Evidence-based nursing – reflections from different perspectives

Till Gustav och Emy

"*Att våga är att förlora fotfästet en stund. Att inte våga är att förlora sig själv.*"
S. Kierkegaard

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Abstract

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The overall aim of this thesis was to describe the use of evidence-based nursing (EBN) with respect to the four cornerstones of EBN: research, nursing theory, the patient's perspective and clinical competence. Study I explored registered nurses (RNs) self-reported research utilization (RU) in relation to their work climate. A quantitative approach was used; further analyze led to a cluster solution of the measured variables, and low reported RU were compared with higher reported RU. The result showed that an academic degree underpinned the instrumental research utilization (IRU), also women reported higher use of conceptual research utilization (CRU). An association between low RU and dynamism/liveliness was seen, and younger RNs and RNs with shorter working experience reported higher scores for playfulness/humor and conflicts. Study II described how nurses conceived working in a ward where a nursing philosophy had been implemented. A phenomenographic method was used. The philosophy supported the clinical work and underpinned reflection and shared values. A prerequisite was a dedicated leader. The RNs described the care being of high quality. First line nurse managers (FLNMs) role and their experience of opportunities and obstacles to support EBN, was explored in study III. Data was collected using focus groups and analysed using phenomenography. The result showed that the FLNMs need to make an entity of vision and reality to be supportive according of EBN. The last study was an integrative literature review and the perspective of the patient in articles reporting on interventions designed to improve nursing was in focus. The result in study IV showed that the perspective of the patient represents five aspects, and that reporting clinical implications is important. In conclusion; the different perspectives all relates to EBN. Registered nurses need to be encouraged to develop their academic training, to be able to work according to EBN. A nursing philosophy provides time for reflection and a feeling of performing care of high quality. FLNMs need to take their role to support the RNs in order to work evidence-based. Conscious and communicated aspects supported the perspective of the patient.

Keywords: clinical competence, evidence-based nursing, nursing research, nursing theory, patient's perspective

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List of studies

The studies included in this thesis are the following:

I. Karlberg Traav, M., Forsman, H., Eriksson, M. (2019) Registered nurses' self-rated research utilization in relation to their work climate – using cluster analysis to search for patterns. Submitted.

II. Karlberg Traav, M., Gabrielsson, H., Cronqvist, A. (2014) Conceptions of an implemented nursing philosophy: A phenomenographic study. *Clinical Nursing Studies. 2*(3) 86-96. DOI: 10.5430/cns.v2n3p86.

III. Karlberg Traav, M., Forsman, H., Eriksson, M., Cronqvist, A. (2018) First line nurse managers' experiences of opportunities and obstacles to support evidence-based nursing. *Nursing Open. 5*(4) 634-641. DOI: 10.1002/nop2.172. 10.1002/nop2.172.

IV. Karlberg Traav, M., Eriksson, M., Dahlberg, K., Cronqvist, A. Is the patient's perspective taken into account? – Interventions to improve evidence-based nursing: An integrative literature review. In manuscript.

In this thesis the studies will be referred to by their Roman numerals (I-IV).

List of Abbreviations

ANOVA	Analysis of variance
CCQ	Creative Climate Questionnaire
CRU	Conceptual research utilization
EBM	Evidence-based medicine
EBN	Evidence-based nursing
EBP	Evidence-based practice
EIN	Evidence-informed nursing
FLNM	First line nurse manager
ICN	International Council of Nurses
IRU	Instrumental research utilization
LANE	Longitudinal Analysis of Nursing Education
LUST	Longitudinell Undersökning av Sjuksköterskors Tillvaro = Swedish name for the LANE-study
PCC	Person centered care
PRU	Persuasive research utilization
RN	Registered nurse
RU	Research utilization
SCDNT	Self-care deficit nursing theory

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Preface

When I started my training to become a nurse, one of the most important issues for me was that the profession of nursing was based on an academic training. I was interested in research and saw it as a natural and inherent part of the nursing profession. This, because my point of view was, that the academic basis gave the profession clarity and authority. For me, it became an obvious and natural way to be able to work safely; research had the answers to different dilemmas or situations that could emerge in the clinical context. Not always and not always very well completed, but as a natural help when making decisions that sometimes dealt with life and death. After learning about nursing theories, I realized that they could guide the way I met the patient and that nursing theories would help me to reflect and refine the way I wanted to act in clinical situations. In the different clinical settings I have been working in, I have also experienced collaboration with clinically skilled registered nurses (RNs) who have guided me to strive for clinical competence. Their knowledge and commitment to the patients has always been a leading star to follow.

In the same context, the clinical setting, I also realized that bringing all parts of nursing together was not that easy. I, together with many other nurses before me, realized that "the gap" between the educational training and the clinical context, was a reality. What I had learned and tried to achieve during the nursing education and training, was not always compatible with the workdays at my ward. Most RNs, including me, also have a desire to work evidence-based in the daily clinical work side by side with the patient, more as a "skilled companion" rather than someone who tells the patient what to do or how to live.

Today, in the fast changing health care sector, with all its struggles, the discussion or reflection about these topics is limited. "We don´t have the time" is a regular remark or comment from different levels, both from RNs, their leaders and the organizations. This picture is established by the media, reporting mostly when the care fails or when there is a shortage of RNs. My point of view concerning time and workload on an edge of what is conceivably; to work evidence-based in a reflected way is the only way to ensure patient safety.

My pursuit to understand nursing in its complexity and entirety actually started in direct connection to what was supposed to be the ending of the educational part of my training to become an RN. I "signed in" to the next

level of the educational ladder to try to deepen my knowledge about nursing and care, and thus my journey towards this thesis began.

In this thesis my intention has been to look both into some perspectives that helps RNs to work evidence-based but also into what obstacles one can experience. My expectation is to contribute and encourage the RNs working bedside along with the patients, to realize that RNs are capable of working evidence-based in nursing. There is no contradiction between for example lack of time and what one as an RN, can achieve when working evidence-based with the patient in focus.

Background

The aim of this research project was to contribute to the understanding of the concept evidence-based nursing (EBN). In this thesis the concept EBN is considered being a composite of research, nursing theory, together with the patient's perspective and clinical competence (Hoeck & Delmar, 2018; Ingersoll, 2000; Scott & McSherry, 2009). The concept has been viewed and reflected on from the different perspectives of research utilization (RU) in relation to work climate, the use of nursing philosophy (one level of nursing theory), the role of first line nurse managers (FLNMs) and last but not least, from the perspective of the patient. The background section starts with a description of the concepts of nursing, followed by a deepened presentation of EBN and its four cornerstones in relation to the specific aims of this thesis.

Nursing

The International Council of Nurses (ICN) defines nursing as follows:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (ICN, 2002).

Registered nurses (RNs) are expected to work in an independent and ethical way in line with best available knowledge and with the individual patient's best interest in focus, according to Svensk sjuksköterskeförening (2016). It rests with the individual RN to use best available knowledge and skills according to the profession (Svensk sjuksköterskeförening, 2016). Registered nurses have a complex and responsible position in the health care sector, being in charge of the care closest to the patient when working in a clinical context. The focus in the role of RNs is described by Svensk sjuksköterskeförening (2016) as being based on nursing theory and application of the knowledge, research, development and education together with leadership. Svensk sjuksköterskeförening also describes the ethical code for RNs - to promote health, prevent disease, restore health and

ease suffering- in relation to four different aspects: the RN and the society, the RN and the professional work, the RN and the profession and finally, the RN and the relation to colleagues (Svensk sjuksköterskeförening, 2020). Altogether, RN as a profession has developed, and can be seen as an important profession that holds its own discipline in relation to the society (Svensk sjuksköterskeförening, 2016).

Evidence-based nursing

The use of the concept "evidence-based" began with evidence-based medicine (EBM) and the need to be able to rely on research when the physician was deciding, for example, on treatment or medication for the patient (Djulbegovic & Guyatt, 2017). Evidence based medicine started as a concept in the 1990s, by the University of McMaster and was defined as: "a systemic approach to analyze published research as the basis of clinical decision making." (Claridge & Fabian, 2005). In 1995, Sackett and Rosenberg described EBM as a lifelong learning process, and stated that the responsibility lies with the individual to keep her or himself updated with current research in favour of the patient (Sackett & Rosenberg, 1995). After the concept of EBM was established, the need for a similar way of conceptualizing the use of research within other professions in health care, paved the way for evidence-based practice (EBP) and evidence-based nursing (EBN) (Beyea & Slattery, 2013).

Evidence-based practice is a more widely used term in the literature and in the clinical context than EBN. It seems that RNs can relate more easily to EBP than to the concept of EBN in the clinical context (Saunders & Vehvilainen-Julkunen, 2017). Evidence-based practice can be understood as a concept being built on three cornerstones; research, established experience and the patient's perspective, (Gerrish, Ashworth, Lacey, & Bailey, 2008; Scott & McSherry, 2009). The use of EBP is regulated by the law and applies to any of the health-related professions working in the health care sector according to Socialstyrelsen (2019). The relation between EBP and EBN is not well described in the literature, and there is a need for trying to make a clarification regarding the meaning of the two concepts (Hoeck & Delmar, 2018). While EBP is a concept that can apply to any profession in healthcare, EBN takes into account the specific conditions and contexts of nursing. Evidence-based nursing can be considered having four cornerstones, as earlier stated in this thesis. The fourth cornerstone, beside research, clinical competence and the patient's perspective, would be a

theoretical framework; a theoretical base for EBN (Hoeck & Delmar, 2018; Ingersoll, 2000; Scott & McSherry, 2009).

The concept of evidence-informed nursing (EIN) has also been used (McSherry, Simmons, & Abbott, 2002) but it seems that the term "evidence-based" is more commonly used than "evidence-informed", both when it comes to the clinical context and when used in a theoretical context. In this thesis the concept of EIN will not be further discussed.

Research

The area of research relevant for RNs in a clinical context, which is aimed to develop nursing, is constantly growing (Polit & Beck, 2018). It is of importance that the focus is on the interest of the patient, as well as on how RNs can use and understand research as an area for professional growth and professional increased professional knowledge (Polit & Beck, 2018). The research for clinically working RNs needs to be pertinent, intelligible, accessible, useful and possible to implement (Kristensen, Nymann, & Konradsen, 2016).

Nursing research and the body of knowledge for RNs consists of different approaches and methodologies and the research question or the phenomenon of interest should guide how research studies are being conducted (Dahlberg, 2013).

Research utilization

Research utilization can be defined as a conscious and reflecting relation to research. The term is not interchangeable with "evidence" or "evidence-based practice" (EBP) (Estabrooks, 1999). The concept of RU can be seen as a required part of both EBP and EBN (Nguyen & Wilson, 2016; Strandberg et al., 2014). The RN needs to be able to formulate questions around problematic areas; find, read, and evaluate research to find an answer to the formulated questions; and suggest plans for using and implementing new research results (Squires, Estabrooks, Gustavsson, & Wallin, 2011). This is time-consuming and sometimes difficult to do in a hectic clinical setting, though it is necessary if the care is to be evidence-based. Moreover, the RN needs to feel confident in using research findings in clinical settings (Boström, Rudman, Ehrenberg, Gustavsson, & Wallin, 2013).

When it comes to the question of the extent to which RNs use research, some of the results from the Longitudinal Analysis of Nursing Education (LANE) study (Rudman, Omne-Pontén, Wallin, & Gustavsson, 2010)

showed different factors associated with low RU. Among newly or recently graduated RNs, these factors were: working in psychiatric nursing, role ambiguity, insufficient staffing, low work challenge, being male, and having had low student activity during undergraduate nursing education (Forsman, Rudman, Gustavsson, Ehrenberg, & Wallin, 2012). As pointed out in that study, most of those factors are modifiable and the results reflected individual variations, as well as contextual factors. Studies have also shown that the use of research in a continuous way is a complex process and that RNs have to be motivated for an intervention to improve RU to be successful (Mortenius et al., 2013).

Research utilization can be understood in different ways and an attempt has been made by Estabrooks (2011) to describe RU and its use in the clinical context. The definition of RU as presented by Estabrooks (1999) comprises three parts, described as instrumental RU (IRU), conceptual RU (CRU), and persuasive RU (PRU).

Instrumental RU is defined as occurring when findings from research are used in a concrete, specific, and direct way, as for example when guidelines and directives are used for the benefit of the patient (Estabrooks et al., 2011). Instrumental RU is probably the most used RU in the clinical context because the research linked to IRU leads to concrete and direct use of the research findings (Estabrooks, 1999; Strandberg et al., 2014).

The understanding of CRU is more vague than IRU, but also more general in its use; CRU leads to new insights and can for example guide discussions about the care RNs perform. It supports the use of theories or concepts, but in a less specific manner (Estabrooks et al., 2011). Conceptual RU is perhaps the most complicated part of RU as it requires both time and a change of attitude, which can be considered slow processes and may therefore perhaps not be applicable in today's health care system (Strandberg et al., 2014).

Persuasive RU, finally, refers to how RNs can argue for research findings to legitimate, justify, or mobilize support for actions or decisions (Estabrooks, 1999). This part of RU, used in a concrete way, could encourage RNs to approach different clinical problems if they find that research gives them arguments to use in a discussion, for example about changes in existing routines (Estabrooks, 1999).

Leadership and first line nurse managers

One factor, which is well described in the literature, is nursing leadership and its impact on patient safety and RU among nurses (see, for example,

Andreasson, Eriksson, & Dellve, 2016; Fleiszer, Semenic, Ritchie, Richer, & Denis, 2016; Merrill, 2015). Less is known about how FLNMs look upon their responsibility and possibilities to support RNs in working evidence-based. First line nurse managers are the closest leader to the clinically working RN and are in charge of the quality of nursing on their ward (Sjølie, Hartviksen, & Bondas, 2020). Supportive leadership from the FLNM is an important factor when organizing nursing in an evidence-based way in the interests of the patient's safety, as shown for example by Merrill (2015). The hypothesis in Merrill's study was that a transformational leadership style could give the leaders strength and possibilities to support the RNs in working in a patient-safe way (Merrill, 2015). A transformational leadership style can briefly be described as the style of a leader who is proactive, makes people motivated, and sees the individual (Merrill, 2015). First line nurse managers (FLNMs) have varying academic backgrounds and forms of leadership training (Ericsson & Augustinsson, 2015). Both leadership training and having an academic background can be considered useful for ability to organize nursing in an evidence-based way.

Interventions have been made, though to a limited extent, where researchers have tried to improve the leadership in terms of using research in clinical care. Tistad et al. (2016) pointed out the importance of the FLNMs' approach in facilitating implementation of research. In their study, the FLNMs' plan for implementation did not include reflections on their own importance for implementation of the guidelines (Tistad et al., 2016). The workload of the FLNMs is often heavy with meetings, scheduling, and other practical issues that need to be managed (Ericsson & Augustinsson, 2015). There has been a transformation of the role of FLNMs, from being the most skilled RN on the ward to becoming an FLNM with pure management tasks such as scheduling and recruiting new staff (Ericsson & Augustinsson, 2015). The transformation has been pointed out as difficult (see, e.g., Ericsson & Augustinsson, 2015). This, together with the responsibility of creating a working climate that motivates and supports EBN, and keeps it sustainable, has to be considered a difficult task for FLNMs (Fleiszer et al., 2016).

Nursing theory

When describing the historical development of nursing theories, there is a need to mention the work of Florence Nightingale, as probably one of the first nursing theorists. Nightingale started to frame the profession and shape the fundamentals of nursing (McDonald, 2001). She also had the capacity

to understand the importance of keeping statistics when noticing improvement related to developed ways of treating the patients, so in some way she also became a researcher in nursing (Mackey & Bassendowski, 2017; McDonald, 2001). Though, not using the term "evidence-based practice" or "evidence-based nursing," Florence Nightingale was the first nurse to understand the importance of comparing and evaluating different ways of treating, and caring for, patients (Mackey & Bassendowski, 2017). Nursing science and nursing theory can be perceived as a profession-specific science and theory. The concepts can be used to develop the work RNs do, for example in a clinical context (Hoeck & Delmar, 2018; Hörberg, 2015). After Florence Nightingale, other RNs has dedicated their work to improving nursing through different nursing theories (Alligood, 2014), as for example Eriksson (2002) and Roy (2018) among others.

Nursing theories can be tools for providing EBN (Fawcett & Garity, 2009; Hoeck & Delmar, 2018). The existing nursing theories have in common that they have the patient in focus and that they are built on research. Alligood and Marriner-Tomey (2010) made an attempt to sort and organize nursing theories, by reflecting on different levels of abstraction of the theories (Alligood, 2010; Alligood & Marriner-Tomey, 2010). The highest level, according to these authors, is nursing philosophy. The term nursing philosophy can sometimes be used interchangeably with nursing theory. Alligood and Marriner-Tomey (2010) describe the following levels of nursing theory: nursing philosopies, nursing conceptual models, nursing theories, and middle range nursing theories. They argue that critical thinking and reflection will facilitate learning about the theoretical foundation, for RNs (Alligood & Marriner-Tomey, 2010). In this thesis, the term nursing theory will be used when any of the above levels of nursing theories is referred to.

Patient's perspective

The patient's perspective is regulated by the Socialdepartementet (2014:821) in Sweden. The law applies to patient's rights concerning for example, information, participation, accessibility and consent. The part of EBN that could refer to the patient's perspective, is not so often described, but is sometimes articulated as "the voice of the patient" (Abbasinia, Ahmadi, & Kazemnejad, 2020; Delmar, 2013). The patient does not always have the possibility to express or declare what her or his wishes are (Abbasinia et al., 2020; Delmar, 2013) and this raises the need for RNs to

be the patient's advocate and to have the patient's perspective in focus (Abbasinia et al., 2020).

Patients of today often inform themselves via different channels of varying standards when taking decisions (Wahlstedt & Ekman, 2016). The wide range of sources of information can be problematic, but the RN needs to respect and support the patient's endeavour to be informed. The well-informed patient, who interacts with the nurse and participates in her or his care, will be more capable of making her or his own decisions concerning care (Ahola Kohut et al., 2018).

Patient participation in nursing can have a vague meaning, but it concerns both the relation, and meaning and trust for the patient (Nilsson, From, & Lindwall, 2019). For the RN, a caring relationship to the patient, the communication skills, continuity, and organizational conditions are meaningful when promoting patient participation (Nilsson et al., 2019).

When the concept of patient participation is applied in research, the expectation is that the patient is fully involved in the research, both when formulating the research question, and when designing the research and presenting the findings (Crocker, Boylan, Bostock, & Locock, 2017). This will ensure that the research conducted follow the interest of the patient and will be assessed in the same way (Crocker et al., 2017).

Clinical competence

Clinical competence can be seen as the part of EBN which involves the process that starts when RNs enter the nursing profession. (Lejonqvist, Eriksson, & Meretoja, 2012). The development of clinical competence rests on individual "knowing, performing, maturing and encountering but also improving" as an RN, according to Lejonqvist et al. (2012). It is not related directly to a timeline; at the same time; the need of experience is connected to the possibility to observe and act in clinical situations. Clinical competence is sometimes defined as proven experience or clinical expertise (Robertson-Preidler, Biller-Andorno, & Johnson, 2017).

The context surrounding an RN must be considered having an impact on the forming of her or his clinical competence (Caricati et al., 2014). In a literature review carried out by Sandström, Borglin, Nilsson, & Willman (2011) about how to promote implementation of evidence in practice, the characteristics of the organization were shown to be important, as were leadership and the culture at the ward (Sandström et al., 2011). Working climate and caring culture are factors that affect the RN's possibility to work in an evidence-based way. Rytterstrom, Cedersund, & Arman (2009)

described how the RN, who were employed as part of a job pool, in the absence of a permanent work place, quickly developed "a feeling for" the working climate and caring culture at the current ward and adapted to the prevailing mood. If the ward presented a welcoming and "homelike" feeling, the RNs felt relaxed and were able to work according to their own values, whereas if the ward presented a working climate and caring culture characterized by implicit and "unspoken" rules, the RNs were more likely to "just do their job" and nothing more (Rytterstrom et al., 2009). Bender (2016) discusses the same when listing four fundamental findings; "facilitating effective on-going communication; strengthening intra and inter-professional relationships; building and sustaining teams; and supporting staff engagement". These factors can be understood as influencing the work climate and caring culture, as well as including a strategy for leadership; all factors are needed for development of clinical competence (Bender, 2016; Rytterstrom, Cedersund, & Arman, 2009).

Rationale

Registered nurses (RNs) are expected to work ethically, independently and in line with best available knowledge. Evidence-based nursing (EBN) comprises research, theory of nursing, the patient's perspective together with clinical competence. The patients most likely expect the nursing to be evidence-based and of high quality. This, together with the legal requirements that clinical work should be performed in an evidence-based way, calls for an active approach for EBN. Registered nurses need to have an active, reflective and critical approach to research; they need to be able to utilize research. Leadership for RNs and the impact on how the leader's role supports EBN can be further investigated to be better understood.

Altogether, there is a need for a deeper understanding of some of the different perspectives that either support, or have a prohibitive effect on EBN in clinical context. This thesis aims to contribute to knowledge by clarifying, and reflecting on, some different perspectives in relation to EBN.

Aim

The overall aim for this thesis was to study, explore and describe the use of EBN in the clinical context with respect to the four cornerstones of EBN: research (studies I, III, IV), nursing theory (study II), the patient's perspective (studies II, IV) and clinical competence (studies I, II, III). The specific aims of the different studies, together with the design of the studies, are presented in table 1.

Method

Research approach

The studies in this thesis all relate to clinical nursing work. This can be understood referring mainly to the work RNs do in their daily work in a clinical context, interacting with the patient. The different aims of the studies in this thesis and the type of knowledge required called for different methodological approaches (Table 1). From the perspective of philosophy of science, both humanistic science approach as well as positivistic science approach contribute to meet the different aims. The methods used, when related to humanistic science, are based on linguistic approaches or sometimes observing, and takes an interest in understanding people's lived world (Dahlberg et al., 2008). Within the positivistic research approach, it is understood that the scientist has an objective and distanced relation to the subject of interest (Coleman, 2019). The subject studied will be quantified and measured at a group level, for example as part of a certain diagnostic group of patients or as part of a group of nurses with a similar profile (Coleman, 2019). Both ways of approaching the phenomenon of interest in this thesis have been found useful. The humanistic scientific research approach has guided the research process in study II and III whereas the phenomenon in interest in study I was more favourable to study using a quantitative approach.

Study IV, the integrated literature review, called for a combined research approach but a humanistic scientific research approach guided the interpretive part of the study.

Table 1. An overview of the studies in the thesis.

Study	Aim	Method of data collection	Material and participants	Approach and method of data analysis
I	To describe and study the association between RNs' self-rated RU and their work climate	A cross-sectional survey, using CCQ together with three additional questions measuring IRU, CRU and PRU	RNs (n=599) working in clinical setting in a university hospital	The analysis was done using variable- and pattern-oriented approaches. Descriptive and comparative statistics were used to analyze and present the data
II	To describe how RNs' conceive their work on a ward where a nursing philosophy had been systematically implemented	Individual, thematized interviews	RNs (n=7), working on a ward where a nursing philosophy had been implemented	A phenomenographic method, with an epistemological base in the perspective of the life-world
III	To explore FLNMs' experiences of opportunities and obstacles for supporting EBN	Focus group interviews	Four focus groups with 3-6 participants, (15 in total) working as FLNMs in a clinical ward	The method used was phenomenography
IV	To detect and analyze how the patient's perspective have been met in research aiming to develop EBN	Database searches in PubMed, CINAHL, Embase and PsycINFO	A first identification of 1833 studies resulted in a final inclusion of 47 studies after title-, abstract-, and full text reviews	Extraction and categorization of data following the integrative review methodology

Study I

In study I the aim to describe and study the association between RNs' self-rated RU and their work climate guided the design and approach to the research question. An approach suitable for quantitative measuring and evaluating was chosen. The assumption was that the working climate in a university hospital, could underpin the RU.

Participants

Eligible participants in study I were RNs working in a clinical context in a university hospital. Altogether, 1,563 RNs with an active email address at work were approached, and 599 answered the questionnaire. All email addresses of the clinically working RNs were obtained from the Human Resources Department at the university hospital.

Study context

The study was performed at a university hospital with approximately 550 beds, in a middle-sized city in Sweden. The clinical context can be described as mainly inpatient, specialized 24-hours stay care.

Data collection

Data was collected through a survey distributed by email. The option to resend the questionnaire to a private email address was given if the RNs preferred to answer the questions outside of working hours. Two reminders of the questionnaire, were sent to all RNs via email after 2 weeks and again after 4 weeks. A paper questionnaire was distributed 2 weeks later; this was sent to the FLNMs at the different wards, with the request to distribute it to the RNs. Since the incoming answers were anonymous, the reminder went to all eligible participants with an addition to ignore the email if one had already responded. For the reminder in paper form, the internal mailing system at the hospital was used.

Instruments

The Creative Climate Questionnaire (CCQ) constructed by Ekvall (1996) was used to measure the work climate in study I. The purpose of the CCQ is to illustrate the climate in an organization as either innovative or stagnated, through ten different dimensions considered to either underpin or undermine a creative work climate at the work place in focus. The assumption that a creative climate supports a work climate that embraces and affirms EBN led to the decision to use the CCQ-survey. The

instrument's ten dimensions describe the areas of challenge, freedom, idea support, trust/openness, dynamism/liveness, playfulness/humor, debate, conflicts, risk taking, and idea time, and for each dimension, five different statements are given. This gives a total of 50 statements, and the participant is required to answer these on a 4-point Likert-type scale, from 0 = "not at all," to 3 = "to a high degree." The mean value for each dimension is calculated and a high value indicates a creative climate at the workplace except for the conflict dimension, where a high value indicates the opposite. The Creative Climate Questionnaire (CCQ) has been validated and tested for reliability in different context, including health care organizations (Carlfjord, Andersson, Nilsen, Bendtsen, & Lindberg, 2010; Ekvall, 1996; Söderlund, Norberg, & Hansebo, 2014).

Three single items to measure RU were added to the CCQ. The items were used in the LANE project (Forsman, Rudman, Gustavsson, Ehrenberg, & Wallin, 2012). The questions concerning RU were originally developed by Estabrooks (1999), and they consisted of three ways of using and understanding RU; instrumental, conceptual, and persuasive RU. In each item an example was given of a situation in which the different RUs could be used. The respondents answered how often they had used RU during their work shifts in the last 4 weeks. This was done on a 5-point scale where 1 = "never," 2 = "occasionally on a work shift," 3 = "during approximately half of the work shifts," 4 = "on more than half of the work shifts," and 5 = "during almost all work shifts". It was also possible to answer "I don't know.

Data analysis

In study I, the presentation of data was made with variables and proportions, means and standard deviation, or medians and interquartile ranges. Group differences were analyzed with the Chi-square test for nominal data. Student's t-test or one-way analysis of variance (ANOVA) was used for analyzing continuous data. The Mann-Whitney U-test or Kruskal-Wallis test was used for ordinal data and continuous data that were non-normally distributed. The level of significance was set to 0.05 and multiple significance correction were conducted with the Bonferroni method. The analyzes were performed using IBM SPSS Statistics version 24 (IBM Corp., Armonk, NY, USA).

To study different RU profiles in patterns, a cluster analysis was performed. Each cluster consisted of a group of RNs with a similar individual response profile. Ward's hierarchical agglomerative method was

used for calculations of clusters including only respondents with responses on all the three RU variables. The total sample for clustering was 453 RNs answer, after single linkage was used to identify outliers (n=2). Practical considerations concerning meaningfulness and interpretability of the cluster solutions also guided the decision on the number of clusters. An agglomeration schedule and a scree plot, showing the change in the distance coefficient, guided the decision on how many clusters to use together with practical considerations concerning meaningfulness and interpretability (Mooi & Sarstedt, 2011). The stability of the cluster solution was assessed with K-means analysis using cluster centroids from the Ward's method as seed points. After that, cases in the dataset were randomly ordered. The cluster solution was repeated three times on the rearranged data (Mooi et al., 2011).

Study II

The next study took an interest in if a nursing theory, or as in the studied ward, a nursing philosophy, could have a notable impact on the care given. To understand how the care was performed, and how the RNs perceived and expressed their conceptions of the eventual difference from more regular organized care, the decision was taken to use interviews to collect data.

Participants

Participants were RNs working dayshift at a ward where a specific nursing philosophy had been systematically implemented. After an initial contact with the FLNM at the specific ward, contact with the RNs was established and an invitation to participate was sent out. All seven RNs working dayshift were approached by the author, and agreed to participate. The participants were female and had worked at this particular ward for between 6 months and 16 years.

Study context

Study II was carried out in an inpatient ward with 24-hour care in a larger city in Sweden. The ward of interest had systematically implemented and worked with a chosen nursing philosophy for the past several years with the intention to improve the nursing care.

Data collection

Study II was designed as a qualitative study, and included face to face interviews. The interviews were conducted over a period of 2 weeks. Each interview lasted between 45 and 75 minutes. All interviews were carried out during work hour at the workplace, in a remotely located conference room.

Interview

In the interviews, questions formulated in a thematized interview guide were used, focusing on how the RNs at the specific ward conceived working with an implemented nursing philosophy in their clinical daily work. The different themes covered in the interview guide were a) conscious choice to work on the ward, b) perception of why and how the ward made its choice of nursing philosophy and what the philosophy entailed, and c) reflections and views on how the day-to-day work was conceived on the basis of this nursing philosophy. The questions were open-ended and follow-up questions as for example: "How was that?" or "Could you describe more?" were formulated during the interview.

Data analysis

Phenomenography was used to analyze the data in study II. The core element in phenomenography is formulated "you can only understand the world as you know it" (Marton & Booth, 2009).

Each interview was audiotaped and transcribed verbatim. The first analysis phase began with reading of the interviews to obtain an overall picture. Then, specific statements were identified that responded to the question "Is nursing philosophy useful in practical work?" Preliminary categories were then formulated. In the next phase, all preliminary categories were compared and accordingly five categories were formulated, with an overarching statement. As a final step, the outcome space was created from the categories and the overarching statement.

Study III

In study III, the understanding of how the FLNMs experienced their own importance as FLNMs related to EBN, was in focus. The expectation that the role had both obstacles and opportunities for supporting EBN led to the decision to design and perform focus groups with FLNMs to create an opportunity to discuss these together.

Participants

The first invitation was sent out via email to all FLNMs at a university hospital, without any positive response. The next step was an invitation by telephone. The offering of a lunch sandwich and coffee, together with the possibility to participate during the lunch hour, was more successful and a total of 15 participants were recruited. They were divided into four groups, by own choice based on selecting a suitable time slot for themselves.

Study context

Study III was performed in the same setting as study I.

Data collection

Study III was designed with a qualitative approach and the data was collected in focus group discussions. Three of the focus group discussions were conducted by two researchers; one researcher as interviewer and the other as observer. The last focus group was conducted without an observer present, due to the experience that the focus group interview form was functioning. All interviews took place during lunch hour at the actual hospital. The setting was a conference room away from the FLNMs regular wards.

Before the first focus group was performed, a pilot interview with FLNMs (focus group) was carried out with a thematized interview guide. The richness and depth of the data was assessed to be unsatisfactory; this led to a discussion in the research group, about how to create a positive and permissive atmosphere in the focus groups. A decision to create the base for the discussions in the focus groups, in a scientific article, was taken. The article *"The responsibility of someone else': a focus group study of collaboration between a university and a hospital regarding the integration of caring science in practice"* by Lindberg et al. was selected (Lindberg, Persson, & Bondas, 2012). The result from that specific study was formulated in three sentences and the discussion started with the question: "Do you recognise this?" Throughout the whole session, follow-up questions were asked where needed. The data from the pilot interview was not included in the final data set.

Interview

An interview guide was formulated based on the scientific article of Lindberg et al., (2012). Themes were developed and formulated: (a) integration — someone else's responsibility; (b) the hospital — a culture of

production; and (c) the hospital and the university—different realities. Based on these themes, we asked the participants: "Do you recognize this?" This was followed up with supplementary questions, for example: "Could you explain"? and "Could you describe an episode"? when needed.

Data analysis

As in study II, phenomenography was used to analyze the data. The core assumption, already presented under study II, that "you can only understand the world as you know it" (Marton & Booth, 2009) guided the analyzes in study III. The focus group interviews were audiotaped and transcribed verbatim. The first step in the analyzes was to read through the data repeatedly to gain an overall picture in the familiarization phase. Preliminary conceptions were identified and then discussed in the research group to reach agreement on the final formulation of conceptions. This relates to the articulation and condensation phase described by Han, Barnard & Chapman (2009).

Four categories of description were formulated from the conceptions and were arranged hierarchically, this was done during the phase of grouping and comparison. The overarching category gave the highest level in the hierarchy and formulated the outcome space representing the relationships between the conceptions (labelling, contrasting) (Han et al., 2017). The research group worked both individually and together when performing the analysis, reading and rereading of the material. Confirmation through mutual discussion that the data was understood the same way on the second and third reading was done by conducting a dialogical check (Collier-Reed, Ingerman, & Berglund, 2009).

Study IV

In the last study of this research project, the patient's perspective and her or his interest in nursing interventions was in focus. When an intervention is designed with the purpose to develop nursing, it is important to consider the perspective of the patient, as one of the four cornerstones of EBN. How this can be done and whether the patient's perspective is presented in published studies, paved the way for the decision to perform an integrative literature review.

Study design

An integrative literature review was designed, as described by Whittemore and Knafl (2005). A meta-theoretical research approach was integrated to

support the understanding of the epistemological foundation of nursing knowledge (Hoeck & Delmar, 2018) and in this study, more precise, how the perspective of the patient was approached in nursing research. The five stages of an integrative literature review were followed in study IV: the problem identification stage, the literature search stage, the data evaluation stage, the data analysis stage, and presentation (Whittemore & Knafl, 2005. The study protocol was published in PROSPERO (Eriksson, Karlberg Traav, Dahlberg, & Cronqvist, 2020).

Inclusion - exclusion

Studies designed with an intervention aiming to improve nursing and published in English from January 2008 until March 2019, were included. Exclusion criteria were interventions performed by multidisciplinary teams or other health care professionals i.e. not RNs, participants being under the age of 18 years, pilot studies, quality assurance projects, study protocols, conference abstracts, implementation of guidelines and editorial comments.

Search and screening process

The literature search was done in the databases PubMed, Cinahl, Embase and PsycINFO, and all searches were conducted together with an experienced librarian. The following search terms were used: "Patient", "Patient´s", "Perspective" "View", "Experience" "Evidence-based Nursing", "Evidence-based care", "Research-based nursing", "Research-based Care", "Intervention", "Evaluation". The online software Covidence was used for storing and screening of the papers. A total of 1,908 papers were imported into Covidence, and after removing duplicates, 1,833 papers were screened. All screening was done independently by two authors, and the eventual conflicts were solved by discussion with a third author. The screening process is presented in a PRISMA flowchart (Figure 1).

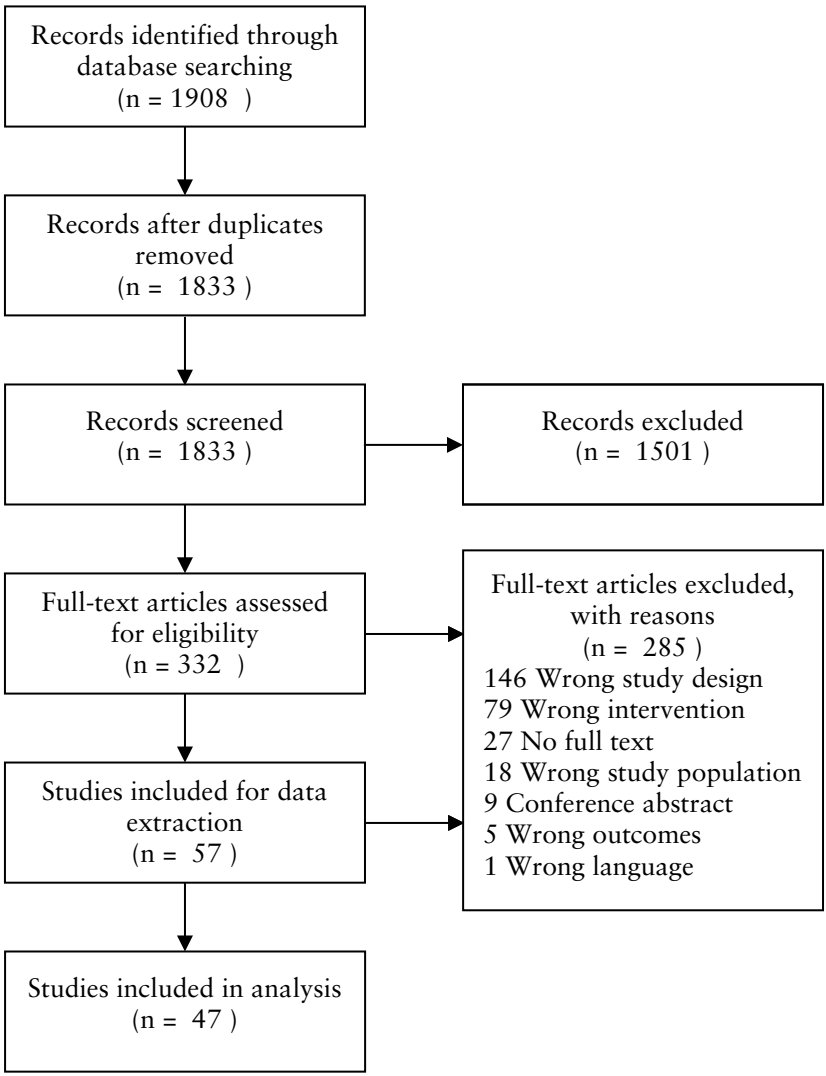

Figure 1. Flowchart showing data searching, screening and analysing of articles.

Data analysis

The analysis process in this study followed the steps described by Whittermore and Knafl (2005): data reduction, data display, data comparison, conclusion drawing, and verification.

The initial analyzes began with the extraction of data. Two different tables were created, one giving an overview of the chosen articles with main authors, year of publication, journal, country, design, intervention and measurements, the other indicating how the perspective of the patient was present in the Background/Rationale, Discussion, Conclusion and Clinical implications sections of the included articles. To be able to understand the presence of the perspective of the patient, questions addressing the different headings were formulated, and quotations answering the questions were extracted from the papers (Table 2).

Table 2. Questions to find the patient perspective in the different sections of the included articles.

Background and Rationale:	**Discussion:**	**Conclusion:**	**Clinical implications:**
How was the patient's perspective addressed; was the problem expressed from the patient's perspective?	How was the patient's perspective discussed? Were the results discussed from the patient's perspective, i.e., were the eventual benefits for the patient discussed?	How was the patient's perspective addressed? Was the conclusion explicit regarding patient benefits and the eventual benefits?	How was the patient's perspective addressed? Were clinical implications presented as "future actions" in relation to the patient's perspective?

Ethical considerations

Some decisions of ethical character have been made during the development of this research project and will be addressed in this section.

Throughout this project, the ethical considerations of the declaration of Helsinki (2011) have been followed. This means, for example, that the participants taking part in study II and III were informed about the research both orally and in writing. They were assured of voluntariness and the right to withdraw without giving any reason, i.e. informed consent was obtained. The participants in study I were informed in written text. All participants were further assured that all information would be treated confidentially and that their identity would be kept anonymous in the upcoming reports. The data collection in study II was originally conducted as a work at an advanced level at Ersta Sköndal Bräcke University and was discussed with the research ethical committee at the department of Health care Sciences. As it was found not covered by the ethical review law's requirement for approval, no application was submitted to the regional ethics review board. Also in study II, the data was collected in a specific ward, which at the time for the study, had a specific nursing philosophy implemented to guide the clinical work for the RNs. Neither the specific ward nor the chosen philosophy have been described in the paper; this might enable identifying the ward and, hence, the possibility to link statements to specific RNs might arise.

The ward mentioned under "Acknowledgement" in study II has provided the opportunity to accomplish that study and is not the ward in focus in the study.

Further, for study III, focus groups guided the data collection, this decision was based on the consideration that the participants might feel offended or even provoked if the research question could be perceived as questioning the way they led the clinical work at their ward. Although, this apprehension was not experienced by the researcher. Contrary to this concern, the participants expressed that they appreciated the opportunity to share their experience and conceptions about the phenomenon of interest.

For two of the studies (I and III), a research-ethical permission was applied for from the Regional Ethical Review Board in Uppsala. We were informed that no additional approval was needed to carry out neither of the studies (Dnr. 2014/266; Dnr. 2015/049).

Results

The overall aim for this thesis was to study, explore and describe the use of EBN in clinical context with respect to the four cornerstones of EBN: research; nursing theory; patient's perspective and clinical competence. In this section, the results from the four studies will be presented. The section will end with a summary in which the studies' results will be synthesized and merged to meet the aim of this thesis.

Study I

In study I the relation between the work climate and self-rated RU was studied. When analyzing the background variables and RU, women compared to men, reported higher CRU (p=0.044) and RNs with higher academic degree reported increased IRU (no academic degree vs. Master's degree, p=0.027) (overall effect (Kruskal-Wallis) (p=0.024). For PRU, no significant differences were seen. Concerning the work climate, a relation between age and playfulness/humor was detected, together with a relation between age and the dimension of conflicts and idea time.

The cluster analyzes resulted in five different groups with different RU profiles, where the largest group reported low use of all three types of RU (n=156). The other four groups, where all three types of RU were reported high in at least one of the different types of RU, were merged into one single group (n=297) and compared with the group that had reported low use of RU (n=156) (Figure 2). There was an association between reported low use of RU and low values for the dimension of dynamism/liveliness (p=0.021).

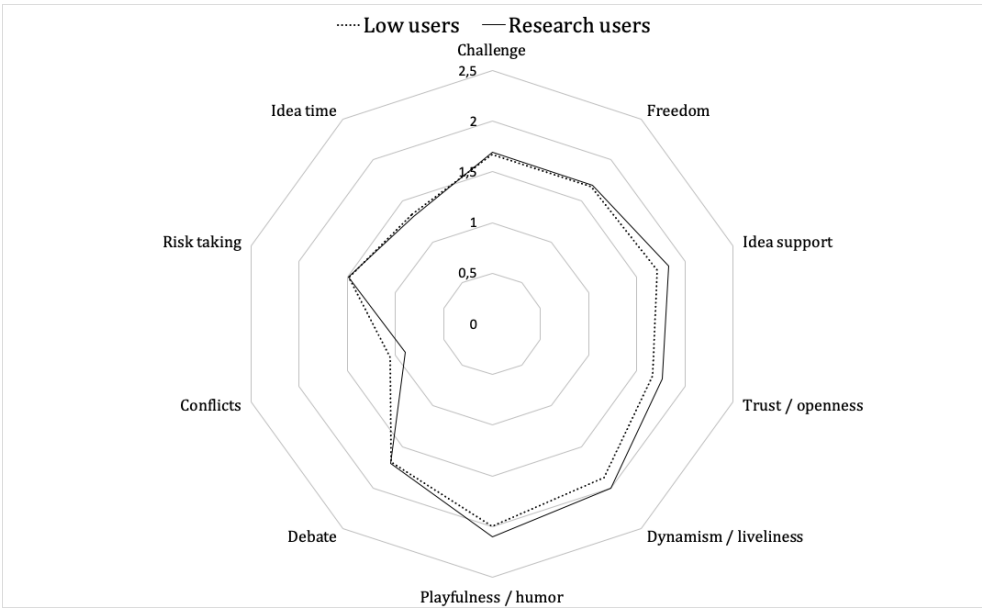

Figure 2. Diagram showing mean values for the ten work climate dimensions reported by low users and research users.

Study II

In study II, another cornerstone concerning the perspectives in this research project was chosen; study II had focus on the use of a nursing philosophy in clinical context and how it could affect the care given by the RNs on a ward. To describe the phenomenon in interest a qualitative approach was chosen and therefore another type of result emerged. The result was based on the conceptions and reflections the participants shared on how they experienced their work on this particular ward.

The included RNs experienced feelings of being secure and being able to reflect which had an impact on both the professional growth and the work climate. The participants' conceptions were interpreted as that they experienced "Increased perspicuity of the significance of reflection when working with a nursing philosophy in daily work"; and this formulated the outcome space (Figure 3).

The RNs on this ward described a process "From implicit to explicit – where openness and freedom to speak are essential", and stated that certain conditions were needed for this process. The process was central to the

participants' to be able to feel secure and the possibility of reflection provided the most important contribution to this feeling.

The participants delineate themselves as reflective individuals and this gave a base for processing complex and difficult situations through recurring sessions of reflection.

The RNs especially highlighted the importance of their leader on this ward, which was captured in the category "*Making it happen - the manager's significance for implementation"*. The leader on this ward had for several years led and created conditions for the RNs to be guided in their work by the chosen nursing philosophy; something that required conditions in terms of both time and money. The RNs emphasized in several of the interviews that without their leader, the nursing philosophy would not have been implemented at the ward as it was by the time for this study.

The participants experienced how the chosen philosophy could be a platform for discussion and a direction of shared values among the group of RNs working together. The process started within the individual RNs own professional self and embraced the working group as a whole when discussing and developing nursing given in the ward. This was captured in the category phrased "*Integrating the philosophy within me – creating a collective platform"*.

In study II the shared culture in nursing was central to the participants. They phrased that they felt proud and that they shared a feeling of a "welcoming atmosphere". They felt a presence of a caring atmosphere and this was also a reason for RNs to choose to work at this particular ward. The chosen philosophy influenced on the work climate in a positive way and was described as *"Welcome to us" – a caring atmosphere"*.

The participants in study II lifted that their experience was that their patients had expressed they were being seen and that this was a sign of good quality of care. It gave the patients a feeling of being confirmed and was formulated: "*The patient's sense of being confirmed – establishing quality of care"*.

Contrasted to the view on how the nursing was experienced in this particular ward, was the feeling of being something of "an outsider" as described in the category named: *"Us and them" – being inside or outside"*. The participants talked of being "an outsider" when meeting other health care professionals. They also gave examples from other workplaces they had been working at, where colleagues looked upon nursing care that rests on a nursing theory as complicated and difficult.

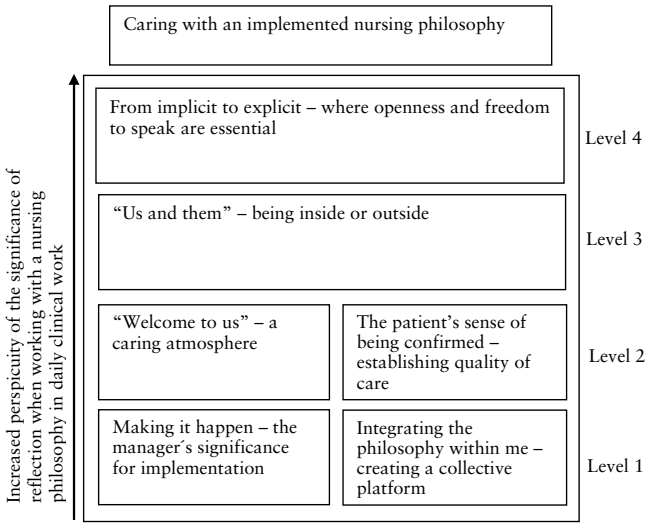

Figure 3. The outcome space: nurses experiences working with an implemented nursing philosophy.

Study III

Study III had the focus on how the FLNMs perceive their role as being a support to RNs when organizing the work evidence-based. The approach for this study was also qualitative and the results rests on discussions performed in focus groups and on the conceptions the FLNMs shared in those focus groups. The overarching statement in study III described a FLNM who can take the lead related to EBN when he or she has taken an active approach towards EBN, and when the internal relation between reflection and active support is present. This process was framed as: "The individual path – how to make vision and reality become working entity around evidence-based nursing" and was presented as the outcome space (Figure 4).

The process for the participating FLNMs in this study, started from a basic level described as "Uncertainties about evidence-based nursing and nursing research" together with a feeling of being overwhelmed with every day-duties, "Manage the everyday work vs. evidence-based nursing". On this basic level, the divergence shaped an obstacle during the daily routines when trying to work supportive related to EBN. The FLNMs' could not see themselves being the person responsible for creating space for the RNs to work evidence-based, the "daily work" was the first priority. They

expressed that "someone else" or even "everyone" should be responsible for the nursing care to be evidence-based.

The FLNMs also described their own uncertainty according to EBN, research and nursing theory. The discussion concerning the concept of EBN in specific never gave a clear picture of whether they relied on any definition of EBN, or what they meant when using the term "evidence-based". The phrase "evidence-based" was frequently used synonymous with "research", and it was unclear if they considered that research in different areas could improve nursing. They were clear about that medical research was the predominant and encouraged research area at their workplace and they stated that the hospital had a strong history of practising EBM.

Another central issue for the FLNMs was the question of time. Time was in many ways considered an obstacle and stood in the way of being a supportive leader concerning EBN. In all focus groups the statement "If I only had more time" was made. The FLNMs were torn between their duty to perform their daily tasks and their awareness that the question concerning research and the time needed to address it, was often neglected.

The result also showed how the process of being active towards EBN and accepting a more supportive role as a FLNM, started with the insight of their own importance. Some of the participants talked about "just doing" without making a big fuss about how they discussed research in nursing at their ward. All participating FLNMs saw the benefits of having nursing students at the ward, who could contribute to, and deepen discussion, about research and EBN.

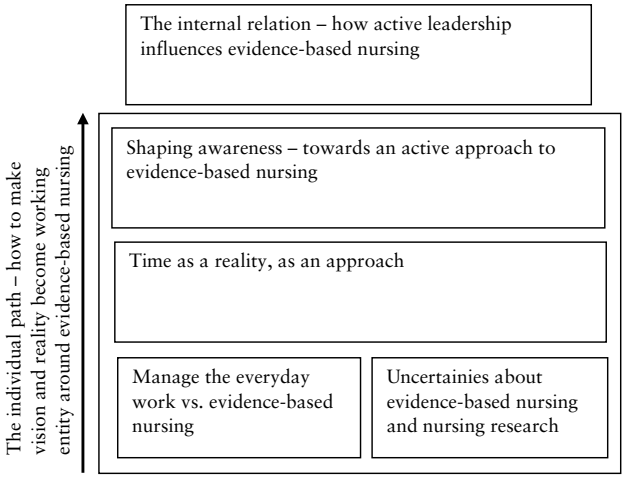

Figure 4. The outcome space.

Study IV

In the last study of this research project, the focus was on the patient's perspective and how it was taken into account within interventions aimed to improve nursing. The research field concerning the patient's perspective, or, as it is sometimes referred to, "the patient's voice", is most often understood implicitly. To accomplish an overview of the existing research field related to the patient's perspective, the design was an integrative literature review.

The review consisted of 47 articles, and the results of the review comprised two parts. The first part was descriptive, outlining where the studies had been conducted, and how they had been evaluated; the second part was interpretive. The first part of the review revealed that the main part of the conducted research was performed in the Western world, predominantly in the USA (n=23). The non-Western world had its representation of Taiwan (n=1), Turkey (n=2) together with China (n=5). Most of the articles used a quantitative approach (n=38), which is not surprising since we had searched for studies including interventions. Some of the chosen articles (n=6) had a qualitative approach. The use of both approaches was not common (n=3). Most of the articles included reported research conducted in a hospital setting (n=23). The second most common setting, was outpatient clinics (n=13) (Table 3). All participants together in the articles were 7,509.

Table 3. Properties of the included articles.

Study design	
Quantitative	38
Qualitative	6
Quantitative and qualitative	3
Country	
USA	23
China	5
Australia	4
Canada	4
England	4
Turkey	2
Taiwan	1
Sweden	1
Scotland	1
Netherlands	1
Ireland	1
Setting	
Hospital	23
Outpatient	13
Community	3
Other	8
Patient perspective described in the different sections of the paper	**Yes/No**
Background/Rationale/Phenomenon	27/20
Discussion	41/6
Conclusion	29/18
Clinical implications	10/37

Under the heading Background/Rationale in the included articles, the presentation of the patient often was on a group level. The patient's perspective was most presented in terms of a disease or a condition. In the Discussion sections the perspective was explicit, but it took different shapes and nuances. The Conclusion sections sometimes presented an

improvement for the organization or for the RNs rather than presenting the perspective of the patient. Clinical implications as heading, was often missing; and, when present, the focus was split between the organization and nursing and left the perspective of the patient unspoken.

The second part of the results in this review, the interpretation, completed the picture with some aspects that did or could guide nursing interventions to incorporate the patient's perspective. Articles that had a quotation under all headings (n=5) and articles with a quotation under the three first headings (=13) were selected for the interpretative part. When analyzing the chosen quotations under the different headings in the selected articles (n=18) the following five aspects emerged; respect, relation, independence, relief and wellbeing as a patient. These aspects all had a close relation to nursing.

The first aspect, respect, is central for to the experience of being seen and listened to. There seemed to be a mutual feeling of respect between the RN and the patient when the underlying assumption that the patient was a competent person worth listening to was detected. This paved the way for a relation built on equality and a possibility to work collaboratively. The RN did not take a stand as "informer" or "teacher" instead, the relation worked, as stated, on a more equal level.

The aspect of independence highlighted the importance for the patient of being able to cope with one's situation but also of being able to handle the situation as patient, even though one is in need of care in some way. This was related to relief – relief, for example, from pain. The aspect of relief also supported the perspective of the patient in a positive way.

The last aspect was formulated as wellbeing as a patient, and all the other aspects are prerequisites to be able to experience wellbeing in the situation as a patient from the patient's perspective.

In all the quotations interpreted (18) more than one of the aspects were detected and underlined the perspective of the patient.

Summary

The results of the included studies show reflections on different perspectives related to the four cornerstones of EBN. This research project has shed light on factors that seem to support the use of EBN in the clinical context, as well as complicating factors.

In both studies II and III the impact of leadership for clinically working RNs came through. In study II, leadership was seen as a prerequisite for the

implementation of a nursing theory, one of the four cornerstones of EBN. The leader in that clinical context did select a nursing theory and organized the work in a way that supported reflection, which gave the RNs the possibility to discuss the theory and how it could develop the nursing. In study III the participating FLNMs expressed a more ambivalent relation to EBN. They did not see their role as the obvious facilitator for encouraging the RNs to work towards EBN, and their own view on EBN was also vague.

Another issue expressed in study III, was the FLNMs relation to time; they always experienced lack of time. In study II we found that reflection was a prerequisite for the RNs to work with the implemented nursing philosophy. One conclusion drawn was that dedicated time is a necessity to be able to reflect on EBN and its use in the clinical context.

The importance of the academic training became obvious in the results, particularly in study I, but in partially also in study II. The RNs who had a higher academic degree reported higher use of research, and the RNs that used a nursing theory in study II had the possibility to use research in line with the implemented theory on the ward. For example, they used common concepts related to the nursing theory when reflecting on clinical situations.

The patient's perspective as a cornerstone of EBN was studied mainly in study IV. The result showed how the patient's perspective could be understood, and presented in research, which could help clinically working RNs to look for the presence of patient's perspective when making an effort to implement and use research.

The perspective of the patient is important as for example when using PRU, a perspective of RU that RNs found difficult as seen in study I. The patient's perspective was also seen in study II; the participants had an awareness of the impact the nursing philosophy had on the patient's experience of the care received, as being of high quality.

The perspectives reflected in this research project show a complex picture of EBN. The need to try to agree on the different parts of EBN, and its usefulness in the clinical context, requires further research; however, the result from this project can move the current knowledge forward. If EBN is understood as comprising research, nursing theories, the perspective of the patient, and clinical competence, the clinical working RN needs to be able to be supported by the leader, get dedicated time for reflection according to research and nursing theories. Further, clinical competence needs to be understood as an important part of EBN, altogether to be able to in companionship support the patient's perspective.

Reflections on the results

The aim of this thesis was to study, explore and describe the use of EBN in clinical context with respect to the four cornerstones of EBN: research, nursing theory, the patient's perspective and clinical competence (Scott & McSherry, 2009, Ingersoll, 2000). There are several factors and processes that interact and support the RNs in working evidence-based, or sometimes prevent them for doing so, in clinical work, e.g. leadership, work climate, academic training, and the relation to time, as discussed and reflected on in this section. This section also includes a methodological discussion.

Research

Study I showed that the RNs had a complex and sometimes weak relation to research in contrast to study II, were the nurses used a nursing theory to improve the nursing at their ward. The different approaches in the two studies, range from not using or reflecting over research at all (I), to a theory-based relation to research, that also provides the opportunities to act in line with research (II). Research utilization (RU) can be divided into the concepts of IRU, CRU, and PRU as described above. Overall, the studies showed that RU among the RNs related to gender, where women used CRU to a greater extent compared to men (I). In the same study, it was seen that academic training was associated with higher use of IRU among the participants. Berthelsen & Hølge-Hazelton (2017), problematized the term of "nursing research culture" and one of the main findings in their study was that academic thinking supported a nursing research culture, together with daily research use as a part of daily nursing practice (Berthelsen & Hølge-Hazelton, 2017). In line with this, RU and academic training must be understood as two prerequisites for EBN.

Warren et al., (2016) conducted a cross-sectional study to learn about RNs beliefs, perceptions and attitudes towards the organizations' possibility to support work in an evidence-based way (Warren et al., 2016). The results showed that fewer than half of the participants believed they could be involved in implementing EBP. At the same time, the participants reported no, or only low involvement in actions related to use of research in clinical practice, as for example actions such as formulating questions, use of guidelines, sharing research findings with a colleague, evaluating a care initiative or changing practice in line with research outcomes (Warren et al., 2016). The participants reported that the knowledge they had about EBP came from their educational training to become a nurse. In line with the

results in the present study I, the study by Warren et al., (2016) and also by Aiken et al., (2014) showed that RNs with a higher academic degree had a more favourable attitude to use of evidence in clinical work (Aiken et al., 2014; Warren et al., 2016). The transformation from training to become a nurse and the importance of higher academic degree are two perspectives that calls for further discussion; how RNs and organizations can contribute via those two perspectives, to develop EBN. Where an organization supports higher academic education, the impact on EBN will probably increase. Research on how to support RNs in being "research consumers" has highlighted the importance of leadership in relation to EBN (Andreasson et al., 2016; Stetler, Ritchie, Rycroft-Malone, & Charns, 2014).

In study III the FLNMs expressed an uncertain stance in relation to research. The most frequent opinion was that medical research –being a fundament of EBM - was the leading genre of health research and it was also to EBM that the participants in study III mainly referred. In the same study, (III) the FLNMs reflections on the use of research connected to nursing, gave a picture of the complexity of their role. The role of FLNMs has transformed from being the most skilled nurse to a role of a manager (Ericsson & Augustinsson, 2015). This calls for an understanding of the relation between academic training and EBN when education and training to become a FLNM is organized of the health care sector. It also calls for the individual FLNM to develop an awareness and acceptance of the impact her or his role will have on EBN.

Nursing theory

Study II in particular showed the perspective of a nursing philosophy underpinning the clinical work on a ward. The nurses working in that particular ward stated that the nursing philosophy gave them the possibility to be reflective in relation to their clinical work, using the concepts and expressions specific to that nursing philosophy. Meeting each other in reflection on the nursing philosophy, implied an opportunity to develop a common value base. The possibility to support EBN via a theory-based approach has been outlined for example by Wazni & Gifford (2016). They used Orem's self-care deficit nursing theory (SCDNT) in a clinical setting, and the theory gave the RNs a tool for providing the physical and mental needs of patients diagnosed with schizophrenia, resulting in a care that the authors described as holistic and integrated.

This can be related to how the RNs in study II described the care they performed at their ward, giving the patient the feeling of being confirmed and seen. The participants talked about how the nursing philosophy helped the RNs to perform a care they described as being of high quality related to the nursing philosophy used. The specific philosophy was not interpreted as having the main impact; rather, it was the opportunity to have time to reflect together that was of paramount importance.

In study III, hardly any nursing theories were discussed. The FLNMs did not see nursing theories as helping to improve nursing in their settings. In a study by Ranheim, Kärner, & Berterö, (2011) the result showed that RNs used an approach to nursing, broadly based on nursing theories in their clinical work, though unreflected. When reflecting together with the interviewer in that study, the RNs themselves found a relation to theory in their clinical work (Ranheim et al, 2011). The research of nursing theorists can be helpful when being implemented as a base for common reflection, but a theory can also be useful in clinical practice.

The patient's perspective

With very few exceptions most of us wants to stay healthy and be able to take care of ourselves. When someone ends up being in a situation as a patient and in need of the health care in different ways, it is natural that the expectations of support and interaction are high. In study IV the result showed a picture of how five aspects supported the patient's perspective; respect, relation, relief, independency and wellbeing as a patient. Since these aspects seem to be central, they can be used when designing and performing an intervention aimed to improve nursing with the patient's perspective incorporated.

In a literature review by Rewakowski (2018) the term of respect is problematized from the perspective of nursing and some closely related disciplines such as medicine and psychology (Rewakowski, 2018). Respect builds the relation in close connection to dignity, which in the situation of a patient, creates independence. Interpreted from that review; interpersonal relations constitute us as human, if built on dignity and respect. The review concluded that respect is central in different theories across different disciplines (Rewakowski, 2018). This is in line with the results from study IV in the present research project; respect and relation are central aspects when designing research aimed to develop nursing.

The relationship between RNs and patients has to relay on trust and safety, together with respect and dignity, to be helpful for the patient

(Norlyk, Haahr, Dreyer & Martinsen, 2016). To be able to build trust it is of importance that RNs make safe decisions, can communicate and can argue for the patient's care in an evidence-based way. In a study performed by Hogg et al., (2018) complaints about behaviour, attitudes and communication between healthcare staff and patients were analyzed (Hogg, Hanley, & Smith, 2018). The authors found that the interaction between the healthcare professional and the patient, when it was unsuccessful, had effects both on the experience, rehabilitation and the clinical outcome. Hogg et al. (2018) reported that patients avoided seeking healthcare when eventually needed, if the patient had experienced poor attitude or poor behaviour or communication from health care staff (Hogg et al., 2018). Therefore, the patient's perspective has to be lead the way for RNs when improving nursing.

In study I and study II the patient's perspective was highlighted from different angles. In study I the use of PRU was reported as low by the participating RNs. Persuasive RU to some extents consists of "being the voice" of the patient, by representing her or his interest and arguing for changes in the interest of the patient. This requires insight concerning the patient's need and wishes, but it also require courage to speak up for the patient. One definition of the concept of patient advocacy showed a picture including supportive, compassionate and emphatic care from the nurses (Abbasinia et al., 2020). Persuasive research use can be considered a way of advocating in the interest of the patient, and RNs need to improve and understand PRU if they want to consider themselves "advocates for the patient".

In study II, as mentioned, the RNs in the ward followed a nursing philosophy. The participants in study II described both an empathic and compassionate care when talking about the care given on that particular ward. To choose a nursing philosophy or theory to organize the nursing could support the patient's perspective in line with patient advocacy.

The use of a theory stance when working in clinical context is not that common as previously stated. Although, we now see that person-centered care, (PCC) is more and more accepted and practised to support the development of nursing.

Person-centered care can be described as a partnership between the patient and her or his next of kin and the providing caregiver (Ekman et al., 2011; (Olsson, Jakobsson Ung, Swedberg, & Ekman, 2013). The relationship builds on the story the patient share with the RN. In the integrative review, study IV in this research project, the patient's perspective

was present when a relation could be detected. The ability to create a partnership in a relation is a prerequisite. This, together with a plan for recovering or handling chronic diseases and providing other treatment, well documented and agreed between the RN and the patient, is the goal when a PCC approach to nursing is taken (Ekman et al., 2011).

The relational part of PCC is described as built on the persons own story of her or his life, expectations and wishes, strengths and rights (Ekman et al., 2011). This contrasts with the view that the patient is a passive receiver of care, reduced to just a diagnosis or condition (Olsson et al., 2013). The results from study IV, also showed a connection between the patient's perspective and the presence of respect i.e. when the patient is listened to.

Clinical competence

The understanding of clinical competence, or as it sometimes addressed: "clinical expertise" or "proven experience", has not been the main focus in this project. However, some of the perspectives that have been studied in this thesis show implicitly how the RNs relate to this cornerstone of EBN. The concept of clinical competence refers to an ongoing process for the RN (Lejonqvist et al. 2012). A clinically competent nurse is distinguished by her or his often intuitive ability to grasp a situation and efficiently make correct decisions (McHugh & Lake, 2010). Clinical competence can also be described as "a hybrid of practical and theoretical knowledge" (McHugh & Lake, 2010). Seen in the same study; the contextual factors also have to be considered important when the individual RN is shaping her or his clinical competence (McHugh & Lake, 2010). In this research project some contextual factors relating to EBN, i.e. working climate and leadership were studied.

In study I, the RNs reported their views on their work climate, a perspective that has an impact on how long a person intend to stay at a workplace. The impact of working climate has been studied from job satisfaction and turnover intent (Abou Hashish, 2015). Hashish' result indicates that the RNs experience of an ethical work climate, together with the perceived support from the organization, influenced the RNs decisions concerning leaving or staying in their workplace.

Clinical competence cannot always be related to a timeline; still, the possibility to stay at the same workplace underpins the growth of this expertise.

In study II the participants talked about how the nursing philosophy – which can also be perceived as a contextual factor - helped them to develop

their understanding of nursing. They reflected together from the common platform of the nursing philosophy, and the RNs expressed their professional growth in relation to this.

Even more, however, the nurses in study II emphasized the importance of leadership, for which there is good scientific support (Farag, Tullai-Mcguinness, Anthony, & Burant, 2017; Hecke et al., 2019; Lunden, Teräs, Kvist, & Häggman-Laitila, 2017). The participants in study II described their leader as a prerequisite, giving the RNs at the ward, both time and postulate to work according to the nursing philosophy.

Study III by contrast, was based on the leaders' perspective. The participating FLMNs rather described their role as one of mainly "putting out fires" and trying to manage the day, with for example, scheduling and meetings high on the agenda. If the clinical everyday life is experienced in this way by FLMNs, the task to maintain "an active approach towards latest knowledge" (Lejonqvist et al, 2012) - and in thus to contribute to the development of clinical competence among the nurses - seems difficult. The participants description of their leadership also seems to be distanced from what Salmela et al., (2016) argue for in in a paper concerning nurse leaders as managers of ethical caring cultures. The authors state that if the RNs felt they could give a respectful care - care that is evidence-based and economic - that would be a basis for good care (Salmela, Koskinen, & Eriksson, 2017).

It seems important to encourage FLNMs to make demands for support from their organization to develop their conditions and qualifications to shoulder the role of embracing and leading the process of evolving clinical competence – including "an active approach towards latest knowledge". This requires, among other things, time dedicated to reflection on clinical situations.

To conclude the discussion of clinical competence, some inherent tensions or ambiguities that the concept seems to contain, need to be highlighted. One aspect of this is that clinical competence is perceived by many professionals as almost synonymous with experience, and does not include taking in current research. Against this background, research can be seen as a competing, rather than a complementary, aspect. Nibblelink & Brewer, (2018) saw in their literature review that RNs in acute surgery context, esteemed collegial advice higher in decision-making than other sources of information (Nibbelink & Brewer, 2018). When turning to a colleague it also contained a social aspect, but it was not clear how the process who to turn to for advice, was done (Nibbelink & Brewer, 2018).

Nurses may find that research has a higher status and that one needs to defend the experience of being considered less worthy. Therefore, it is important to point out that clinical competence is indeed one of the four cornerstones of EBN and that the concept encompasses both practical and theoretical knowledge.

Methodological considerations

As previously stated, the methodological approaches in the different studies included in this thesis, comprises both quantitative and qualitative methods. This was a deliberate choice to be able to understand the different research questions from the most suitable angle. In the following section some methodological considerations are discussed, building on the different methods and instruments used.

When designing the scientific studies included in this research project, the question of rigor and trustworthiness was essential (Roberts & Priest, 2006). The effort to reduce error and making misleading interpretation has been handled through regular discussions in the different research teams connected to the different studies.

Study I was designed with a variable- and pattern-oriented approach and used a questionnaire developed for self-reported data from the participants. The results should be considered in the light of the low answering rate, which could indicate low interest in the questions asked, limited time to participate or that we did not reach the right respondents. Though, the distribution over age and gender was in agreement with the hospitals distribution of clinical RNs at the time the study was carried out (personal communication with the Human Resources Department, January 2018). The gender distribution was in line with the national statistics for RNs working in the health care sector at the same period (Socialstyrelsen, 2018).

The possibility to conduct interviews or focus groups to deepen the data set with the same sample may have completed the picture in a more nuanced way.

The use of clusters in this study complemented the approach to variables, and the clusters showed different profiles among research users. This must also be considered in relation to the response rate; would there have been other profiles with a higher answering rate? However, the results were similar to current research with a comparable design and were therefore considered reliable (Roberts & Priest, 2006). Study I used a questionnaire, the CCQ (Ekvall, 1996) which was found suitable as it has been validated

and found reliable in different settings, including health care organizations (Carlfjord et al., 2010; Söderlund et al., 2014).

In study II and III phenomenography was used. Both studies have been approached with the underlying device "you can only understand the world as you know it" (Marton & Booth, 2009). In study II the specific ward and the chosen theory were intentionally not presented, because of the importance of preserving the anonymity of the ward and the participants. This has been considered a strength as in this way, the readers would not be influenced by their eventual preunderstanding of the theory.

In study III focus groups were carried out to collect data. The use of focus groups when collecting data for phenomenographic studies has previously been questioned, but is increasingly applied (Arveklev, Berg, Wigert, Morrison-Helme, & Lepp, 2018; Loan Minh et al., 2016) and should no longer be considered a limitation. The choice to use focus groups rested on the assumption that the participants might experience a feeling of being questioned in their role as FLNMs, if a researcher asked about research and their way of handling that as a FLNM. However, the experience in the research group was that the focus groups supported the discussion and helped the participants to share their conceptions.

In the same study (III), the decision was to inspire and start the discussion with the use of the results by a scientific paper. The discussions among the participants were engaged and the data set was considered rich. Another consideration related to the use of a scientific paper in this way, might be the possible influence it could have on the research group. This was handled as stated previously, by conducting a "dialogic check" (Collier-Reed, Ingerman & Berglund, 2009).

The last study (IV), was designed as an integrative literature review. Whittermore & Knafl (2005) describe the integrative literature review as a review method that allows diverse methodologies to be included; for example both experimental and non-experimental research, which gives the possibility to collect and synthesize the existing research on the phenomenon of interest. The decision to use an integrative literature review rested on the assumption that the patient's perspective in research performed to develop nursing, can have diverse methodological standpoints, and therefore using this perspective would be a feasible direction (Dahlberg, 2013). When conducting a review it is important with the selection of papers and that the "right" search terms underpins the choice of papers forming the data set. This was handled by working together with an experienced librarian.

To detect the best quotations for representing the perspective of the patient, a question pointed towards the different headings was constructed to guide the selection. This could maybe have misled the choices done, and were handled by checking the chosen quotations by more than one of the authors.

Conclusions

In this project, performed to understand and contribute to the discussion of how EBN can be used when developing nursing, there are some conclusions to be drawn. Firstly, the FLNM can be proactive concerning implementation of the use of research and nursing theories and organize the work in the specific ward to be supportive towards EBN; enhancing RNs clinical competence. Secondly, the perspective of the patient needs to be prominent during the designing of interventions aimed to develop nursing, this, to be perceived as developed in line with EBN. Furthermore, how the results of the interventions are presented in scientific articles, needs to support the clinical working RN in using research according to EBN. Finally, EBN as a concept needs to be further discussed and tested to be understood and used in nursing.

Clinical implications

The agreement has to be reached that the basis for nursing is evidence-based i.e. the four cornerstones as described which require systematic reflection in relation to EBN. Registered nurses (RNs) need academic training as a prerequisite for EBN, and this need has to be supported and organized by the health care sector. The FLNMs have to accept and take charge for their own importance and they need to challenge the support in their role of acting in line with EBN.

Further research

This research project has taken an interest in how the concept of EBN can be understood and useful in the clinical context, and what underpins and counteracts EBN in the said context. To further develop the knowledge and acceptance of EBN, and with this, try to support implementation in daily use, it would be of interest to examine the use of EBN through a theoretical lens.

Today, and has been for some time now, the research performed to develop nursing, has focused on how to implement research findings in the clinical setting. The focus tends to target how facilitators or "extern" individuals should be in charge of the process that ease evidence to be implemented and updated. As an extension, it would be of interest if the research focused on the personal path that grows RNs into solid "research consumer" in the interest of the patients.

Regarding research in relation to the use or the usefulness of a theory-based nursing in clinical setting; there is a need for performing interventions that can either support or waive the use of different levels of nursing theory in the clinical context.

Concerning research focusing on clinical competence, there is a need for studies that investigate how the health care sector values experience. Studies on how clinical competence can be measured or evaluated to assure its relevance and how it is used in clinical settings would likewise be useful. The tendency that we "keep things the way they are" just because it is the easiest way or because we do not have the time to search for the research, has to be analyzed in a transparent way.

Patient participation needs to be developed and understood both concerning clinical context and within research, to consolidate how the perspective of the patient is understood and exerted properly.

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Svensk sammanfattning (Swedish summary)

Bakgrund

Sjuksköterskans arbetsområde kan framstå som självklart, dock finns det begrepp som kan behöva förtydligas rörande sjuksköterskans vetenskapliga område. I den här avhandlingen är begreppet evidensbaserad omvårdnad definierat som det huvudområde som sjuksköterskor utgår från. Evidensbaserad omvårdnad omfattar forskning, omvårdnadsvetenskaplig teori, patientens perspektiv samt klinisk expertis, och när sjuksköterskan arbetar med en teoretisk hållning, med forskning som bas, och strävan mot klinisk expertis för patientens bästa, så utövar sjuksköterskan omvårdnaden evidensbaserat. Begreppet omvårdnad definieras i det här projektet som när den tillämpade omvårdnaden sker i klinisk kontext i mötet mellan patient och sjuksköterska. För att kunna hävda att sjuksköterskans arbete är baserat på den senaste och bästa forskningen krävs att sjuksköterskan kan formulera frågor, söka, hitta, förstå och använda den forskning som finns. Klinisk expertis går att förstå i ljuset av begreppet beprövad erfarenhet. Dagens patienter förväntar sig att den omvårdnad som sjuksköterskor arbetar med i klinisk kontext är baserad på forskning. Till det kommer att sjuksköterskan enligt lag ska bedriva sitt vårdande utifrån aktuell forskning.

Syfte

Det övergripande syftet i avhandlingen var att studera, undersöka och beskriva användningen av evidensbaserad omvårdnad i klinisk kontext från de fyra hörnstenarna i evidensbaserad omvårdnad: forskning (delarbete I, II, IV), omvårdnadsteori (II), patientens perspektiv i forskning avsedd att utveckla klinisk omvårdnad (II, IV) och klinisk kompetens (I, II, III).

Studie I

Den första studien (I) i den här avhandlingen är en kvantitativ studie med fokus på hur sjuksköterskor använder forskning i sitt kliniska arbete. I studien mättes deltagarnas egen uppfattning om sin forskningsanvändning och hur de själva skattade sitt arbetsklimat och ledarskapet på sin arbetsplats. Det kreativa arbetsklimatet undersöktes via ett frågeinstrument: Creative Climate Questionnaire (CCQ) Till frågeformuläret var ytterligare tre frågor tillagda om hur sjuksköterskan skattade sin forskningsanvändning med utgångspunkt i tre olika typer av användning.

Dessa är 1) en övertalande form av forskningsanvändning (persuasive research utilization, PRU), då sjuksköterskan använder forskning som underlag för att påtala en vårdhändelse och försöka förändra omvårdnaden, 2) en form av forskningsanvändning där sjuksköterskan kan omforma sin egen syn på en fråga efter att ha använt forskning, kallad indirekt eller konceptuell forskningsanvändning (conceptual research utilization, CRU) och slutligen 3) den typ av användning då sjuksköterskan använder t.ex. vårdguider och riktlinjer i omvårdnaden: direkt eller instrumentell forskningsanvändning (instrumental research utilization, IRU). I studien görs antagandet att ett kreativt arbetsklimat går att jämföra med det vi i vardagslag kallar att ha ”högt i tak” i en arbetsgrupp, vilket då skulle gynna diskussioner och reflektion kopplade till forskningsanvändning. Resultatet visade att kvinnliga sjuksköterskor använde forskning i högre utsträckning än manliga sjuksköterskor, samt att högre akademisk nivå var kopplat till högre skattad forskningsanvändning. Resultatet visade också ett samband mellan ålder och hur deltagarna såg på klimatet på sin arbetsplats vad gällde lekfullhet och humor, samt hur de såg på konflikter.

För att söka ytterligare mönster eller beskrivningar av hur forskning användes, skapades olika kluster av forskningsanvändare, där de som överlag skattade lägre forskningsanvändning utgjorde ett kluster och övriga som skattade någon form av högre forskningsanvändning utgjorde ett kluster. Jämförelserna visade att de som skattat sin forskningsanvändning som lägre också uppfattade sin arbetsplats som mindre dynamisk och livlig.

Studie II

Studie II är en kvalitativ studie med avsikt att förstå hur omvårdnadsvetenskaplig teori kan påverka sjuksköterskornas omvårdnad. I studien genomfördes intervjuer med sjuksköterskor som arbetade i en klinisk kontext där omvårdnadsvetenskaplig teori hade valts som gemensam utgångspunkt för mötet med patienterna. Intervjuerna genomfördes med samtliga sjuksköterskor som arbetade dagtid på den aktuella avdelningen. Resultatet analyserades med fenomenografi, för att förstå sjuksköterskornas egen erfarenhet av det aktuella fenomenet. Resultatet visade att det inte gick att säga att det var just den aktuella teorin som gav arbetet den positiva inramning som deltagarna talade om, istället formades vården av det aktuella ledarskapet tillsammans med tillfällen till reflektion med avstamp i den omvårdnadsvetenskapliga teorin. Den valda teorin gav också sjuksköterskorna en gemensam plattform för reflektion och en gemensam begreppsvärld. Vid de reflektioner som kontinuerligt genomfördes utgick

diskussionen från forskning baserat på den omvårdnadsvetenskapliga teorin.

Studie III

I studie III tillfrågades enhetschefer, som närmaste chefer för sjuksköterskor på ett universitetssjukhus, om deltagande i fokusgrupper för att diskutera hur de såg på sitt ansvar för att sjuksköterskorna ska kunna arbeta evidensbaserat i omvårdnaden. Fyra fokusgrupper genomfördes och i resultatet framkom att de deltagande chefernas syn på sina uppdrag varierade vad gäller att skapa förutsättningar för sjuksköterskorna. Det framkom att enhetschefen själv behöver göra en egen ”resa” eller skapa en inre hållning där evidensbaserad omvårdnad är integrerad. Resultatet visade även att tid är en faktor som en chef måste förhålla sig till. Det går att använda tiden på två sätt, antingen som en ursäktande faktor eller som en faktor som inte får stå i vägen.

Studie IV

Delstudie IV hade för avsikt att undersöka hur patientens perspektiv är tillvarataget i interventioner som har designats för att förbättra omvårdnad. För att undersöka detta genomfördes en litteraturstudie, en så kallad integrativ litteraturöversikt, vilket innebar att de valda artiklar som ingick omfattades av olika metoder, både kvalitativ, kvantitativ och mixad ansats och metod. I de 47 artiklar som inkluderades analyserades delarna bakgrund/rational tillsammans med diskussion, konklusion och kliniska implikationer för att om, och i så fall hur, patientens perspektiv framkom i de olika delarna. Analysen bestod av två delar, en beskrivande del där land, klinisk kontext, vilken metod forskarna hade använt sig av, samt hur de olika delarna i studien hade representerat patientens perspektiv. Efter det genomfördes en tolkande analys där fem aspekter framträdde som centrala för patientens perspektiv. De fem aspekterna var respekt, relation, självständighet, lättnad samt en hanterbar situation som patient.

Sammanfattande reflektioner

Den här avhandlingens avsikt var att undersöka och förstå evidensbaserad omvårdnad i klinisk kontext med utgångspunkt i skilda perspektiv. De perspektiv som har betraktats är alla viktiga beståndsdelar i hur och om omvårdnaden i klinisk kontext kan hävdas vara evidensbaserad.

De fyra studierna i det här forskningsprojektet, har tillsammans skapat en bild av förutsättningar och svårigheter för evidens-baserad omvårdnad i

klinisk kontext. Studierna har lyft hur evidens-baserad omvårdnad antingen kan förstärkas eller försvåras med utgångspunkt från de i projektet, valda perspektiven. De perspektiven var forskningsanvändning och arbetsklimat, att använda vårdvetenskaplig teori i kliniskt arbete, hur sjuksköterskors ledare ser på sin roll vad gäller att stötta evidens-baserad omvårdnad, samt hur patientens perspektiv finns med i interventioner som skapas för att utveckla omvårdnaden.

För att ytterligare kunna stärka sjuksköterskors forskningsanvändning behöver arbetsklimatets betydelse för forskningsanvändningen förstås djupare. Arbetsklimatet har i andra sammanhang förståtts som en påverkansfaktor för till exempel trivsel och antagandet att arbetsklimatet även påverkar sjuksköterskors forskningsanvändning behöver ytterligare beaktas (I). En teoretisk hållning till omvårdnadsvetenskap i den tillämpade omvårdnaden visade sig ge sjuksköterskorna möjlighet till gemensamt grundad reflektion. Sjuksköterskorna kunde dela begrepp och värderingar som gav omvårdnaden kvalitet. Det var dock inte säkert att det var den speciella omvårdnadsteorin som skapade detta. Ledarskapet gav möjligheterna i den aktuella studien (II). Vad gäller ledarskapets roll för sjuksköterskors forskningsanvändning kan det utgå från ledarens egen inställning tillsammans med kunskap om forskning. Sjuksköterskornas ledare behöver ha insikt i hur de uppfattar forskning och evidens-baserad omvårdnad (III). Patientens perspektiv kunde uppfattas i interventioner som skapas för att utveckla omvårdnaden, om aspekterna respekt, relation, självständighet, lättnad samt en hanterbar situation som patient var med (IV).

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