went on the road with this one last March. Uh, what was it like? You know, it was… What do I have to say? The reaction was just not – I mean, I think because we're so gifted here and what we have and how we're supported that people were like,

“Wow, you were able to work with a department of [name]?” You know, they were, like, really blown away.

Essential Theme IV: Empowerment

The nurses described that the transformation they went through as a result of the cumulative EBP project experiences resulted in a change in the way they interacted with information, and in the way they were willing to use their new way of thinking in the improvement of patient care. This included challenging the status quo and making a difference in patient care.

Challenging the status quo

Beth

> No, it’s just, you know, I think it’s… you know, it makes a lot more sense with the way we practice nursing that you look for, you know, evidence and research that’s been done instead of always saying, “Oh, well, we’ve always done it that way,” which is, you know, for years and years, that’s – “Well, that’s the way we’ve always done it.” With no real research or evidence to back it up. So it makes a lot of sense.

Jeanne

> And I find that as a nurse, we have to question what we do. ‘Cause there are a lot of old-timers around who say, “Well, this is just the way we’ve been doing it.” Well, it doesn’t mean that things can’t change.

Carol

> I felt respected. I did not ever – No. I’ve spoken internally, you know, at things, presented here. I think I felt very respected.

Making a difference in patient care

Alice

> You know. And always, like, thinking of, "OK, well, how can I improve my patient care? You know, what can I do differently?" You know. 'Cause I'm really bored with some of the things that we're doing. I'm for over 10 years teaching the same thing to patients. And then sometimes it really makes me think, like, you know "Am I doing – Am I just rambling, or these are the things that will make a difference in their lives?" I mean, they're sick, you know? Am I doing – saying something that will help them? Or maybe something out there that can help them, that I'm still, like, using these same medications or saying the same medications. So evidence-based is fun.

Carol

> So the reception was just incredible. I mean, people were just really very impressed with what we think is such a, you know, a simple little thing, but…really went far.

Summary of the Findings

The data analysis will be represented in two forms. A textual interpretive statement or summary of the essences as well as a visual representation through the PINNACLE model provide two expressions of the findings.

Textual Interpretive Statement

Expressing the themes in the form of a textual interpretive statement brings the words I choose even closer to the experience of the nurses' participation in EBP projects.

The themes are empowerment, evolutions, supports challenges and making a different in patient care. The interpretive statement combines the themes to describe the essence of the experience, answering the original question of "What was the experience of participating in an Evidence-Based Practice project?": *Participation of nurses in an EBP project is an empowering evolutionary journey marked by supports and challenges towards improvements in patient care.*

PINNACLE Model of EBP

The findings from the data analysis were used to create the form of a model (see Figure 1). The model represents the synthesis of the nurses' experiences formulating the themes and sub-themes as depicted in the model. This model shows the evolution of their experiences as EBP as implemented within their unit and the organizational system.

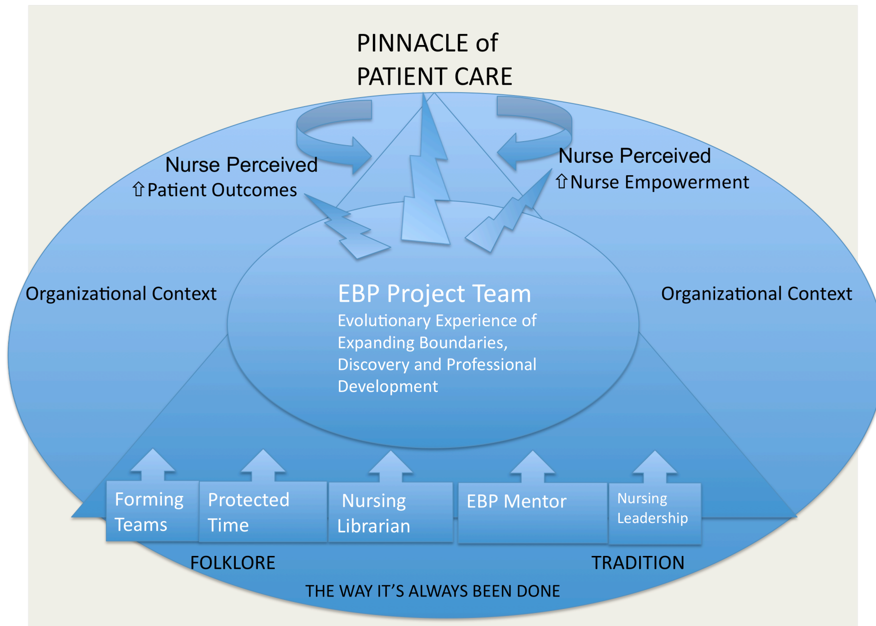

Figure 1. PINNACLE: **P**atient-**C**entered **I**nnovations in **N**ursing

to **A**chieve **CL**inical **E**xcellence through **E**BP

An inductive nurse participant-described model of EBP

Description of the Model

The model represents an upward movement from their original thinking and practice, at the lowest level, to perceived improved patient care and nurse empowerment at the PINNACLE level. The model depicts the nurses' thinking at the beginning of their experience when their practice was based more on tradition, folklore and "the way it's always been done." The base of the triangle represents supports the nurses described: forming of teams, protected time off the unit, dedicated nursing librarian, and EBP mentor, that may be unit or organizationally based. However, what happens at the unit is

influenced by organizational support. For example, protected time occurs at the unit level but it is through the support of the nursing leadership that the protected time is implemented. From here, the nurses conduct EBP within a circle that represents the EBP Project Team that is unit based (the triangle). Within the EBP Project Team circle, there is an Evolution of the individual which is characterized by Professional Development and Discovery and Transformation/Expanding Boundaries. These Evolution sub-themes unfolded during the EBP project process. The "PINNACLE" is nurse-perceived improved patient outcomes and nurse-perceived nurse empowerment: the swirling arrows show how each contributes to the other.

Chapter Summary

This chapter contained a description of the study, the setting, the sample, the participants and the research findings. The participant transcripts were analyzed according the hermeneutic phenomenological method described by van Manen. Five essential themes were identified by the researcher and supported by statements made by the participants. The study findings were illustrated with the PINNACLE Model of EBP, an inductive nurse-participant described model of the EBP experience. The findings were also represented by a textual interpretive statement encompassing the essential themes inferred from the nurses' interviews.

Chapter VI

Reflection on the Findings

This qualitative study was done to illuminate the experience of nurses' participation in an evidence-based practice (EBP) project. This study sought to give voice to those nurses who have been involved in EBP in their nursing practice. The findings from this study led to the development of the following textual interpretation of the experience for nurses who have been involved in an EBP project: *The experience of participation in a group EBP project for nurses is an empowering evolutionary journey of supports and challenges towards improvements in patient care.* This section presents how the results of this study support or amplify the existing body of literature in EBP research and existing models of EBP. It is proposed that the nurses' experience of participating in an EBP project described in this study reflect Barrett's theory of power, which is also described in this section.

Synthesis of the Data and Literature

EBP is an important practice for quality patient care (IOM, 2001). Most nurses report, via published survey research, that they do not practice EBP chiefly because of the lack of organizational support in the nursing workplace (Carlson & Plonczynski, 2008). Leaders in the implementation school of research have called upon the practice sector to create EBP infrastructures in the workplace to foster EBP (Estabrooks et al., 2007). The infrastructure for EBP at the study site was created a number of years before this study was initiated and includes a director position of EBP and a research associate. The director created a committee structure for EBP, EBP group project processes and a research fellowship, described in greater detail earlier in this paper.

EBP researchers claim that survey research is saturated (Titler et al., 2007) and call for intervention research to test both EBP theories and EBP implementation strategies (Titler, 2007; Wallin, 2008). However, the voices of nurses who are practicing EBP have not yet been reported in the literature. Before embarking on much needed EBP intervention studies, it is important to hear the voices of nurses who have participated in EBP. Carlson & Plonczynski (2008) conclude, in their integrative review of research studies using the BARRIER Scale, "Observational and phenomenological rather than self-report methods could be used to identify more appropriate and compelling variables" in the design of successful EBP implementation efforts."

This study turned to a workplace environment that created an infrastructure for EBP so as to hear the voices of nurses who practice EBP and to fill this gap in the literature. It is hoped that these findings will inform the design of much needed EBP implementation studies. In the following section the nurses' experiences shared in this study will be reflected upon and synthesized with the existing EBP nursing literature.

Challenges

The challenges described by the nurses were often overcome through the supports provided. For example, the knowledge deficit the nurses had at the outset of the group project was addressed in the didactic presentations, but also in an ongoing manner as needed. The nurses spoke frequently about calling the librarian for consultation and assistance and calling the EBP director and research associate when they got "stuck." Knowledge deficit is consistently reported by nurses as a reason for not implementing EBP in multiple studies using the BARRIERS scale, although it emerges as less of a challenge than organizational context (Carlson & Plonczynski, 2008). Melnyk et al.

(2004) found a correlation between nurses' knowledge of EBP and their use of EBP, although knowledge of EBP was found to be low (Melnyk, Fineout-Overholt, Feinstein, Li, Small, Wilcox, and Kraus, 2004).

The challenge of time was shared by the nurses as a challenge to overcome. This is consistent with repeated reports of the BARRIERS scale (Carlson & Plonczynski, 2008). The nurses in this study were supported through this challenge by the provision of "protected" time by nursing management: time when they would be free from their usual work responsibilities so that they could do the EBP work required. One nurse talked about how the protected time was not enough, and several others talked about how it would often be cancelled based on patient care priorities. All reported that time for participating in the EBP project was more difficult for staff nurses who have more direct care responsibilities, although one clinical nurse specialist also reported the difficulty of getting "protected time" in the face of emerging patient issues and sick calls. In one case, the nurse shared how the Director of EBP intervened with nursing leadership on her behalf to secure more of the needed "protected" time. The difference between these challenges as experienced by the nurses and the challenges, or barriers reported in the literature, is that the nurses in this study share that they value and continue to practice EBP; the challenges were surmounted through the variety of supports to be described in the next section. The BARRIERS survey repeatedly associates these challenges as obstacles that are not overcome; the nurses surveyed claim they are not participating in EBP.

Nurses in this study shared their experience of resistance to change and other difficulties implementing EBP changes in a complex system. These challenges are also

reported in the literature. The BARRIERS scale groups both lack of time and nurses' lack of authority to change care under characteristics of the organization, ranked as the highest barrier (Carlson & Plonczynski, 2008). These are not factors that the individual nurse has control over. The nurses in this study, in reporting these challenges, described how the supports provided saw them through these challenges. The nurses described how the nursing leadership and the EBP team worked together to assist with implementation challenges. This was successful in varying degrees, depending on the project and the implementation challenges being faced, but for the most part the supports were successful: most nurses shared their experience of pride and accomplishment in seeing their work result in practice change for patient care improvements.

Supports

A non-supportive organizational context was identified in an integrative review of the BARRIERS scale as the most commonly reported barrier to EBP (Carlson & Plonczynski, 2008). Estabrooks et al. (2007) researched the components of organizational context that contribute to research use. The study was based on the work from the PARIHS framework, an EBP implementation model, from which several facets of organizational context were derived: responsive administration, control over practice, resources and support, and innovation. A responsive administration was defined as one that has a committed leadership with a planned strategy for EBP implementation. Control over practice was measured as the degree to which a nursing unit had the authority to create their own care practice guidelines or policies. Resources and support were defined as staff education available about EBP. Degree of innovation in the context of an organization was measured in terms of its perceived receptiveness to new ideas by staff.

Results showed that at the univariate level all of the above organizational contextual variables were successful in increasing nurses' reported research use.

The nurses in this study shared their experience of all of the above organizational components in their workplace. For example, degree of innovation was captured by Carol when she said, "All doors opened for us." The nurses repeatedly discussed the supports that they experienced in their work setting, and they were very passionate about it. The infrastructure for EBP – the Nursing Director of Research and Evidence-Based Practice, her Research Associate, and the medical librarian assigned to support nursing – was specifically cited as crucial to the success of the participants' EBP project experience. Didactic educational programs were presented at the beginning of the nurses' EBP endeavors. The quality of the individuals occupying these positions, their work ethic and their availability to the nurses for consultation at any and all times during the course of the EBP projects was repeatedly mentioned in superlative terms by the nurses. The nurses talked about feeling "gifted" by the availability of these resources to them as they worked through their EBP project. The group structure for conducting EBP projects, itself an important support, was created by the EBP Department as the process by which to initiate and conduct nursing EBP projects. The mentoring the nurses received was a model for the mentoring the nurses described they later provided others, thus promoting a self-sustaining culture of EBP in nursing. The presence of an EBP mentor to facilitate EBP has been identified in the literature as a necessary component for implementing a successful EBP program (Melnyk, 2007). Rogers, in his classic work on the diffusion of innovations, first identified the role of local opinion leaders, or champions, in the diffusion of new ideas and practices among Iowa farmers in the 50s and 60s (Rogers,

2003). The role of EBP mentor, or facilitator, has been incorporated into many of the nursing models for EBP implementation (Rycroft-Malone & Bucknall, 2010). The study nurses' experiences confirm and underscore the necessity of an EBP mentor in the workplace.

Interestingly, several nurses experienced their workplace as a supportive organizational context prior to the development of the infrastructure for EBP, but not specifically supportive of EBP. Most nurses mentioned that they had no knowledge of EBP in the workplace prior to the addition of the EBP infrastructure. This suggests that a supportive organizational culture, in the general sense, may be seen as necessary but not sufficient for fostering EBP; EBP did not passively or spontaneously occur. More specific active steps needed to be taken to create a climate specifically fertile for EBP implementation. Organizations may be supportive of their staff, but this is not enough for EBP to occur. The nurses' experience of a supportive workplace prior to the EBP infrastructure coincides with their claim that they had no knowledge of EBP until the EBP Director arrived.

The nurses described the "new" culture at their institution. According to one nurse, the introduction of EBP into the institution was not just in nursing: it was made clear that EBP was the new way of doing business for all. This communication of a shared mission of EBP in the institution joined, all levels of staff, from all disciplines in the common goal of improved patient care. This same nurse explained that EBP included anyone and everyone whose work touches the patients. After the EBP infrastructure was in place, the nurses' experience reflects an organizational culture specifically supportive of EBP.

Evolution

The experience of evolving personally and professionally through their EBP project experiences of discovery learning, expanding boundaries, and professional development opportunities is a finding that adds significantly to the EBP literature. These nursing outcomes have not been previously reported in the literature. The only nursing model of EBP implementation to include nursing outcomes other than increased EBP knowledge after EBP education, is the Advancing Research and Clinical practice through Close Collaboration model (Melnyk & Fineout-Overholt, 2010). The nurse outcomes included in the model are: nurse satisfaction, group cohesion, intent to leave and turnover rate, which the model links with decreased hospital costs. Could the nursing outcomes described in the ARCC model be measuring the latent variable of nurses' evolution?

The research support for the posited nursing outcomes in the ARCC model of EBP were the results of a pilot study. The pilot study tested the implementation of EBP based on the ARCC model in the Visiting Nurse Service of New York (VNSNY). At the time of Melnyk & Fineout-Overholt's writing (2010) there was no published research to support the nursing outcomes component of the ARCC model; these data were reported as supporting research data based upon personal communication with the primary investigator of an as yet unpublished study (Melnyk & Fineout-Overholt, 2010). This study has recently been published (Levin, Fineout-Overholt, Melnyk, Barnes, and Vetter, 2011) and is discussed later in this paper.

This phenomenological exploration of nurses' participation in EBP projects revealed not only the fact of their transformation and expanded boundaries but the meaning it had for them. One nurse stated "I look at everything differently now", from

her newfound critical consumption of sales marketing claims to her new appreciation of the lessons of history as "evidence" to be reckoned with in shaping the future. These experiences, and the meaning of them to the nurses, would have been difficult to capture on a survey. Additionally, the BARRIERS scale only reflects barriers to research use, not facilitators.

Empowerment

The nurses in this study reported experiencing a sense of empowerment as a result of participation in an EBP project. This has been anecdotally reported by some EBP nurse researchers (Melnyk & Overholt, 2010) and others who have reported on non-research implementation projects in the literature (Newhouse, Dearholt, Poe, Pugh & White, 2005). A related concept studied in the literature is that of "ownership": staff ownership of a change in practice has been reported to be a determinant of EBP success, which was measured as a function of "control over practice" (Estabrooks, Midodzi, Cummings & Wallin, 2007) in a study of contextual determinants of research use.

Another concept linked to empowerment in the nursing EBP literature is nurses' work satisfaction. Nursing work satisfaction was measured in a pilot study (Levin, et al., 2011) of nurse and cost outcomes of EBP implementation in the VNSNY. In this recently published pilot, the Index of Work Satisfaction Scale was used to measure nurses' job satisfaction, which includes a subscale measuring autonomy in their practice. Levin et al. found no change in work satisfaction but claims that this may have been due to the multiple subscales in the tool: pay, organizational policies, interactions, task requirements, and professional status (2011). The authors claimed that these findings conflicted with the "qualitative data" of the experimental group which showed increased

job satisfaction, however, any plan to systematically collect qualitative data was not part of the study design addressed in the paper, so it is not clear what qualitative data the authors refer to.

Making a Difference in Patient Care

This theme was closely related to the nurses' sense of empowerment and transformation that they experienced through their participation in an EBP project. They uniformly discussed the meaning the project had to them in terms of "the bottom line"- the patient. They felt empowered to make changes and the possibilities of doing so caused them to think differently about their patient care on a daily basis. The value and meaning of the themes of empowerment and transformation were most consistently addressed in terms of their perception that patient care had improved, and that they had a part in it. Improved patient outcomes are a highly sought after outcome of EBP implementation studies. The nurses' reports are encouraging and have implications for future nursing EBP research, and is discussed in a later section.

Reflections using a nursing model perspective

Historical views of the concept of empowerment, and the relationship of the concepts of empowerment and power will be presented in this section. The concepts of empowerment and power will be presented as seen through the lens of Rogers' Science of Unitary Human Beings, conceptualized and operationalized by a nursing model: Barrett's theory of power.

Relationship between power and empowerment

Empowerment is defined as either giving power or authority to a person, which implies a person in power doing the giving, or a process of enabling, or permitting, where

some antecedent event releases a power that was otherwise, but for the removed obstruction, available to the person. For example, in the current study the implementation of an EBP infrastructure serves as the antecedent that released the power within the nurses.

Theories from other disciplines related to the concept of power include the writing of sociologist Max Weber, feminist theorists and psychologist Carl Rogers. Weber's view of power is finite, with power being seen as transferred through seizure or bestowal. Critiques of this perspective point to the necessity for those who empower others to lose their own power in the process. This is referred to as the "constant sum conceptualization" of power. In the current study there was no support for this viewpoint because the nurses experienced increased power within their current roles, which is consistent with the feminist view of power as something that is shared, e.g., power *with* versus power *over.* Power from the feminist worldview is seen as generated from within, in the presence of antecedent conditions such as self-esteem and knowledge (Masterson & Owen ,2007).

Focus on the individual level of power began with Carl Rogers who saw power as a potential of the individual that can blossom through personal growth, similar to the feminist perspective (Masterson & Owen, 2007). Other theorists counter that the lack of power is not a disability of the individual, failing at personal growth, but a dysfunction of social structures that foster inequality of resources. Both views can be seen at work for the study participants who came to their power through the personal growth experiences they described, but did so once resources were made available to them.

Nursing theory of power

The seminal work on power in the nursing literature is Barrett's work on power (Caroseli & Barrett, 1998). Barrett conducted an exhaustive search of the power literature in many disciplines and arrived at a new theory of power, drawing from the tenets of Martha Rogers' science of unitary human beings, briefly described below.

Rogers introduced her conceptual framework, the science of unitary human beings. The focus of nursing is the human being in mutual process with the environment. The human being is irreducible, cannot be simply described by describing its parts; in fact there really is no part, but a wholeness that is inextricably interacting with itself and its environment (Malinski, 2006). The four postulates of Rogerian science are energy fields, openness, pattern, and pandimensionality. These postulates are also perceived as integral to each other and irreducible. Rogers' principles of homeodynamics are resonancy, helicy, and integrality. These principles, "describe the nature of change in the human-environmental field process" (Malinski, 2006, p. 163).

Barrett developed a new concept of power in nursing in accordance with the new worldview described by Rogers. Barrett defines power as "knowing participation in change" (Caroseli & Barrett, 1998). Power, as Barrett describes it, reflects the Rogerian concept of integrality. Power includes four manifestations in the observable and measurable domain: awareness, choices, freedom to act intentionally, and involvement in creating change. Barrett (2011) explains her concept of power:

> Your capacity to participate **KNOWINGLY** in change is what I call **POWER**. You were born with power. No one can give it to you, and no one can take it away from you. ……..In a nutshell: Power is being **aware** of what one is **choosing** to

do, **feeling free** to do it and **doing it intentionally**. (Author's italics)

Barrett (2011) prefers the term "power" to the term "empowerment" due to the historical association of power as control. The nurses in this study often spoke of feeling "empowered", so I chose to use the term empowerment to be more reflective of the nurses' word use, although their experience matched Barrett's conception of power. Barrett's definition of power as knowing participation in change is reflective of the nurses' experience as they described it. The EBP implementation provided the nurses with knowledge and skills that the nurses applied to create changes in patient care as part of their EBP group practice experience. They spoke of knowingly applying these new abilities to create change in the delivery of patient care in their daily practice. As Barrett states, change is always occurring, but having a knowing and intentional involvement in that change reflects power (Barrett, 2011). When the nurses saw all their work result in positive changes in patient care, they felt their power, and described the experience with the word "empowering". Barrett operationalized the concept of power by developing a tool: Power as Knowing Participation in Change. As Malinski points out, the volume of nursing research employing Barrett's theory of power and the power as knowing participation in change measurement tool supports its relevance and its value to nursing science and nursing practice (Malinski, 2010). The use of Barrett's theory, derived from Rogers' science of unitary human beings represents the worldview of the author and may raise the question of bias, however, the fit was defined by the nurses' stories, and validated by the nurses themselves, as presented in the previous section.

Limitations of the Study

A limitation of this study is the conduct of the study in the participants' workplace. The nurses might not have been as open about the challenges, because the institutional climate is supportive of EBP. In addition, this might have discouraged some nurses from participating. Although qualitative research is based on individuals' unique experiences, the findings may have been biased in favor of a more positive view of the experience.

Summary and Discussion

The purpose of this study was to discover the meaning of the experience of nurses' participation in an EBP group project. The study revealed the experience as expressed in an inductive model of EBP as well as the following textual statement: *the experience of nurses' participation in an EBP project is an empowering evolutionary journey marked by supports and challenges towards improvements in patient care.* The nurses' experiences of the EBP challenges to be overcome and the supports required to overcome those challenges add to the literature on EBP because these supports and challenges exist in a context of an established, ongoing EBP infrastructure. Barriers were not obstacles preventing the practice of EBP, as they are described in the nursing EBP literature, they were experienced by the nurses as challenges that can and were overcome to achieve EBP. The evolution the nurses experienced in both their personal and professional lives has not previously been reported in the research literature. Empowerment, although reported anecdotally, has not been documented. With all these personal and professional benefits that the nurses experienced, they each maintained the patient at the center of the EBP experience, at the center of the greater meaning of the

experience to them: “It’s all about the patient.”

Implications for Nursing

Although qualitative findings cannot be generalized, it is exciting to consider the possibilities for nursing and the nursing workplace if EBP implementation efforts result in the positive nursing outcomes shared by these nurses. The purpose of EBP is to improve patient care outcomes, but the value of concomitantly improving these nursing outcomes might be translated into increased nurse job satisfaction and decreased nurse turnover, as Melnyk & Fineout-Overholt posit in their EBP implementation model (2010). The investment in nursing by establishing EBP infrastructures is one way to meet the demands of healthcare reform and the need for improved patient outcomes in health care. It is possible that the positive outcomes for nurses may also be a source of cost containment. In addition, the most recent IOM report, *The Future of Nursing* (2010), cites the importance of improved interprofessional collaboration and working in teams in achieving improved patient outcomes. The nurses in this study expressed their increased work in teams and increased interdisciplinary collaboration as part of their EBP experience.

Implications for Future Research

The findings from this qualitative study of nurses’ experience of participation in EBP can be used to inform future nursing research, specifically EBP intervention studies. Recommendations for future EBP implementation study designs include addressing the supports provided in these nurses’ experiences, utilization of mixed method approaches, measuring nurse-sensitive patient outcomes, interprofessional collaboration and nursing outcomes such as power with Barrett’s tool. This study addresses the recommendations

from previous research for a qualitative approach; as is true for all research, the findings pose more questions than they answer.

Appendix A

Participant Consent Form

Mary Pilossoph is a doctoral student in the Department of Nursing at the Graduate Center, City University of New York. She is conducting a study about the experience of participating in an evidence-based practice project in an oncology nursing setting. You are being asked to participate in this study because you have been involved in the experience of participating in an evidence-based practice project in an oncology nursing setting. Participation in this study is voluntary, and refusal to participate will involve no penalty to you.

You are being asked to participate in an in person interview. During the interview you will be asked questions about what it was like to participate in an evidence-based nursing project in an oncology setting. The interview will be audio taped and transcribed. It will take place at a mutually agreed upon location and last about one hour. A second, follow up in person interview lasting approximately half an hour will also be done to provide you with an opportunity to review the researcher's transcription and check for accuracy.

The risks from participating in this study are minimal in that they are no more than encountered in everyday life. It is however possible that discussing your experience may raise difficult issues for you. In the event that this happens the researcher has a list of resources that you may contact for assistance should you need them. You always have choices and may choose not to answer particular questions. You may stop the interview process at any time you wish.

There are no direct benefits. However, your participation in this study may increase the knowledge about what it is like for nurses who have participated in an evidence-based practice project. The researcher and her dissertation sponsor are the only ones who will listen to the tapes. No personal identifiers will be linked to the data; your name will not appear on the tapes or transcripts. All identifying information about you will be omitted or disguised. Identifying codes will be used instead of names. Tapes will be destroyed after interviews are transcribed. All materials will be kept in a locked file cabinet in the researcher's office, accessed only by the researcher or her dissertation sponsor. As long as the data exists it will be kept secured, it will be stored for a minimum of three years, and will then be destroyed. The information will be used to produce a doctoral dissertation. Only aggregate data will be used in any reports or publications derived from this research. The researcher is mandated to report to the proper authorities if you are in imminent danger of harming yourself or others or if there is suspected child abuse.

You may discontinue participation at any time without penalty or loss of benefits. If you have questions about the study, you can contact the researcher, Mary Pilossoph at 347-406-3144, or her dissertation sponsor Dr. Keville Frederickson at 212-817-7980. If you have questions regarding your rights as a subject or if you feel you have had a research related injury, please contact Kay Powell at the Graduate Center Institutional Review Board at 212-817-7525.

I have read the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give my consent to participate in this study. I have received a copy of this form for my records and for future reference.

I give consent to be audio taped. Yes No (PLEASE CIRCLE ONE)

Name of Participant__________________Signature_______________Date___________

Name of Researcher _________________Signature ______________Date____________

Appendix B

Participant Information Sheet

Oncology Nurses and the Lived Experience of Participating in an Evidence-based Practice Project

Participant Information Record

Date of Interview:________________________________

Gender 1) Female 2) Male

Age ____________

Educational Background

1) Bachelors degree

1) Masters degree in Nursing

2) Other degrees

Years of nursing experience _______________

Preferred Contact Information: personal or work email

Name_______________________________________ email______________________

References

Bakken, S., & McArthur, J. (2001). Evidence-based nursing practice: A call to action for nursing informatics. *Journal of the American Medical Informatics Association*, *8,* 289–290.

Balas, E., & Boren, S. (2000). Managing clinical knowledge for health care improvement. *Yearbook of medical informatics*. Bethesda, MD: National Library of Medicine.

Barrett, E. (2011). *Living powerfully through health patterning* [Website]. Retrieved from http://www.drelizabethbarrett.com

Bohm, D. (1996). *On dialogue.* New York, NY: Routledge.

Carlson, C., & Plonczynski, D. (2008). Has the BARRIERS Scale changed nursing practice? An integrative review. *Journal of Advanced Nursing, 63,* 322–333.

Caroseli, C., & Barrett, E. (1998). A review of the power as knowing participation in change literature. *Nursing Science Quarterly, 11*, 9-16.

Chinn, P., & Kramer, M. (2008). *Integrated theory and knowledge development in nursing.* St. Louis, MO: Mosby.

Cochrane Collaboration. (2010). [Home page]. Retrieved from http://www.cochrane.org/docs/descrip.htm

Creswell, J. (2007). *Qualitative inquiry & research design.* Thousand Oaks, CA: Sage.

Cummings, G., Estabrooks, C., Midodzi, W., Wallin, L., & Hayduk, L. (2007). Influence of organizational characteristics and context on research utilization. *Nursing Research, 56,* S24–S39.

Denzin, N., & Lincoln, Y. (1996). *The handbook of qualitative research*. Thousand Oaks, CA: Sage.

Drew, N. (1999). A return to Husserl and researcher self-awareness. In E. C. Polifroni & M. Welch (Eds.), *Perspectives on philosophy of science in nursing* (pp. 263-272). Philadelphia, PA: Lippincott.

Estabrooks, C., Midodzi W., Cummings, G., & Wallin, L. (2007). Predicting research use in nursing organizations: A multilevel analysis. *Nursing Research*, *56,* S7–S23.

Estabrooks, C., O'Leary, K., Ricker, K., & Humphrey, C. (2003). The Internet and access to evidence: How are nurses positioned? *Journal of Advanced Nursing, 42*, 73–81.

Estabrooks, C., Winther, C., & Derksen, L. (2004). Mapping the field: A bibliometric analysis of the research utilization literature in nursing. *Nursing Research, 53,* 293–303.

Evidence-Based Medicine Working Group. (1992). Evidence-based medicine: A new approach to teaching the practice of medicine. *Journal of the American Medical Association*, *268*, 2420–2425.

Foxcroft, D., & Cole, N. (2009). Organizational infrastructures to promote evidence based nursing practice. *Cochrane Database of Systematic Reviews, Issue 3.* Retrieved from http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002212/frame.html

Frederickson, K., & Nikitas, D. (2010). Health services research. In Nickitas, Middaugh, & Aries (Eds.), *Policy and politics for nurse and other health professionals: Advocacy and action* (pp. 257-352). New York, NY: Jones & Bartlett.

Gerrish, K., Ashworth, P., Lacey, A., Bailey, J., Cooke, K., & Kendall, S. (2007). Factors influencing the development of evidence-based practice: A research tool. *Journal of Advanced Nursing, 57,* 328–338.

Giorgi, A. (2005). The phenomenological movement and research in the human sciences. *Nursing Science Quarterly, 18,* 75–82.

Glasziou, P., & Haynes, B. (2005). The path from research to improved health outcomes. *Evidence-Based Nursing, 8,* 36–38.

Graham, I., & Tetroe, J. (2007). Whither knowledge translation: An international research agenda. *Nursing Research, 56,* 586–588.

Grimshaw, J., Eccles, M., Thomas, R., MacLennan, G., Ramsay, C., & Fraser, C. (2006). Toward evidence-based quality improvement: Evidence (and its limitations) of the effectiveness of guideline dissemination and implementation strategies 1966–1998. *Journal of General Internal Medicine, 21*, S14–S20.

Hinshaw, A. (2009). Introduction. In Phillips & King (Eds.), *Advancing oncology nursing science* (pp. xii-xv). Pittsburgh, PA: Oncology Nursing Society.

Suzanne Murray 3/15/11 11:05 AM
Comment: **Hi Mary**, First initials for editors and page range of chapter are needed.

Holmes, D., Perron, A., & O'Byrne, P. (2006). Evidence, virulence, and the disappearance of nursing knowledge: A critique of the evidence-based dogma. *Worldviews on Evidence-Based Nursing, 3,* 95–102.

Husserl, E. (1931). *Ideas: General introduction to pure phenomenology.* New York, NY: Collier.

Institute of Medicine. (2001). *Crossing the quality chasm.* Washington, DC: National Academies Press.

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses.* Washington, DC: National Academies Press.

Institute of Medicine. (2010). *The Future of nursing: Leading change, advancing health.* Washington, DC: National Academies Press.

Isaac, C., & Franceschi, A. (2008). EBM: Evidence to practice and practice to evidence. *Journal of Evaluation in Clinical Practice*, *14*, 656–659.

Kitson, A. (2007). What influences the use of clinical research in practice? *Nursing Research, 56,* S1–S3.

Kramer, M. (1988). Magnet hospitals: Institutions of excellence. *Journal of Nursing Administration, 18,* 13–24.

Kramer, M., & Schmalenberg, C. (2002). Staff nurses identify essentials of magnetism. In M. McClure & A. Hinshaw (Eds.), *Magnet hospitals revisited*. Washington, DC: American Nurses Publishing.

Levin, R., Fineout-Overholt, E., Melnyk, B., Barnes, M., Vetter, M. (2011). Fostering evidence-based practice to improve nurse and cost outcomes in a community health setting: A pilot test of the Advancing Research and Clinical practice through Close Collaboration model. *Nursing Administration Quarterly*, *35*, 21-33.

LoBiondo-Wood, G., & Haber, J. (2010). *Nursing research: Methods and critical appraisal for evidence-based practice*. St. Louis, MO: Mosby.

Malinski, V. (2010). Celebrating nursing theory. *Nursing Science Quarterly*, *23,* 5-6.

Malinski, V. (2006). Martha E. Rogers' science of unitary human beings. In M. Parker, (Ed.), *Nursing theories & nursing practice,* 2d ed. Philadelphia: Davis.

Mantzoukas, S. (2008). A review of evidence-based practice, nursing research and reflection: Levelling the hierarchy. *Journal of Clinical Nursing, 17,* 214–223.

Masterson, S. & Owen, S. (2006). Mental health service user's social and individual empowerment: Using theories of power to elucidate far-reaching strategies. *Journal of Mental Health, 15,* 19-34.

McClure, M., Poulin, M., Sovie, M., & Wandeh, M. (1983). *Magnet hospitals: Attraction and retention of professional nurses.* Kansas City, MO: American Nurses Association.

McCorkle, R. (2009). Nurses making a difference: Taking personal responsibility for using research findings. *Cancer Nursing, 32,* 1.

Melnyk, B., Fineout-Overholt, E., Hockenberry, Huth, M, Jamerson, P., & Latta, L. (2007). Improving healthcare and outcomes for high-risk children and teens: Formation of the national consortium for pediatric and adolescent evidence-based practice. *Pediatric Nursing, 33,* 525-529.

Melnyk, B., Fineout-Overholt, E. Feinstein, N, Li, H., Small, L., Wilcox, L., and Kraus, R. (2004). Nurses' perceived knowledge, beliefs, skills, and needs regarding evidence-based practice: Implications for accelerating the paradigm shift. *Worldviews on Evidence-based Nursing, 1*, 185-193.)

Melnyk, B., Fineout-Overholt, E. (2010). ARCC (Advancing research and clinical practice thrugh close collaboration): A model for system-wide implementation and sustainability of evidence-based practice. In *Models and frameworks for implementing evidence-based practice: Linking evidence to action*. Malone, J. & Bucknall, T. (Eds.).

Suzanne Murray 3/15/11 11:05 AM
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Melnyk, B. M., & Fineout-Overholt, E. (2010). *Evidence-based practice in nursing and healthcare: A guide to best practice*. New York, NY: Lippincott Williams and Wilkins.

Merleau-Ponty, M. (1962). *Phenomenology of perception*. New York, NY: Routledge Classics.

Merlin, T., Weston, A., & Tooher, R. (2009). Extending an evidence hierarchy to include topics other than treatment: Revising the Australian "levels of evidence." *BMJ Medical Research Methodology*, *9,* 34–39.

Mitchell, G. (1999). Evidence-based practice: Critique and alternative view. *Nursing Science Quarterly, 12,* 30–35.

Munhall, P. L. (2007). *Nursing research: A qualitative perspective* (3rd ed). Sudbury, MA: Jones & Bartlett.

Oncology Nursing Society. (2009). *Vision*. Retrieved from http://www.ons.org/about/vision/

Oncology Nursing Society. (2010). *Membership*. Retrieved from http://www.ons.org/Membership/Meet

Phillips, J., & King, C. (Eds.) (2009). *Advancing oncology nursing science*. Pittsburgh, PA: Oncology Nursing Society.

Polifroni , C., & Welch, M. (1999). *Perspectives on philosophy of science in nursing: An historical and contemporary anthology*. New York, NY: Lippincott.

Pravikoff, D., Tanner, A., & Pierce, S. (2005). Readiness of U.S. nurses for evidence-based practice. *American Journal of Nursing*, *9*, 105.

Rogers, E. (2003). *Diffusion of innovations* (4th ed.) New York, NY: The Free Press.

Rutledge, D. (2002). Introduction. *Seminars in Oncology Nursing, 18,* 1–2.

Rutledge, D., & Bookbinder, M. (2002). Processes and outcomes of evidence-based practice. *Seminars in Oncology Nursing, 18,* 3–10.

Rycroft-Malone, J. (2004). The PARIHS framework: A framework for guiding the implementation of evidence-based practice. *Journal of Nursing Care Quality*, *19,* 297–304.

Rycroft-Malone, J., Harvey, G., Seers, K., Kitson, A., McCormack, B., & Titchen, A. (2004). An exploration of factors that influence implementation of evidence into practice. *Journal of Clinical Nursing, 13,* 913-924.

Rycroft-Malone, J. & Bucknall, T. (2010). Models and Frameworks for Implementing Evidence-Based Practice: Linking Evidence to Action. John Wiley & Sons: West Sussex, UK

Sackett, D., Rosenberg, W. M., & Gray, J. A. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal, 312,* 1–72.

Sackett, D., Straus, S., Richardson, R., Rosenberg, W., & Haynes. (2000). *Evidence-based medicine: How to teach and practice EBM.* London, United Kingdom: Churchill Livingstone.

Shorten, A., Wallace, M. C., & Crookes, P. A. (2001). Developing information literacy: A key to evidence-based nursing. *International Nursing Review, 48,* 86–92.

Sigma Theta Tau International. (2005). Retrieved from http://www.nursingsociety.org/aboutus/PositionPapers/Pages/EBN_positionpaper.aspx

Stetler, C. (2001). Updating the Stetler model of research utilization to facilitate evidence-based practice. *Nursing Outlook, 49,* 272–279.

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Stetler, C. B. (1994). Refinement of the Stetler/Marram model for application of research findings to practice. *Nursing Outlook, 42*, 15–25.

Stetler, C. B., & Caramanica, L. (2007). Evaluation of an evidence-based practice initiative: Outcomes, strengths and limitations of a retrospective, conceptually-based approach. *Worldviews on Evidence-Based Nursing, 4*, 187–199.

Straus, S. E., Richardson, W. S., Glasziou, P., & Haynes, B. (2005.) *Evidence-based medicine: How to practice and teach EBM* (3rd ed.). London, United Kingdom: Elsevier.

Talsma, A., Grady, P., Feetham, S., Jeinrich, J., & Steinwich, D. (2008). The perfect storm: Patient safety and nursing shortages within the context of health policy and evidence-based practice. *Nursing Research, 57,* S15–S21.

Titler, M., Everett, L., & Adams, S. (2007). Implications for implementation science. *Nursing Research, 56,* 53–59.

Titler, M., Kleiber, C., & Steelman, V. (1994). Infusing research into practice to promote quality care, *Nursing Research*, 307–313.

Titler, M. G., Kleiber, C., Steelman, V., Rakel, B., Budreau, G., Everett, L., et al. (2001). The Iowa Model of evidence-based practice to promote quality care. *Critical Care Nursing Clinics of North America*, *13*, 497–509.

Urden, L. D., & Monarch, K. R. (2002). The ANCC Magnet recognition program: Converting research findings into action. In M. L. McClure & A. S. Hinshaw (Eds.), *Magnet hospitals revisited* (pp. 407-559). Washington, DC: American Publishing.

U.S. Department of Health and Human Services. (2000). *Healthy people 2010: Understanding and improving health* (2nd ed.). Washington, DC: U.S. Government Printing Office.

Van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, NY: State University Press.

Wallin, L. (2008). A descriptive feast but an evaluative famine: Implementation research in nursing. *Canadian Journal of Nursing Research, 40*, 17–23.

Walshe, K. (2007). Understanding what works—and why—in quality improvement: The need for theory-driven evaluation. *International Journal for Quality in Health Care, 19*, 57–59.