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Monnie Abraham

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Dr. Jeanne Connors, Committee Member, Health Services Faculty
Dr. Earla White, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2017

Abstract

A Phenomenological Inquiry of Nurses' Lived Experiences of Implementing Evidence in Practice

by

Monnie Abraham

MSN, Tamil Nadu Dr. MGR Medical University, 1995

BSc (Hons) Nursing, Delhi University, 1990

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Management and Policy

Walden University

November 2017

Abstract

Research-informed practice is crucial to ensure best possible decisions are made during care delivery. In reality, research-based evidence often does not reach patient care due to many elements that impede the implementation process. The purpose of this phenomenological study was to discover the lived experiences of nurses involved in implementing evidence-based practice (EBP) in clinical settings within hospitals in United Arab Emirates. The theoretical and conceptual basis for the study was derived from Promoting Action on Research Implementation in Health Services framework for knowledge translation and Benner's Novice to Expert theory provided the conceptual foundation and theoretical background for the study. Twelve nurses who had experience implementing evidence to practice were the participants of this study. Three themes emerged from the study that included the significance of EBP, the process of evidence translation, and the outcome of evidence translation. Nurses in the clinical settings had basic understanding of EBP and were motivated to translate evidence, but their knowledge and skill in EBP were still limited. The implication for positive social change of this study is the recommendation that leaders in healthcare and nursing, as well as educators, and researchers to recognize the need for building EBP capabilities among nurses. Organizations must include current theories, frameworks, and tools of evidence translation to cultivate a culture of EBP as a foundation for patient care.

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Dedication

First of all, I thank almighty God, for touching me in a personal way and loving me. I dedicate this dissertation to my family.

To my parents, it is your love, dedication, and hard work that made me who I am today. Mummy, your memory inspires to be the woman that you always wanted me to be. You instilled in me the love for God as well as the desire to excel academically. Papa you taught me the importance of education and encouraged me to pursue my dreams and be resilient. I am grateful to you both.

To my dear husband, thank you very much. You provided me with constant support and endless encouragement to ensure that I complete this project successfully. You were like a rock for me and I will always cherish it. I have missed a lot of family time and outings yet you supported me with my studies. To my dear children, Anjali and Allan, I love you both. I cannot forget your support, confidence and unwavering love always. Your smiles went a long way in the successful completion of this dissertation.

Acknowledgments

I give thanks to God through whom all things are possible. I express my unwavering gratitude to my committee chairperson, Dr. Robert Hoye, who provided me with guidance and many months of advice. Dr. Hoye has been a perfect mentor through the years, motivating to work smarter through my dissertation project. I will treasure his advice in all my future endeavors. Special thanks also to Dr. Jeanne Connors, for her valuable comments and recommendations throughout this effort. I acknowledge the time, effort, and expertise you have given to this endeavor.

This thesis would not have been possible without the strong support from my family. I extend my gratitude to my little sister, my in-laws, and Sandhya for the constant support, friendship, and guidance during this journey.

Finally, my gratitude to the participants of this study, I am humbled by your knowledge and dedication to the topic of study. Your enthusiasm for the profession, willingness to change and the level of competence was evident. I indeed learned from you and am grateful for the opportunity to share and engage together.

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Chapter 1: Introduction to the Study

Introduction

Nurses and other health care practitioners frequently face challenging situations requiring important and quick clinical decisions that influence care. It is important that clinical decisions and solutions are tested and evidence based to prevent errors and to improve care. Evidence-based medicine is a careful, precise, and intelligent use of existing and valid research-based solutions for care decisions (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). Evidence-based practice (EBP) is a continuous process to find solutions to problems in patient care or clinical settings using scientific research, matched with patients' inclinations and beliefs, and confirmed through clinicians' expertise (Melnyk, Gallagher-Ford, & Fineout-Overholt, 2014). According to Melnyk et al. (2014), EBP implemented in a supportive environment will help clinicians make choices that produce better care results. EBP promotes "high-value health care, enhances the quality and reliability of health care, improves health outcomes, and reduces variations in care delivery and costs" (Melnyk, Fineout- Overholt, Gallagher-Ford, & Kaplan, 2012, p. 410).

Despite the advantages of EBP, evidence is not being used to set standards, to provide consistency for care, and promote quality (Hebden & Murphy, 2013: Melnyk et al., 2012; Taylor, 2012). Grol and Grimshaw (2003) highlighted that approximately 40% of patients do not obtain treatments that are proved to be efficient and based on research evidence. The Institute of Medicine (IOM, 2001) reported that it takes an average of 17 years to integrate latest knowledge from research into practice. An exceedingly long

slack time persists between the creation of study conclusions and translation of evidence to clinical settings due to various barriers (Ubbink, Guyatt, & Vermeulen, 2013; Warren et al., 2016). The consequence of the ensuing research to practice gap is that patients do not receive the best possible care in a safe environment and results in increased cost (Grimshaw, Eccles, Lavis, Hill, & Squires, 2012). Some of the obstacles of evidence translation are clinicians' misperceptions; inadequate EBP skills among health providers; lack of academic programs that include EBP skills in their curriculum; organizations that do not value EBP; lack of resources that support EBP; and opposition to practice EBP from peers, supervisors, and doctors (Melnyk et al., 2014).

Sustained efforts are mandatory to incorporate EBP into daily practice and to benefit from the results of EBP that supports patient safety and quality improvement. Many regulatory bodies compel organizations to implement EBP in patient care by setting standards that are evidence based (American Nurses Credentialing Center [ANCC], 2014; IOM, 2001; The Joint Commission, 2015). The IOM (2001) stipulates the requirement of effective incorporation of research findings into practice and monitoring outcomes on the identified evidence. The ANCC (2014) grants Magnet status to health care organizations that exhibit provision of excellent care by nurses, quality in nursing care, and the incorporation of EBP into practice. The Joint Commission (2015) uses the current evidence to inform the development of standards and advocates the compliance to EBP standards, protocols, guidelines, and best practices to award their golden seal for accreditation status.

Translation of EBP is the incorporation of health care provider's knowledge with the latest available solution identified through scientific research (Sackett et al., 2000). It is a means of identifying solutions to issues and initiated by outlining a problem of interest, obtaining relevant evidence-based solution, judiciously evaluating and gathering data on the evidence implemented, and then using this knowledge to clinical practice (Sackett et al., 2000). Melnyk and Fineout-Overholt (2015) recommended the following steps for research translation:

1. Nurture an appreciation for studying.
2. Form and delineate pertinent questions.
3. Conduct literature search to collect applicable evidence.
4. Judiciously evaluate the credibility of EBP.
5. Incorporate the best evidence founded on clinician's expertise and patient inclinations.
6. Appraise the results of the implementation. and
7. Publish the results of the change.

Researchers have found that clinicians have an increased level of appreciation for the value for EBP and consider that research-based evidence must inform clinical decision-making (Black, Balneaves, Garossino, Puyat, & Qian, 2015; Hussein & Hussein, 2013; Mohsen, Safaan, & Okby, 2016; Weng et al., 2013). However, the ability to implement EBP differs significantly between clinicians, and when compounded with an organizational culture that does not consider EBP as a priority, it adds to an already complicated situation (Lizarondo, Grimmer, & Kumar, 2013; Mallion & Brooke, 2016).

To successfully integrate evidence into everyday practice, clinicians must have expertise and resources to recognize, evaluate, and review the current research findings (Gardner et al., 2016; Stevens, 2013). Among the clinicians, nurses are important in evidence translation in clinical settings because they can implement philosophies of EBP in the organization and support evidence-based approaches to care delivery. Nurses are useful resources for ascertaining, confirming, and translating research-based evidence to nursing practice. To integrate evidence into practice it is important to develop EBP competencies among nurses, reinforce positive organizational EBP culture, and support the coordination and partnership between nurses and researchers.

Research studies that evaluated the role of nurses in implementing EBP are an excellent means to explore issues related to implementation and its effect on patients' outcomes and patient safety (Eaton, Meins, Mitchell, Voss, & Doorenbos, 2015; Mallion & Brooke, 2016). Upton, Upton, and Scurlock-Evans (2014) identified positive attitudes toward EBP as essential to the uptake of evidence in clinical practice. Among other factors, critical thinking and personal values support efficient practices and the implementation of research findings to practice by an individual nurse (Davidsen, 2013; Schmidt & Brown, 2015; Sullivan, 2012; Tajvidi, Ghiyasvandian, & Salsali, 2014). I attempted to explore the lived experience of nurses involved in implementing EBP and to identify the influence of their values, competency, clinical decisions making skills, and other social factors in the adoption of EBP.

Statement of the Problem

Research-informed evidence is crucial so that the best possible decisions are made during care delivery to support quality improvement, and patient safety (Baird & Miller, 2015; Maaskant, Knops, Ubbink, & Vermeulen, 2013; Mallion & Brooke, 2016). EBP is a process of using the best available evidence from scientific studies to support clinical decisions. In reality, evidence derived from research often does not reach patient care owing to many elements that impede the implementation of evidence to everyday practice (Dudley-Brown, 2012; Hebden & Murphy, 2013; White, 2012). Primarily, the process of change in any setting is difficult and translation of evidence is complicated because a need for significant change in beliefs and attitudes exists. New means to seamlessly introduce EBP to daily care is an important area of research, and an increasing number of researchers have attempted to recognize and understand the best approach to close the research practice gap (Black et al., 2015; Hussein & Hussein, 2013; Mohsen et al., 2016; Schmidt & Brown, 2015; Sullivan, 2012; Tajvidi et al., 2014; Weng et al., 2013).

Nurses are critical in implementing EBP in clinical settings and are excellent resources to study issues related to evidence implementation and its effect on patients' outcomes and patient safety. Results of studies conducted on nurses highlight the dynamics and issues surrounding the implementation of EBP (Canada, 2016; Chaudoir, Dugan, & Barr, 2013; Eaton et al., 2015; Grimshaw et al., 2012; Rudman, Gustavsson, Ehrenberg, Boström, & Wallin, 2012). The majority of the studies have brought to light common barriers in research translation among nurses, and others have attempted to explain and test various theories (Chang, 2014; Sesé-Abad et al., 2014; Shifaza, Evans, &

Bradley, 2014; Stevens, 2013; Thorsteinsson, 2012). Furthermore, some studies aimed to find ways to improve evidence translation (Abdullah, Rossy, Ploeg, & Stacey, 2014; Athanasakis, 2013; Boström, Rudman, Ehrenberg, Gustavsson, & Wallin, 2012; Rudman et al., 2012). Literature reviews on evidence translations have indicated that most studies used quantitative research methods (Rycroft-Malone et al., 2013; Thorsteinsson, 2013; Warren et al., 2016) and few qualitative studies (Bohman, Ericsson, & Borglin, 2012; Upton et al., 2014) exist. Among qualitative studies, few that has evaluated the lived experience of nurses involved in EBP practice using the phenomenological method (Fridman & Frederickson, 2014; Spiri & Macphee, 2013).

The knowledge of how nurses perceive research use, and what factors in their decision-making affect the use of research in their day-to-day practice could add to the existing body of knowledge (Davidsen, 2013; Eaton et al., 2015; Thorsteinsson, 2013). The aim of the study was to assess the complex phenomenon of translation of EBP by evaluating the lived experiences of nurses. Knowledge of the lived experiences of nurses involved in the translation of evidence may expose how personal values and social circumstance affects implementing evidence (Khoddam et al., 2014). The findings of my study potentially may contribute to health care and nursing by presenting details on knowledge translation by reflectively evaluating the use of EBP and thereby improving the quality of clinical practice.

Purpose of the Study

The overall aim of my phenomenological study was to reveal and interpret nurses' lived experiences of implementing EBP in a hospital setting. I attempted to understand

the nature of experiences nurses undergo in the change activity and the associated effects of personal values, opinions, and the social processes in implementing EBP. The study may reveal details of association nurses create from their experience and understanding while implementing EBP. I endeavored to understand the phenomenon, how an individual nurse experiences the change process and how this influences the enactment of current role through hermeneutic phenomenology.

Through phenomenological exploration, I attempted to expose the phenomenon by combining my discernment on the phenomenon as a researcher and the confirmation created by interviewing the participants as the result of the study (van Manen, 1997). By reviewing my personal experience, the knowledge derived from the literature review, and the product of the exploration of the experience of the participants, I expected to expose the true essence of the phenomenon (van Manen, 1997). The result of my phenomenological study could be valuable to further explicate factors in the social processes and nurses' values system that could enhance successful adoption and embracement of the change process. In addition, my study could help confirm and provide evidences about on the social processes involved in the analysis and implementation of EBP.

Research Questions

The main purpose of my study was to describe and explain nurse's understandings of the complex phenomenon of implementing EBP in a hospital setting. The specific research questions of this study were:

1. What are the personal experiences of nurses engaged in implementing EBP in hospital settings?
2. What factors in the nurses' personal values, competence and social systems influenced the decision-making and the practice of EBP in the clinical setting?

Theoretical Framework

The theory and framework for the current research was related to knowledge translation and implementation processes, and clinical expertise and decision-making of nurses. For the current study, I used the Promoting Action on Research Implementation in Health Services (PARIHS) framework to conceptualize, analyze, and discuss the practice of knowledge in the clinical setting (Kitson et al., 2008). The Benner's (1984) novice to expert theory addressed how nurses make decisions in clinical settings and in the translation of evidence. The prior experiences of the practitioners may affect how a nurse makes a decision, so Benner's theory may provide valuable knowledge on the conceptual foundation and clinical reasoning. I used a phenomenological hermeneutic approach to gain a deeper appreciation of the issues of concern in my study. For the phenomenon to be exposed, I used hermeneutic phenomenological approach by van Manen (1990). This theory provided a foundation to understand the "lived experience and the explication of the phenomena as they present themselves to consciousness; the study of essences; and the description of the experiential meanings as we live them" (van Manen, 1990, pp. 9-11).

Promoting Action on Research Implementation in Health Services Framework

The Royal College of Nursing Institute in 1990s developed the PARIHS framework (Rycroft-Malone & Bucknall, 2013). This framework highlighted the intricacies of the process of transformation in translating research findings into clinical practice. The principle of the framework was that for a successful implementation of evidence, three elements are essential including the evidence, contexts and facilitation (Kitson, Harvey, & McCormack, 1998). The credibility of the research findings, environment of implementation, and process that support the implementation are essential elements in the integration of EBP (Kitson et al., 1998; Rycroft-Malone et al., 2013). I assumed that for successful translation of evidence EBP must be precise and accurate, enacted in a supportive surrounding, and must have adequate support to ensure a positive implementation (Kristensen, Borg, & Hounsgaard, 2012). Each of the components in the framework includes many subelements that exist on a continuum from high to low (Rycroft-Malone et al., 2013). The implementation was most successful when all elements were placed high in the continuum.

In the PARIHS framework, the evidence was defined as that which is derived from diverse sources that are tested and determined to be reliable (Rycroft-Malone et al., 2013). The evidence has three sub-elements: research, clinical experience, and patient experience. Firstly, the evidence should be based on a reliable, credible, methodologically sound and robust research (Rycroft-Malone et al., 2013). Second, the evidence should have a supportive professional judgment from clinical experts and confirmed through clinician’s agreement. Last, the patient must value and have a positive

experience from the use of EBP. When evidence is an outcome of scientific investigation, confirmed through a clinician's approval of the finding of the study, and supported by patient positive experience, then the evidence is high on the continuum.

Context or setting is the background or a situation in health care or the circumstances in which the evidence is translated to practice (Rycroft-Malone et al., 2013). The context or circumstances indicate the surroundings or environment in which the translation of EBP takes place, and it has three sub elements that include organizational culture, direction, and evaluation. For successful implementation, the organizational culture must favor organizational learning, and the health care organization has corporate governance that encourages transparency of functions, collaboration, and well-designed organizational constructions (Eaton et al., 2015). The evaluation of different levels of the organization reflects commitment to the implementation of evidence. The context is on the high end of the continuum when all the three elements are at a maximum.

The third element, facilitation in the framework includes the means of enabling the execution of EBP into practice or the process of improving or facilitating research adoption. The facilitation in the framework could be an individual or facilitator who is responsible for supporting professionals, teams, and institutions to implement evidence into practice. A successful integration needed appropriate facilitation. Facilitators are instrumental in prompting the change process, bearing in mind the robustness of EBP and the receptiveness of the relevant context. The sub elements of facilitation included the purpose and the role of the facilitator.

Effective facilitation necessitated suppleness and the capacity to use a variety of methods and means to implement the function with the right expertise, personal attributes, and knowledge (Eaton et al., 2015). The main goal of facilitation could range from giving support and backing to accomplish specific objectives to empowering employees to examine, consider and modify attitudes, responses and everyday practices (Eaton et al., 2015).

According to the framework, the optimal translation of evidence occurrs when the following conditions are met (Kitson et al., 1998; Rycroft-Malone et al., 2013):

1. The EBP is the result of rigorous research, which is supported by opinions of experts in the field and is accepted by the patient.
2. The context or setting that is supportive for implementation of evidence, with effective leadership
3. Enabling structures are suitable from the setting.

Thus, the concepts and process in the PARIHS framework provided a guiding framework for this study and highlighted the importance of evidence, context, and facilitation as determining factors in the translation of EBP to practice.

Benner's Novice to Expert Theory

Benner's Novice to Expert theory of nursing expertise was developed from the theory prepared by Dreyfus and Dreyfus (1986). It suggested that the path from novice to expert level of competency progresses through five levels: the novice stage, the advanced beginner, the competent, the proficient, and the expert stage (Benner, 1984). In the first stage, the new graduates acquired skills through directions related to basic facts about the

subject, characteristics, and accomplishments. In the novice stage, the rules are not based on the context, and so a novice possesses limited capabilities to perform and is not flexible. It is after considerable experiences with the role that a novice moves into the next stage, which is the advanced beginner. In this stage, an individual begins using and creating the meaning of the background conditions, and with the understanding derived from previous experience using the components of the circumstances (Benner, 1984). Gradually, traits or qualities of the role begin to reflect the context in an advanced beginner.

In the third stage, competence stage, professionals build their performances concerning long-term positional plans (Benner, 1984). The competent professional moves to an improved level of skills even when they need conscious and deliberate efforts to plan actions. The fourth stage of the framework is the proficiency stage, and, in this level, the professional perceives the aggregate of a situation and not individual parts (Benner, 1984). The staff considers certain features of a situation as critical and overlooks others. A proficient staff organizes and understands situations intuitively, however; the staff requires rational reasoning to decide on a plan. Last, in the expertise stage, an individual recognizes the responsibilities and the determination of next action intuitively and with ease. Experts display activities naturally without deciding or solving a problem because they have a rich and in-depth appreciation of the circumstances (Benner, 1984).

Clinical Decision-making and Evidence Based Practice

Clinical reasoning and decision-making is an integral aspect of the application of EBP in the everyday practices of nurses, and a fundamental function of nursing practice.

Nursing is a profession and the knowledge in nursing science is based on evidences from research. Furthermore, as a profession, nursing is committed to developing research-based evidence that supports nursing practice and decision-making (The American Nurses Association [ANA], 2015). Thus, research-based evidence guides decision-making in everyday practice and such decisions were expected to improve care planning and patient outcomes (Thorsteinsson, 2013). Through experiences in clinical practice and relevant education in the subject matter, nurses improve their expertise and appreciate the implication of research evidences on practice and the need for research use.

Benner's (1984) novice to expert theory addresses nurses' decision-making phenomenon related to developing competency levels among nurses. Capacity to think critically when making decisions and engaging in problem solving is essential for clinical nursing practice. Clinical nursing practice encompasses clinical judgment, diagnostic reasoning, clinical decision-making and skills (Lee, Lee, Bae, & Seo, 2016). Implementing EBP requires sound understanding of the importance of EBP and using effectively to practice, which reflects on the ability of the nurse to make appropriate decisions. Thus, Benner's theory offers valuable insights into the complex phenomenon of implementing EBP. Benner's theory provides useful information on the conceptual foundation of clinical reasoning and the theoretical background for my study to investigate nurses' decision-making inclinations.

According to Benner (1984), as nurses move to the expert level, they are less dependent on guidelines and other methodical means to decision-making. In reality, expert nurses depend on theoretical principles, visualize circumstances as a complex

whole, recognize conditions comprehensively, and totally involve in the situation (Benner, Tanner, & Chesla, 1992). Essentially, expert nurses deliver highly competent care intuitively, swiftly and without any difficulties and swiftly (Benner, 1992; Sarsfield, 2013). According to Benner (1992), this is possible through the culmination of understanding and abilities derived through experience and from theoretical knowledge (Benner, 1992). The highest care begins from the aggregate of theoretical, assumed, and experiential knowledge. Gadamer (1975) pointed out, through experiences a nurse is able to transform preconceived notions, pre-understandings, and prolong refinements to additional understanding.

Phenomenology

I used hermeneutic phenomenology to help explain how people make implications of what they experience (Cohen, Manion, & Morrison, 2011). Hermeneutic phenomenology was a suitable means to answer the research questions of this study. According to van Manen (1990), a hermeneutic phenomenology is an approach in which the researcher goes beyond the words of the participants to achieve abstraction through interpretation. van Manen (1997) highlighted that phenomenological writing can help find meaning to all actions. van Manen suggested that a phenomenological description includes a genuine spirit of the experience, interpreted such that it reveals the structure of the experience and enables the grasp of the essence and implications in a unique manner. The position of hermeneutic phenomenology is rooted in the belief of the importance of subjective consciousness and the judgment of consciousness as powerful, and the researcher gains direct knowledge of the consciousness by reflection (Cohen et al., 2011).

For van Manen (2007), phenomenology is the reproduction of the lived experience of a person's reality. van Manen defined *reproduction* or *reflection* as not only a description of the characteristics of a phenomenon but that which enables a portrayal of the phenomenon as experienced by the participants in their conscious mind. An investigator could represent the phenomenon by allowing the participants to recollect experiences that the participants have experienced (van Manen, 1997). The phenomenological investigator uses understanding or appropriate prior experiences when reflecting to expose the meaning of data and elucidate implications.

Nature of the Study

The objectives of my study incorporated a hermeneutic phenomenological approach to investigate the experiences of nurses involved in the translation of evidence in a clinical environment (Matua & Van, 2015). The phenomenological method highlights the fundamental implications or essences related to nurses' experiences (Matua & Van; van Manen, 1990). In searching for the essence of the phenomena of my study, phenomenological approach as the research methodology may help to determine the underlying perception of nurses through their personal accounts of the circumstances in which the experience happens. Through the interviews, I encouraged the nurses to communicate their understandings and experiences, which will help to fashion the meaning or value they hold to these experiences (Davidsen, 2013; Matua & Van, 1990). My main aim was to elicit information about the experiences, values, and the clinical reasoning experience of nurses when involved in the translation of evidence including the social processes, barriers, and facilitators in the process.

Definitions of Terms

The aim of my study was to explore the perceptions and lived experiences of nurses who are involved in implementing EBP in a hospital setting. Some of the common terms that I used in my study are listed below:

Evidence-based practices (EBP) or evidence: EBPs are practices that have demonstrated through scientific study as effective in improving patient outcomes.

Implementation: The decision to adopt research-based evidence into practice and the act of making the necessary changes so that the EBP is used in every practice.

Nurses: Nurses who are licensed to work as registered nurses and who work in different roles such as staff nurses, in-charge nurses and nurse managers, as well as nurses with any number of years of experience who are involved or who have participated in implementing EBP in a hospital setting.

Perception or lived experience: The expression of experience by the participant regarding their feelings, emotions, and values that are derived from participating in the change process as understood by the researcher.

Research translation or translation or adoption: A range of activities including use of research findings, dissemination of new knowledge, and implementation of these results in clinical decision-making.

Assumptions

My aim in this qualitative phenomenological research study was to explore the perceptions and lived experiences of nurses who participated in implementing an EBP. My first assumption was that as the researcher, I could understand nurses who were

involved in the change process. My second assumption was that participants would be honest about their experiences and honest during the explanation of their experiences. Third, I expected that the participants of the study would recollect the particulars of their experiences. Last, I assumed that I would be able to bracket my personal experiences and assumptions. That is, I would be able to discover the lived experience of the nurses without justifying their understandings based on my experiences.

Scope, Delimitations and Limitations

This qualitative phenomenological study on nurses lived experiences of implementing EBP in the clinical setting included the following limitations:

The proposed sample size of the study was 10 to 15 nurses as participants, but I was able to reach saturation with 12 participants, which was the final number of participants in the study (Converse, 2012). Participants were nurses working in hospitals in different roles such as staff nurses, charge nurses, and nurse managers who had experience implementing evidence to practice. I selected all participants were selected through purposeful sampling and snowballing technique. There is a possibility that the participants may not have given truthful answers, which could affect the data.

The research study was susceptive to investigator bias because I am a nurse administrator. I used the process of bracketing to reduce researcher bias.

Significance of the Study

Insights derived from nurses' lived experiences of implementing evidence may provide insights that could add to the body of knowledge related to the use of evidence. The collective nursing experience expressed by the participants helped to define the

significance of translation to promote practice reforms, and stimulate advances in the quality of nursing care (Titler, 2014). Information derived from the study participants may further add value to nursing care and support developments in nursing care delivery, patient outcomes, and enhanced patient safety (Baird & Miller, 2015; Maaskant et al., 2013; Mallion & Brooke, 2016; Melnyk et al., 2012; Thorsteinsson, 2012).

EBP is the best available model to guide clinical decision-making. EBP refers to the identification of the valid and reliable evidence, including research results and its implementation in patient care. More understanding derived from this phenomenon may help inform the clinical guidelines, techniques, building of organizational processes, and educational programs that may support evidence translation in clinical settings. The outcome of this investigation may further complement the current body of knowledge related to the translation of evidence by nurses. Within phenomenological examination, I strived to realize the implications of the distinctive experiences of nurses and to appreciate and define connections and alterations that produce the everyday problems or successes.

Summary

There is an increasing inclination toward adopting research evidence to guide practice in the hospital. My aim in this phenomenological study was to investigate the perceptions and lived experiences of nurses who were involved in implementing EBP in a clinical setting in hospitals. I attempted to reveal and interpret the nature of experiences that nurses undergo in the change process and the associated influence of personal values, beliefs, and the social processes in implementing EBP. The nature of participants'

experiences from this study may help reveal details of implementation successes and failures to see how they were relevant to and reflective of the current implementation models and research. In Chapter 1, I presented the introduction of the study and highlighted the significance and the circumstances of the examination of the perceptions and the lived experiences of nurses to gain more understanding of the phenomena of implementing EBP. In Chapter 2, I will review literature on the topic of study, theoretical frameworks, and the justification for my choice of the method of study. I will discuss historical and current literature related to EBP and clinical decision-making process and the methodology that I used to understand the perceptions of nurses. In Chapter 2, I also present the theoretical framework of the study.

Chapter 2: Literature Review

Introduction

The purpose of this phenomenological study was to explore and translate the nurses' lived experiences with implementing EBP in a hospital setting. I endeavored to reveal the nature of the experiences encountered by nurses and their effects on individual nurses' values, beliefs, and the social processes in the implementation process. In Chapter 1, I outlined the research questions, significance of the study, aims and theoretical basis of this research study. According to van Manen (1990), the first step in a phenomenological study is to identify the nature of lived experiences. Chapter 2 is a summary of my findings of a review of literature conducted on the phenomenon and the method of study. In this chapter, I also position the study inside the current body of knowledge. Such an undertaking will help to station me in position to the phenomenon and will elucidate my conjectures and pre-understanding. The phenomenon of the study was unique, as few phenomenological studies have explicitly investigated the lived experiences of nurses involved in implementing EBP (Fridman & Frederickson, 2014; Spiri & Macphee, 2013). Hence, the aim of my literature review was to establish the necessity of the study. I also sought to provide a summary of research studies conducted on the phenomenon to understand the experience of research participants and justify my research design decisions (van Manen, 1990).

To establish the need for my study, I reviewed existing studies on research translation was undertaken. The review of literature helped me to understand the nature of the phenomenon and to support the bracketing interview (Converse, 2012; Davidsen,

2013; Heinonen, 2015a). In the second section of my literature review, I highlight the theoretical framework for knowledge translation, the PARIHS framework, and Benner's theory. The Benner's theory emphasizes the importance of a nurse's clinical judgment and decision-making competencies for evidence interpretation. In the last section of the literature review, I provide support for the selection of my study design and van Manen's (1990) hermeneutic phenomenological approach as the methodological frame that supports my findings of the study.

Literature Search Strategy

The aim of my strategy for literature search was to create an understanding of the current knowledge base on research use and EBP; particularly the research use among nurses. I used "the implementation of EBP and the nurse's perception" as the basis for the selection of key words for the literature review. The keywords were *nurses/ nursing, EBP, implementation, knowledge translation, and application*. I selected literature that included studies on EBP, published from 2012 to 2017, in English-language journals and peer-reviewed journals in health care. I conducted an initial search in PubMed followed by searches in the following databases: MEDLINE, CINAHL Plus, ProQuest Nursing and Allied Health Source, ScienceDirect, and PsycINFO. Subsequently, I reviewed articles derived from different databases to remove duplication of studies and other non relevant articles. Following the initial review, I conducted a deeper examination of the studies and isolated in 41 articles related to EBP and nursing, and translation of evidence. From the resultant articles, I appraised the abstracts and, when needed, the complete articles, and I reviewed the relevant studies on implementing EBP in nursing.

Evidence-Based Practice

EBP is the collection, explication, and assimilation of tested, significant and pertinent evidence, which is accepted by the patient, appreciated by the clinician, and is research-based (McMasters University Evidence-Based Medicine Group, 1996). According to Melnyk et al. (2014), EBP is a continuous method of finding solutions for the provision of health care, which is methodologically rigorous, appreciated and valued by patients, and accepted by an expert in the field. Sackett et al. (2000) defined "evidence-based medicine as the conscientious, explicit and judicious use of the current best evidence in making decisions about the care of individual patients" (p. 169). Straus, Tetroe, & Graham (2009) highlighted EBP as a vibrant and ongoing method, that comprised of creation, propagation, discussion and ethical adoption of evidence to advance care outcomes.

Results of studies have validated that EBP promotes high-value health care, enhances quality and reliability, improves quality of life, and improves standardization of care delivery (Black et al., 2015; Facchiano & Snyder, 2013; Khoddam et al., 2014; Melnyk et al., 2012; Ubbink et al., 2013; Warren et al., 2016). Implementing EBP in the clinical environment brings about a transformation in the settings and supports the clinician collaboration and nurses' involvement in the required change (Fridman & Frederickson, 2014; Marshall & Mountford, 2013). In addition, incorporating EBP to day to day nursing care results in improved client outcomes, greater patient satisfaction, and supports patient-centered care (Eaton et al., 2015; Powrie, Danly, Corbett, Purath, & Dupler, 2014; Thorsteinsson, 2013). However, EBP is not being used effectively to set

standards for care and improve quality (Irwin, Bergman, & Richards, 2013; Melnyk et al., 2014; Yost et al., 2014). Grol and Grimshaw (2003) highlighted that about 40% of patients do not have access to treatments that are tested and based on evidence. Institute of Medicine (2001) reported that it takes an about 17 years to integrate new knowledge gained from research to practice resulting in ineffective use of limited health service resources. With studies highlighting the research to practice gap and the current demands on health care to ensure that practices are evidence based, cost-effective and accountable, there is an increased interest in knowledge translation research (Steven, 2013; Tan, Sahin, & Özdemir, 2012; Yost et al., 2014).

Research Use in Nursing

One of the essential components in the translation of evidence is to efficiently use nurses in the process because they are strategically placed in the clinical environment and are effective in implementing evidence. Nursing as a profession is committed to using scientific research to support nursing practice and decision-making. The American Nurses Association (ANA, 2015) affirmed that scientific investigation is an integral part of professional practice. Nurses and health professionals are responsible and obliged to ensure EBP is implemented to practice. Many studies on nurses highlighted the dynamics and issues of implementing EBP by nurses (Canada, 2016; Chaudoir et al., 2013; Eaton et al., 2015; Grimshaw et al., 2012; Rudman et al., 2012). Outcomes of most studies have highlighted that there are many barriers in research translation among nurses (Chang, 2014; Sesé-Abad et al., 2014; Stevens, 2013; Thorsteinsson, 2012).

One of the positive findings of research studies was that nurses had high awareness and appreciation for translating research into practice (Athanasakis, 2013; Bohman et al., 2012; Eaton et al., 2015; Fridman & Frederickson, 2014; Mohsen et al., 2016; Stokke, Olsen, Espehaug, & Nortvedt, 2014). However, some studies have highlighted that nurses lack the knowledge and ability to engage in effective research-based practice (Barría-Pailaquilén, 2013; Eaton et al., 2015; Thorsteinsson, 2013; Spiri & Macphee, 2013; Warren et al., 2016; Weng et al., 2016). One of the common issues nurses encounter was the inability to generalize research results and make it relevant to daily practice (Eaton et al., 2015; Shafiei, Baratimarnani, Goharinezhad, Kalhor, & Azmal, 2014; Spiri & Macphee, 2013; Powrie et al., 2014).

The focus on research use in nursing began in 1970s, but the concept was considered more as a comprehensive and complete evaluative process (Schmidt & Brown, 2015; Upton et al., 2014). In the 1980s and 1990s, the Agency for Healthcare Research and Quality (AHRQ, 2000) provided funding for research in translating research into practice (TRIP). The main aim was to develop health care practices and problem solving through the use of evidence and to support the clinical, organizations, and public policy makers. Subsequently, many international organizations such as the National Institute for Health and Clinical Excellence (NICE), the Scottish Intercollegiate Guidelines Networks and the National Institute for Clinical Studies in Australia were established with an effort to incorporate evidences for decision-making in health care (Gerrish et al., 2007). As a result, various models were formulated that defended and provided frameworks that supported implementation of evidence (Estabrooks, Thompson,

Lovely, & Hofmeyer, 2006). Further, number of empirical studies were undertaken to find theories, methods, and tools to improve evidence translation (Abdullah et al., 2014; Athanasakis, 2013; Boström et al., 2012; Kitson & Harvey, 2016).

Some of the most common models for implementing EBP include the Advancing Research and Clinical Practice through Close Collaboration (ARCC) model, the ACE Star model of knowledge translation, the Iowa model, the PARIHS Framework, the Stetler model, and the Johns Hopkins nursing EBP model (Canada, 2016). The ARCC model uses six stages that support evidence translation that include the following (Melnyk, Fineout-Overholt, Giggleman, & Cruz, 2010):

1. Assessing organizational culture and preparedness.
2. Evaluating positives and barriers.
3. Employing of EBP facilitators.
4. Evaluating clinicians' attitudes to EBP.
5. Implementing evidence.
6. Appraising the outcomes.

The ARCC model focused on the influence of an organization's philosophy and resulted in the formulation of the Organizational Culture and Readiness for System-Wide Integration of Evidence-Based Practice Scale, the Evidence Based Practice Beliefs Scale, and the Evidence Based Practice Implementation Scale (Melnyk et al., 2010).

The IOWA model for implementation of EBP was introduced that identified three essentials for a change to occur (Titler, 2014). The first element was organizational commitment for EBP, which is evident in the mission and objectives of the organization

and effectively communicated in all processes. The other important elements were identifying and utilizing change champion and ensuring that the evidence translation is a planned process (Goode & Titler, 1996). Thus, research translation or implementation is the synthesis of scientifically derived research evidence by a clinician such that it supports clinicians and interpretation of patient values, needs, and expectations to make health care decisions.

The ACE Star Model emphasized the need for essential components in translating knowledge that was derived from research supported by clinical expertise and patient acknowledgment. The ACE Star model of knowledge translation focused on information transformation at the personal and establishment levels. The five stages of action in the EBP process were evidence detection, examination of the clinical inquiries and the conclusion of evidence; knowledge outcomes, including evidence production; transformation into policies and protocols; incorporation into care, which involves the application of evidence; and the evaluation of the results (Steven, 2013). The Stetler Model encompassed six stages of implementing EBP that included development, validation, evaluation, decision-making, adaptation, and utilization and evaluation (Stetler, 2001). This model included both the individuals, as well as the organization and considered most useful when practiced by clinicians with EBP skills (Schaffer, Sandau, & Diedrick, 2013).

Promoting Action on Research Implementation in Health Services Framework

The PARIHS framework related to the concept of EBP with a focus on the compound nature of translation of evidence to practice. This framework had been widely

used as it provides a structure for evidence translation in a natural, realistic and practical manner for organizations that are involved in EBP implementation (Kitson et al., 2008; Gozdzik, 2013). The research and development team at the Royal College of Nursing (RCN) Institute in the late 1990's (Rycroft-Malone et al., 2013) developed the PARIHS framework inductively. This structure was used in this study as an analytic framework, which provided focus and construction for discussing the investigation of the implementation of EBP and is presented in the following section. The model offered a simple structure that involved three elements, which include evidence, context, and facilitation.

Evidence. The assumption of the framework was that, for the efficient translation of EBP; there must be a clear understanding regarding the quality of the evidence, the nature of context, and the types of facilitation required (Gozdzik, 2013; Rycroft-Malone et al., 2013). The first element of the framework, evidence, included three sub-elements; research, clinical experience and patient preferences/experience (Gozdzik, 2013; Kitson et al., 1998; Rycroft-Malone et al., 2013). Each of these sub elements can be evaluated on a continuum. The first sub element evidence emphasized the need for research-based evidence. The second sub element, clinical experience, highlighted the acknowledgment of the usefulness of evidence by experts in the field and the acceptance of change by the patients. The inclusion of patient experience and clinical experience as sub-elements of evidence was a unique aspect of the PARIHS framework.

The Context. The second element of the PARIHS framework was the context. Context denotes the background in which the evidence is translated to practice (Gozdzik,

2013; Rycroft-Malone et al., 2013). The context is comprised of three sub-elements: leadership, organizational culture and evaluation or measurement (Mallion & Brooke, 2016; Powrie et al., 2014; Tan, Akgün Sahin, & Kardas Özdemir, 2012; Yoder et al., 2014). Gozdzik (2013) defined a meaningful context as the one that has clarity in the social, organizational and cultural background; availability of sufficient resources; fair and transparent process for decision-making; apparent authority; monitoring and feedback processes, and is open to the transformation. According to Grimshaw et al. (2012), factors that increased commitment in clinicians to evidence translation essentially enhanced implementation outcome, in particular, staff involvement, response, and teamwork. Other contextual factors included academic associations; functional differentiation; evaluation, access to resources; education; a learning environment; organizational readiness for change; supportive leadership style; decision-making structure; and autonomy (Eaton et al., 2015; Gozdzik, 2013; Irwin et al., 2013; Powrie et al., 2014).

The notion of commitment was supported in the literature as a broad category that described how the organization as an entity facilitated or hindered EBP in the clinical area (Eaton et al., 2015). Leaders who had clear and genuine goals were essential for the facilitation of research translation as they were influential and proactively engaged in gaining feedback and exhibit positive leadership approaches (Eaton et al., 2015). In addition, the literature revealed that empowered staff nurses committed to change based on new knowledge, engaged in ongoing quality improvement initiatives and maintained a high-level of motivation (Rycroft-Malone et al., 2013; Powrie et al., 2014).

The final sub-element of context was an evaluation that was initially described by Kitson et al. (1998) as measurement. This sub-element referred to the existence or nonexistence of conventional examining systems in the organization. High measurement included audit and feedback, peer review, as well as external measures. The sub-element was expanded to include feedback on multiple levels (individual, team, and system), various sources for performance, and multiple methods.

Facilitation. An effective integration necessitated suitable enablement. There is a need for suppleness and the capacity to integrate a variety of diverse methods in which the enabler carries out the role with the right expertise, individual qualities, and awareness (Shifaza et al., 2014). The drive of the facilitation process was to provide necessary support to achieve the aims of the change process and to empower individuals and teams to scrutinize the change approaches, behaviors, and day-to-day practices (Gozdzik, 2013; Grimshaw et al., 2012; Kitson & Harvey, 2016; Rycroft-Malone et al., 2013).

The Continuum. Each of the elements in the framework evidence, context, and facilitation has sub-elements. The component, evidence, had three sub-elements that include research, clinical experience, and patient experience. The second element, context, had three sub-elements that include leadership, culture, and evaluation. The third element, facilitation, had three sub-elements namely the facilitator capabilities, the leadership support and the staff involvement in the change. All sub elements of the core three elements evidence, context, and facilitation can be placed on a scale that ranges from high to low. Each sub-element positioned under the elements can be assessed to be

towards high. A successful implementation was more likely when all the sub-elements and thereby elements are evaluated as high in the continuum. Firstly, the EBP needs to be evaluated and assessed, coordinate with the clinical experience and patient choices. Second, the context is responsive to change with sensitive cultures, supportive management, and suitable monitoring processes (Gozdzik, 2013; Rycroft-Malone, 2013).

Individual Nurse and Research Translation

Generally, EBP is a system-wide activity and the organization and nursing leadership has a significant effect on the staff nurse (Gozdzik, 2013; Rycroft-Malone et al., 2013). Though many studies focused on organizational factors, the individual nurse is an essential part of the EBP implementation process (Mark et al., 2014). So it is important to understand the nurse's perspective on the change process. The outcomes of translation studies have highlighted that the significant barriers to research translation among nurses and tested various methods of improving evidence interpretation. Review of literature on evidence translation indicated that most studies used quantitative research methods (Rycroft-Malone et al., 2013; Thorsteinsson, 2013; Warren et al., 2016) and few studies employed qualitative methods (Bohman et al., 2012; Upton et al., 2014). Among the qualitative studies, phenomenological studies that evaluated the lived experience of nurses were few (Fridman & Frederickson, 2014; Spiri & Macphee, 2013). Evaluation of research translation using various methods of research is important to bring to light the means of improving evidence uptake.

Studies had identified that there are various factors in the personal characteristics of nurses that can influence the nurses' knowledge translation capability (Gozdzik, 2013;

Mark et al., 2014; Rycroft-Malone et al., 2013). The knowledge of how nurses perceived research utilization, and what factors in their decision-making skills affected the use of evidence in their day to day practice could add to the body of knowledge (Eaton et al., 2015; Davidsen, 2013; Thorsteinsson, 2013). The aim of my study was to examine the complex phenomenon of translation of EBP by evaluating the lived experiences of nurses. Knowledge of the lived experience of nursing involved in the translation of evidence could expose how personal values and social circumstances could effect the implementation of evidence (Khoddam et al., 2014). The findings of my study could contribute to health care and nursing by presenting details on knowledge translation and reflectively evaluating the use of an EBP and thereby improving the quality of clinical practice.

Use of research findings to benefit with clinical problems was dependent on the nurses' capability to investigate the evidence, evaluate the benefits, appraise the uses, and possess a positive mindset to the potential of and contribute to problem solving (Canada, 2016; Grimshaw et al., 2012). In a study conducted by Grimshaw et al. (2012), it was identified that strategies, such as personal education, reminders, and using change champions were ways that could support nurses in the adoption of research findings to inform care decisions and knowledge translation. In a study conducted on nurses to identify their EBP beliefs and behaviors in cancer pain management, it was identified that it was important to embed scientific evidence in hospital policies and procedures, and that senior nurses are to develop such policies and procedures (Eaton et al., 2015). Other factors that supported the creation and practice of research results were monitoring

practices in the clinical settings; discussions with colleagues and feedback from patients (Irwin et al., 2013). Some of the factors that hindered research translation and EBP by nurses included lack of time, lack support from organization for research utilization, and the lack of capabilities of nurses to conduct research (Akerjordet, Lode, & Severinsson, 2012; Heinonen, 2015a, Mohammadi, Amani, Rezaeian, & Setoodehzadeh, 2015; Ubbink et al., 2013).

The American Nurses Association (2015), the Canadian Nurses Association (2015), and the Nursing & Midwifery Council (2008) have included translation of knowledge as an important ability and behavior for nurses and have included the standards of practice and accreditation. The ability of nurses to make decisions related to implementing evidence is dependent on the clinical expertise of the nurse (Canadian Nurses Association, 2015). The ability to correlate research findings to decision-making in patient care, and the willingness or inclination to improve current practice were crucial factors for knowledge translation (Baird & Miller, 2015; Maaskant et al., 2013; Mallion & Brooke; 2016). Availability of role models in the clinical setting was an essential element that helped nurses develop abilities and inclination to utilize EBP in their everyday practice (Fridman & Frederickson, 2014). This section of the literature review summarized current knowledge regarding, nurses' values, philosophies and experiences, and the clinical decision-making capacity, and its, effect on evidence translation. Further, it explored how Benner's (1984) framework of the novice to expert informs the clinical judgment and reasoning of a nurse.

Decision-making is an intricate process and, in clinical settings, the nurses' capability to make appropriate and quick judgments is crucial for the delivery of nursing care. Clinical decision-making is a process of using discriminative thinking models when making decisions in implementing care (Benner, 2001). According to Benner (1984), experiences influenced nurses' clinical judgment, and an expert nurse made sound decisions on their sub conscious mind and did not depend on policies and guidelines or use structured processes to decide actions. Clinical decision-making occurred when nurses' integrated research-based knowledge, experiences and clinical judgment to a particular scenario (Benner, Tanner, & Chesla, 2009). Such effort promoted a hidden meaning to the patient care conditions and helped them to advance from relying on theoretical knowledge and prescribed instructions to an in-depth understanding. When outcomes of decisions were appropriate, nurses were inclined to trust on previous experiences and utilize unique characteristics as a core for clinical decision-making (Benner, 1984; Tanner, 2006). Thus decisions reflect an understanding of the importance and the effect of the context (Benner, 1984; Tanner, 2006). Through Increased experience, nurses tend to make fewer mistakes in judgment and can identify dissimilarities in their decisions.

In clinical decisions, Benner's theory (1984) highlighted the importance of gaining a comprehensive or larger picture of the circumstances. Expert clinical decision-making skill reflected the shift from an attitude to compile relevant bits to a consideration of composite whole with unique and essential elements (Benner, 1984). This comprehensive approach helped to gain information regarding the details of

circumstances that supported clarification (Sarsfield, 2013). According to Benner, a full consideration of circumstances increased decision-making capacity. Benner's novice to expert theory is a theory of skill acquisition and was used in this study to gain focus on skills acquisition related to knowledge translation in nurses.

Benner's Novice to Expert Theory

According to Benner (1984), to gain expertise, it was essential to develop nursing skills within the circumstantial experiences. The competency was established through prescribed and ongoing didactic education and know-how. The experience was the total exposure to the field specific to nursing knowledge. The blending of academic knowledge and the utilization of the knowledge in the clinical environment enabled the understanding of practice and nurtured clinical judgment. According to Benner, Tanner, & Chesla (2009), when nurses gain more experience, this supported the development of intuition that was unique to nursing. Intuition was knowledge without reasoning that Benner (1982) highlighted as art rather than science. The nurse gained internal logic and intuition that supported the professional to understand the clinical situation from the standpoint of the client and as a clinician and not as a task (Benner, 1982; Benner et al., 2009; Forsberg, Ziegert, Hult, & Fors, 2014). Each stage of skill acquisition constructed on the preceding stage when nurse refined conceptual philosophies and extended as the nurse increases clinical experience.

Benner's theory was based on Dreyfus and Dreyfus (1986) model, in which an individual moved through five levels of competency in achieving professional skills: novice, advanced beginner, competent, proficient, and expert. Advancement through

these stages was reliant on the incorporation of intensity and the variety of clinical exposure in the clinical setting, which proportionately improved with longer duration of time spent delivering nursing care to patients (Forsberg et al., 2014; Sarsfield, 2013). With the complexities of nursing practice and the knowledge required to provide qualified safe care, it is imperative to identify the means to nursing knowledge and the skill acquisition. The levels of competency were established on the following features of clinical competency (Benner, 2001):

1. The capacity to make decisions based on abstract philosophies to concrete information derived from experiences.
2. Visualizing changes in circumstances from a fragmented view to a more comprehensive understanding.
3. A shift from uninvolved onlooker to an active performer.

Novice. A novice is a professional who starts work with no experience of the job in which they have gained knowledge and intended to practice (Benner, 1984). According to Benner (1984), to learn skills, a novice must be placed into the new clinical environment and be educated about a patient's condition using objective and quantifiable goals. Benner (1984) identified that direct interaction with the complex clinical environment promotes the novice to think reflectively, and link existing knowledge to the new circumstances. As the novice nurses moved through experiences from the clinical setting, they developed expertise. According to Benner (1984), new nurses are inflexible and as a consequence need stringent guidelines to tackle scenarios as they have limited clinical experience. The use of quantifiable objectives helps a novice distinguish

characteristics of the patient's condition without being influenced by circumstances (Benner, 1982; Benner & Tanner, 1987). Novice nurses learning strategies include following role models, asking experts, reviewing theories and attending formal courses.

Advanced beginner. The next level of skill accomplishment was the advanced beginner. Benner (1984) described the advance beginner as a nurse who demonstrated a certain amount of satisfactory functioning. An advanced beginner has had experience coping with adequate real-life situations that enable them to understand the significant situational factors critical to decision-making (Dreyfus & Dreyfus, 1986). The advanced beginner gained values that were constructed on understanding gained from experiences and started to utilize these skills acquired from such experiences to guide their actions.

Competent. At this level, a nurse has completed experiences for two to three years of expertise in similar settings or similar circumstances (Benner, 1984). Benner (1984) stated that nurses gain competence once they were able to visualize patterns or plans actions to achieve long-term goals. A competent nurse was able to prepare responses using the principal characteristics of the situation rather taking into consideration individual elements of the circumstances (Gerber, Thevoz, & Ramelet, 2015). For a competent nurse, the proposal created clear standpoint founded on substantial deliberate, conceptual, methodical review of the situation at hand (Benner, 1984). The key feature of this stage was the ability to plan, which enables the nurse to be productive and systematic.

Proficient: The proficient nurse recognized situations in its entirety than as different pieces. According to Benner (1984), a proficient nurses' perception was not

contemplative but evolved established on experience and current occurrences. Discernment was essential to a proficient nurse. In this level, the nurse comprehended more holistically which improved decision-making. The proficient nurse gained skill from experiences of everyday occurrences in a clinical environment and evaluated on how to change plans to meet the requirements of a situation (Benner, 1984).

Expert. The last stage in Benner's model (1984) was the expert nurse. An expert nurse could develop subconscious relationships and perceptions of the circumstances (Benner, 1984). The expert intuitively understood conditions and used this information to decide on what to do (Gerber et al., 2015). The performance of the expert nurse was fluent, effortless, and highly skilled. Benner (1984) stated that an expert nurse acquired skills through testing and refining proposals, assumptions, and principle-based objectives in a real situation in practice. Unlike at other stages, at the expert stage, a nurse identified the setting as a whole, used earlier actual occurrences, and identified the correct position on the issue. There is no inefficient contemplation of inappropriate possibilities (Benner, 1984). An expert possessed an instinctive understanding of the setting and has a rare capability to comprehend and perceive structures of scenarios (Benner, 1984).

Benner (1984) considered that the expert nurse did not rely on rules to solve problems and to make a decision used intuitive thinking. The intuitive thought was an understanding of a situation without justification. It was related to the tacit knowledge, which was the knowledge that professionals used but found it difficult to define. The actual meaning of intuition was the appreciation of impression gathered within previous exposures and the recognition of faint variations in clinical settings. Intuition was the

capacity of the nurse to comprehend the clinical situations immediately and to understand patterns (Tanner, 2006). Inferred expertise developed from participation in clinical settings, where actions was converted to instinctive actions devoid of deliberate awareness of the understanding and justification.

Benner and Tanner (1987) identified six key concepts that reflected intuitive judgment. The first one, pattern recognition was the capability to visualize and distinguish affiliations devoid of any preconception of any parts of the complete circumstance (Benner & Tanner, 1987). New nurses employed a methodical process to identify impressions, and with experience learned to become less aware of self and more of the situation as a whole. Second, similarity recognition was the ability to identify problems based on previous similar or dissimilar conditions. Third, common sense understanding was the capacity to see the subtle nuances of a situation. Common sense knowledge permitted the nurse to see the nuances of a novice nurse.

The fourth concept, skilled know-how was the decision-making ability based on embodied intelligence. One of the features of intuition was the ability to handle complex clinical circumstances. The fifth concept, sense of importance was the capability to identify events and observations that were important. An expert possessed an increased inclination to understand the link between important matters in the environment and methods of reacting to such situations (Benner, Tanner, & Chesla, 1996). Experts also developed a capability to establish what was significant for a specific patient in a particular situation. The last concept was deliberative rationality, which denoted the process to interpret viewpoint by considering more than the given situation and consider

the whole. According to Benner (1984), proficiency in nursing was established through clinical settings that were similar, and as the nurse progressed to the expert level of competency, and can identify the significance of circumstances precisely to a great extent (Benner, Tanner, & Chesla, 1997).

Phenomenology as the Philosophy and Method of the Study

To support the translation of evidence within nursing this study investigated aspects that had an effect on the implementation of evidence based nursing care in hospitals. The qualitative research approach was suitable as it supported the objectives of the study, which was to interpret the phenomena in context and to investigate experiences, perceptions and social elements that influenced a nurse (Davidsen, 2013; Matua & Van, 2015). The attempt was to utilize phenomenology to unearth the world of nurses as described and practiced by them. Phenomenology aimed at achieving an in-depth appreciation of the nature or implications of the life experiences of nurses involved in implementing evidence to practice (Heinonen, 2015a; Matua, 2015; Matua & Van, 2015; van Manen, 1990). Phenomenologists are concerned about personalities as fabricators of life meaning and study significant action than behavior. Phenomenology breakdowns an individual's experiences with a phenomenon to a story and recognizes the phenomena as an article of human experience (Matua, 2015). Thus the expressed experience was the starting point of a phenomenological study (Heinonen, 2015a).

Husserl (1977) was regarded as the originator of phenomenology. He introduced the notion of subjectiveness and life experiences, and the evaluation of a phenomenon must initiate from with the phenomenon (Cohen et al., 2011; Fjelland and Gjengedal,

1994). Husserl considered phenomenology as a supportive and expounding discipline in its full potential (Converse, 2012). Husserl assumed that human understanding is what human recognize and this cognizance had significance and should be studied scientifically (Lopez & Willis, 2004). For Husserl, a person leads life without any particular plan or belief. A phenomenologist strived to gain insight of the personal cognizance of a person to give meaning to the individual facet of life. For Husserl, phenomenology was a means of attaining a genuine understanding of a phenomenon by drilling deeper into the reality. Phenomenology was about the relationship between cognizance and knowledge of objects. Husserl aspired to produce a discipline of phenomena that described how entities were encountered and assumed by a person's cognizance (Heinonen, 2015a).

Following Husserl, Heidegger improved the phenomenological philosophy considerably and focused from epistemology to existential ontology. Heidegger (1985) called every individual's action as “in being" and according to him phenomenology is not easy, but it is more difficult (p. 161, p. 12). After Husserl and Heidegger, other philosophers such as Maurice Merleau-Ponty, Jean-Paul Sartre, Adaemo Giorgi, Hans-Georg Gadamer and Max van Manen, combined or improved the concepts and procedures of phenomenology (Langdridge, 2007). There are two types of phenomenology; the descriptive or transcendental phenomenology and the hermeneutic or constructivist or existential phenomenology. In descriptive phenomenology, the substance of understanding was correlated with how it was experienced. In a descriptive or transcendental phenomenology, the researcher could transform the phenomena and

implications being examined to yield a worldview of what was discovered and understood. To prevent bias in the understanding of the meanings of human experiences the researcher used “bracketing off” around the phenomenon to acquire the extracts (Heinonen, 2015a).

Heidegger’s theory was known as interpretive or hermeneutic phenomenology (Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013). Heidegger called his approach as hermeneutic since he identified his theory as more a method for exploring the meaning of experiences (Tuohy et al., 2013). Hermeneutic phenomenology was about living in the world life creating life themes and giving meaning to it through the hermeneutic circle (Tuohy et al., 2013). Human experiences were results that are influenced by culture, fashioning thoughts and actions in human lives and revealed through expressions (Tuohy et al., 2013). Therefore, the experience can only be illuminated as a statement of the lived experience of individuals.

van Manen’s Hermeneutic Phenomenology

According to van Manen (1990), hermeneutic phenomenology was a discipline that studied about human lives. He applied this methodology to school education and childrearing and considered that a hermeneutic phenomenological was mainly related to education, health, and nursing (Converse, 2012). Phenomenology as a human science was contemplative in its ways to bring the variety of implications of phenomena to consciousness (van Manen, 1997). van Manen (2003) highlighted that to make themselves known; human beings required understanding, consideration, and thinking. Human consciousness was critical, and that it was in the sphere of awareness that the

phenomenon was uncovered (Heinonen, 2015a; Matua & Van, 2015). The understanding was the unknown implications of daily life are the emphasis of hermeneutic phenomenology, or it was a theory and practice of interpretation (van Manen, 1997).

Conscience the Unit of analysis. The domain or the unit of analysis of hermeneutic phenomenology was the consciousness (Matua, 2015; Matua & Van, 2015). According to Valle, King, and Halling (1989), life experiences existed when human consciousness recognizes it, and in turn, consciousness existed when there were life experiences. So, life experience presented itself through consciousness (Matua, 2015; van Manen, 2003). The knowledge of motivation and basis was essential to comprehend the details of life world. Motivation or intentionality denoted the fact that cognizance was always focused concerning those activities additional other than self (Giorgi, 1997). Intentionality was a stage where the mind focused on the phenomena of study (Matua, 2015). Instinct was a feature of cognizance that brought phenomenon to the researcher (Matua, 2015). Intuition provided a general viewpoint, while experience related to a restricted observation.

Hermeneutic phenomenology assumed an inductive attitude and discovered the confirmation in descriptions. Discovering essence was a fundamental component of descriptive phenomenology (Matua & Van, 2015; van Manen, 2003). Phenomenology was a means of examining the spirit or significant implications of phenomena (Matua & Van, 2015). Thus the perspective of hermeneutic phenomenology was the belief in the importance and primacy of subjective consciousness and the understanding of consciousness as active. The researcher gained knowledge of the meaning and the

necessary organizations to consciousness through reflections (Cohen et al., 2011; Matua & Van, 2015). The essence and the reflections were required for the researcher to understand the phenomenon.

Hermeneutic phenomenology was the means of replicating the meaning of life experience of human beings (Matua, 2015; van Manen 2007). Reflection did the explanation for the essence of a phenomenon, but it was the explanation of the phenomenon as it evolved the awareness and the replication of lived experience was always about bringing to life; it was a reproduction of life experience that was already finished (van Manen, 2007). Thus, in hermeneutic phenomenology, the behavior was not observed in isolation, separated from the contexts in which these occurred. Essential elements of hermeneutic phenomenology were time, the participant's presence and relation to the domain around them. Heidegger (1997) described the essence of a phenomenon as "the way in which it remains through time as what it is" (p. 3).

Phenomenology as a method. van Manen (2007) stated that phenomenological approach enlightened, altered, converted, accomplished and pre-formulated the interactions between existence and exercise. Subjectivity implied that the researcher must to be sharp, insightful, and judging to expose the subject of study to its full bounty and gravity (Converse, 2012; van Manen, 2003). The core idea of phenomenology as a methodology was that it was not about objectivity, as is the case in the social sciences. According to van Manen (1990, 1997), there was no particular or established procedure to conduct phenomenology but suggested six steps for hermeneutic phenomenological research. The steps were:

1. Converting the understanding of lived experience in essence through articulating a research question (Matua & Van, 2015).
2. Examining the experience as it occurred or as the participant lived it through in-depth interviews (Davidsen, 2013).
3. Identifying the essential themes of the phenomenon through reflection, analysis and attempting to collect the necessary implication of the experience. According to van Manen (1997), “appearance and essence,” were different, that is, what was observed every day, and that which was hidden, but a phenomenological study helped to bring to attention (p. 31).
4. During the analysis, highlighting the phenomenon using the skill of documenting and reviewing. Within the development of recording, the aim was to bring to light the mindsets, contemplations, and outlooks of the participants. The phenomenological writing endeavored for accuracy and thoroughness by aspiring for interpretive explanations that replicate the actual richness and comprehensiveness of detail and investigated to the point of precision (van Manen, 1997). Specifically, the purpose of phenomenological scripting was to highlight the life experiences and enable the formation of an impression (van Manen, 2002). Phenomenological stories were extracted from the interviews to support the reader to locate the subjectivity of the experience (Converse, 2012; van Manen, 1989). The purpose of phenomenological documentation was to discover precise, and complete expression focused on

the phenomenon to bring to light the realistic fullness, revealing intensity, adequately actual application and intellectual rigor (van Manen, 1990).

5. The researcher must attempt to continue to focus on the research question to sustain robustness of the phenomenon. To ascertain a convincing relationship with the research question or phenomenon of study, the researcher cannot adopt an approach scientific objectiveness (van Manen, 1997).
6. Consistent matching to the research context by regularly reviewing the global design of the study and the implications each fragment bring into the textual construction (van Manen, 1997).

According to van Manen (1997), the researcher always moved between each of these steps even when they are sequential throughout the investigation. Researchers continually recorded in a diary an examination of their thoughts and appreciation of the phenomenon during the study (Converse, 2012; Davidsen, 2013; van Manen, 1990). This diary was a constant conversation between the outcome of the data collected through the interview and the perceptions of researchers on the phenomenon.

Data generation and analysis. The purpose of hermeneutic phenomenology was to produce a description of human experiences that are related to the background and the extent of the investigation. The data from the participants were collected using interviews, from reviewing written documents such as personal journals and through observations of participants against the background of their settings (Heinonen, 2015a; Davidsen, 2013). van Manen (1997) preferred personal interview as the best means of data collection. In hermeneutic phenomenology, the interview was to explore the

meaning of the experiences, and the researcher ensured that the understanding of the phenomena was the focus of the interview questions (Heinonen, 2015a). The contemplative interview records are required for examination such that the researcher can reveal and develop an explanation that reflected the interviewee's experience (van Manen 1997).

In the interpretive framework, the researcher's understanding of the phenomena was integrated into the data collection and data analysis and guided the knowledge of the phenomenon (Matua & Van, 2015). van Manen (1997) recommended three methods for separating themes during data analysis. The methods included a thorough review of the data by reading through, underlining significant findings in the data, and the reading the data comprehensively with a rounded approach. In the first method, the investigator reviewed statements separately or cluster of comments and checking what it revealed about the phenomenon. The second approach focused on accounts that most uncovered the phenomenon. In the third method, the rounded approach, van Manen (1997) suggested considering the writing in its entirety and identifying which significant expression revealed the essential meaning. These themes formed a framework that formed the basis for the phenomenological writing and explained the underlying meanings of the phenomenon. Overall recommendation was that the researcher maintained candidness, understanding, and appreciation (van Manen, 2011).

Summary and Transition

In this chapter, I presented the review of the literature on EBP in nursing and the emergent issues related to the history and concepts of EBP, barriers to implementation. A

comprehensive exploration of the literature revealed that there were limited research studies that directly addressed the lived experience of nurses implementing EBP. Identification of nurses lived experience of knowledge translation was expected to contribute further insights that influence the utilization of evidence derived through research. The collective nursing experience might add to the significance of translation and promote practice reforms, stimulating advances in the quality of nursing care. The study findings were envisaged to reveal information that may offer the prospects for dialogue and investigation of the current understanding, explanations, and measurement used to understand and develop an implementation of EBP.

Studies showed that even though practitioners expressed positive attitudes towards EBP, the application of research to practice did not necessarily follow through (Black et al., 2015; Hussein, & Hussein, 2013; Mohsen et al., 2016; Weng et al., 2013). Some factors that affected the translation of evidence included individual characteristics such as lack of interest and knowledge towards research. The organizational factors included the lack of access to research studies, a paucity of time, inadequate support and insufficient authority, and the complexity of the presentation of research articles (Heinonen, 2015a et al., 2015; Ubbink et al., 2013). The PARIHS framework (Kitson et al., 1998; Rycroft -Malone, 2004) consisting of evidence, context, and facilitation examined selected attributes of EBP. Organizational culture that support EBP and leadership support were needed to eliminate barriers and enhance EBP. The PARIHS framework focused on the intricacy of the change processes that take place when translating evidence. It was a valuable, concrete and theoretical structure that helped to

set the process of translation of EBP and had the prospective to be used as a convenient and practical tool at the point of implementation (Kitson, 2008).

The ability of the nurses to make decisions related to implementing evidence was reliant on the clinical expertise of the nurse (Canadian Nurses Association, 2015). The review of the literature identified that the capability to correlate research findings to decision-making in patient care and the willingness and inclination to improve current practice were crucial factors for knowledge translation. The overall appreciation of the circumstantial experiences advanced decision-making. Benner's novice to expert theory was a theory of skill acquisition provided focus on skills acquisition related to knowledge translation in nurses.

This phenomenological investigation aimed to understand the implication of the human understanding of the process of the implementation. Through phenomenological research, the intention was to reveal, illuminate and deduce the universal themes or significances of the phenomenon. An understanding of the implications of the perceptions of nurses provided details that have a crucial effect on nursing practice and health care outcomes. In Chapter 3, I will provide an in-depth consideration of the research design and will outline the research methodology and collection of data.

Chapter 3: Methodology

Introduction

In this phenomenological study, I aimed to reveal and interpret the lived experiences of nurses involved in implementing EBP in clinical settings (Matua, 2015). I attempted to describe and understand nurses' experiences regarding the complex phenomenon of implementing EBP in a hospital setting. In this chapter, I summarize the methodology and the procedures that I used to investigate elements in the clinical environment and the personal factors that facilitate implementation of evidence based knowledge by nurses. In Chapter 3, I present a comprehensive description of the study design, the selection methods for the participants, data collection, and data analysis methods. I also highlight the information regarding my position as the researcher and its effect on the research study. I describe the phenomenological attitude, the relevance of the methodology to the purpose of the study, participant information and ethical considerations.

EBP is a systematic adoption of solutions for patient care issues, which is identified through rigorous study, acknowledged by the expertise of clinician as well as patient acceptance. Research use by nurses is dependent on the nurses' capacity to examine the evidence, evaluate the benefits, assess the vigor, and acquire a confidence that support problem solving (Canada, 2016; Grimshaw et al., 2012). The ability of nurses to correlate research findings to decision-making in patient care, and the inclination to improve current practice were crucial factors for knowledge translation. The decision-making ability depended on the clinical expertise of the nurse and

understanding of the clinical situation, and other organizational factors that are crucial to the phenomenon of study. Thus, I used Benner's Novice to Expert theory and the PARIHS as a framework for this study.

Research Design and Rationale

I attempted to understand the complex phenomena of implementing of EBP, as well as the influence of personal values beliefs, social factors and the underlying reasons that support implementation (Heinonen, 2015a; Matua, 2015). The specific research questions of this study were as follows:

1. What are the personal experiences of nurses engaged in implementing EBP in hospital settings?
2. What factors in the nurses' personal values, competence and social systems influenced the decision-making and the practice of EBP in the clinical setting?

I used hermeneutic interpretative phenomenology to explore the nurses' lived experiences in specifying an understanding of nurses' actions and values from their viewpoint (Matua & Van, 2015). This methodology was suitable to the investigation of phenomenon relevant to the nurses because they experienced the change process in implementing EBP in the clinical environment along with their lived experiences. I explored of the participants' understandings of their lived experience, and how to recognize what was the personal outcome of the participants by interpreting their experience (Matua, 2015; Matua & Van, 2015).

In hermeneutic interpretative phenomenology, the investigator and participants communicate and the resultant evaluation provide conclusions (Matua & Van, 2015). The

personal impression was of great importance, as the researcher of the study, I actively involved in the participant's experience, and in their reality (Matua & Van, 2015). In this way, hermeneutic interpretative phenomenology illuminated the meaning of the phenomenon revealing knowledge previously obscured (Matua & Van, 2015). Nurses communicated their understanding of themselves and their experiences that helped to fashion meaning or value to these experiences (van Manen, 1990). The main aim was to elicit information about the influence of personal values, belief systems, the clinical reasoning skills, the competence of nurses involved in the translation of evidence as well as the social processes, barriers, and facilitators in the process.

In hermeneutic phenomenological research methodology, the researcher appraises the texts of transcripts and the articulated descriptions of personal experiences, and segregate themes (van Manen, 1997). The focus of the hermeneutic phenomenology was the understanding and the awareness of the implication of the texts, namely, the meaning of the expressions or words of the nurses against the background of the phenomena (Matua & Van, 2015). Hence, using hermeneutic phenomenology, I scrutinized the text to expose the substance to uncover crude expressive, meaningful, and thematic meaning (van Manen, 1997). Once I isolated the phenomenological themes, I constantly revised the writing while deciphering the meaning of the phenomenon or lived experiences.

Role of the Researcher

In a hermeneutic phenomenological study, the researcher will serve as the principal data compilation tool (Matua & Van, 2015). The researcher will move beyond their personal view of the meaning of the phenomenon of study, that is, being

transcendental (Matua, 2015; Matua & Van, 2015). In this study, I used two means to achieve epoch and truthfulness. Namely, I consciously moved beyond my personal biases or assumptions about the phenomenon by acknowledging my understanding of the phenomena (Tuohy et al., 2013). I accomplished the phenomenological reduction by bracketing my perspectives to reach a state of the epoch. Bracketing presumptions helped me to not reaching any hasty and personal conclusions (Heinonen, 2015a; Tuohy et al., 2013; van Manen, 1997). Specifically, I wrote short descriptions of my life experiences, which offered precise and essential background that led to the development of my understandings (Heinonen, 2015a; Matua, 2015; Tuohy et al., 2013). The detail of the account was an outcome of my contemplation of those areas from my experiences that laid the foundation to my understanding of the phenomenon. The emerged themes represent the fundamental of my prior understanding of the phenomenon and my involvement with the phenomenon (Converse, 2012; Davidsen, 2013; Tuohy et al., 2013). Thus, by bracketing my prejudices, I avoided justifying the meaning of the data that support personal deductions regarding the phenomenon (Tuohy et al., 2013).

In addition, the researcher can accomplish bracketing by engaging in discussion with an associate to examine their prejudices regarding the phenomenon (Heinonen, 2015a; Paltved & Musaeus, 2012). The researchers can also create an account of their experiences during the data collection to offer the experience that helped to form perceptions related to their experiences. Secondly, I continued to examine my knowledge of the phenomenon during the study by recording my understanding in a diary (Davidsen, 2013; Tuohy et al., 2013; van Manen, 1990). The log was the record of my perception of

the phenomenon during the study (Heinonen, 2015a; Davidsen, 2013; van Manen). The diary was a thoughtful conversation concerning the texts derived from the interview and the lived experiences of the researcher on the phenomenon. I have enclosed the product of my bracketing consideration in the next section as themes that have emerged.

Bracketing My Perspective

This section is an attempt to bracket my perspective of the phenomenon of study. The first section is a short description of my experience coming to understand and implement evidence to practice as a nurse in the varied roles that I have undertaken. Here I attempt to establish appropriate answers to some personal details about me, which will help to frame my background as the researcher. I reflect on my grasps of phenomenology, specifically, the concept of intentionality and gaining an appreciation of the spirit of the phenomenon that I connected with the purpose of my study. In the second section, I present a review of themes from my understanding based on the description of my prospect of the phenomenon. These themes represent the foundation of my prior understanding of the phenomenon based on my experience with the phenomenon.

Researcher's Context. EBP had become an important part of my career and academic interest for nearly 20 years. My experience in nursing and health care started over 20 years back when I graduated with a nursing degree and started my career at a young age. I had a deep-seated desire to serve others and give back to the society that compelled me to continue in the profession. This insight had shaped the way I think about my work, and I was determined to engage in activities that had a definite value and contributed to the wellbeing of others in meaningful ways. As a nurse at the bedside, my

focus was to provide care to patients in the best possible manner I could. I relied on what was taught to me in the nursing school as I made clinical decisions. As I started gaining experience, I realized that there are many other means of providing care to patients and that each patient is different. I started to advance my understanding of different situation and used different methods that I gained by observing my seniors, listening to conversations, performing, and confirming my actions. When my actions brought positive outcomes, those actions became my library of lessons learned and throughout these measures were refined, validated and fine-tuned.

At this point, I recognized that I needed to gain more understanding and I proceeded to complete my Masters in nursing study specializing in pediatric nursing. This opened a whole new world of what research is and how to conduct a research study. More importantly, I learned the importance of reading research and understanding, critiquing research studies, and evaluating the findings of the studies. As I progressed through different levels in nursing and health care, the complexity inherent in health care became clearer to me, and I realize that health care is a limited commodity. Many people globally do not have the privilege to access basic health care effectively and at the right time. Not conforming to what is currently available and finding new ways to improve health care was crucial. There was a need to translate research into practice. Further, I started questioning, “How can we improve our practices” and “how can research inform practice?” This led to my further involvement in the topic and to current research study “evidence translation.”

As I progressed through administrative positions in nursing, I got actively involved in implementing EBP at a larger scale, hospital wide. This included activities that involved meeting international standards where the standards are always derived from evidence and also making hospital wide change initiatives that are evidence-based. I designed, along with my colleagues and managers to develop EBP knowledge, skills and behaviors for nurses and actively involved in the methods to translate evidence to practice. Assuming the accountability for success of translation created in me a sense of fulfillment and an increased commitment to actively participate in such activities in a larger scale. Thus I got engaged in helping organizations to meet international standards as a Joint Commission International Consultant. This was a new experience as the role expanded and I involved by getting involved in setting standards globally and engage in activities with international organizations in their quest to improve quality and patient safety through meeting international standards.

Through my experience, other questions evolved such as, "Why is the translation of research to practice so difficult?" "Do all the health care providers have necessary skill to understand and translate evidence into their everyday practice? "What are the nurse's beliefs about EBP and do they practice EBP in daily clinical decisions?" Seeking to understand how nurses apply EBP represents a unique area of study and has the potential to inform practice.

Evidence translation is a skill required for all levels of nursing along with the ability to understand standards and how to bring to practice. I gained skills in evidence translation through practicing, observations, teaching, reading, sharing, leading and

reflecting on my experiences as a nurse. Through active reflecting and reading, I also recognized that EBP is the combination of best available research evidence, clinician expertise, and patient values for clinical decision-making (Sackett et al., 2000). I had the privilege to successfully engage in the translation of evidence. Nurses working in clinical setting come from different background and have differing experiences. All of them do not think alike or act alike and their educational preparations differ. Hence, in a clinical environment there are nurses with differing viewpoints, attitudes, and values. To be committed to translate evidence from research to care and thus provide the best possible options to patients differ considerably between nurses and healthcare providers.

I recognized that not all nurse are prepared to identify the appropriate evidence and translate it to practice. Not all nurses possessed the required knowledge and skill on research. Though there could be some facilities in the hospital for implementing evidence, there are no organized means to supporting the change process. When support is available at the patient care scenarios then the change is effective. Further when nurses are supported, appreciated and recognized, this created a sense of self-worth specifically at the beginning of the change. Administrators and leaders must step forward to support evidence translation. Following were the themes that represent the basis of my prior understanding of the phenomenon.

Personal commitment to best patient care. As a health care professional I was imbibed with knowledge that we are to be committed to provide best possible patient care. This commitment had consolidated over years as I engaged in daily activities of patient care. As my journey in my career progressed, my goals became clearer and

refined. My personal vision and mission started to evolve and merge with my professional goals. Patients are the basis of the work we do and there is a need to ensure that we did the best with limited resources. Especially, it was not about just delivering care but about ensuring that there is effectiveness, efficiency, reduction of cost, and improve patient safety. There was a need to commit to continuous personal and professional development and improve the manner in which we deliver care.

Self-reflection and competency development. Knowing and experiencing the importance of EBP to patient care changed my attitude towards the manner I practiced and related to patient care. The experience and understanding about the phenomenon created in me an inquisitive to know more and do more. As result I reflected regularly on my successes and failures. I sought ways to improve my knowledge and skill in identified areas that need improvement, reviewing and conducting research studies, and change management principles. My research on the phenomenon exposed me the work that has already been done in field. Theories, methodologies, tools and research outcomes provided me with the required insights. Through my professional development and networking I spent time reading research articles on evidence translation. I improved my skills in conducting literature reviews and critiquing research study that provided me the necessary knowledge and skill that support the translation of evidence. Consequently, I learnt to identify relevant and important questions in clinical setting that needed evidence-based answers, and the skill of translating research-based knowledge to standards, policies, protocols and guidelines.

This dissertation has provided me another important opportunity to learn another important skill, which is conducting a qualitative research. In addition, I constantly worked hard to improve my skills in data analysis, presentation of findings, communication skill, building interpersonal relationships, teaching and preparing curriculum for nurses, evaluating patient care against standards, and plan and develop projects to implement changes.

Engagement in change management. In this era of change and nothing is constant. There is a compelling need to change to meet the changing needs and problems. Change management is not easy and as professionals we must commit to engage in change initiatives, and preserve to improve patient care. Change must start with adequate planning and including stakeholders into change process from the beginning. There is a need to constantly support and guide those who are involved in the change and helping them through the process. Proper planning and implementation goes a long way in ensuring the effective implementation of change. The implementation activities include a constant evaluation of the process and problems that evolve with the change. As change is completed the effectiveness of the results are important to monitor over a period of time and sharing the success of what was gained.

Methodology

In phenomenological research, it is important to communicate the methodology, phenomena of study, and an explanation of the steps of the investigation (Heinonen, 2015a). This study used van Manen’s (1990) method for conducting phenomenological research. For van Manen, undertaking a phenomenological study was about searching for

the means by which a person experiences the world. In hermeneutic phenomenological work, the phenomenological writing was important as it help to meet the research goals and to create meaning in certain aspects of a nurses' lived experience, made coherent and comprehensible through reflections (van Manen). van Manen's method necessitated an obligation to transcribe the development of investigation and consideration. I used van Manen's phenomenological procedures for this study that includes:

1. Identify the nature of lived experience: I achieved this by conducting a literature review that oriented me to the phenomenon, helped me to formulate the research question, and to explicate my assumption and pre-understanding.
2. Conduct existential investigation: The outcome of literature review and data collection helped me to carry out the existential inquiry. My personal experience was the first step for research, which was followed by a continuous attitude to explicate etymological sources, idiomatic phrases, and experiential description from the subject and the literature. I was able to achieve this by bracketing my experience with this phenomenon and highlighted in the section "role of the researcher."
3. Phenomenological reflection: The next step to phenomenological reflection was conducting thematic analysis and determining existential themes. The literature review, coding, and interpreting the data helped me to achieve phenomenological reflection, which was further explained in the data analysis plan.

4. Phenomenological writing: The last step involved interpreting and describing the findings of the investigation. During this phase, as a researcher, I was particularly attentive to the certain languages or statement or feeling in the remarks in the subjects' responses, and then wrote and rewrote the interpretation of the data. In the current study phenomenological writing is reflected in Chapter 4.

Participant Selection

According to van Manen (1990), in phenomenology, the research subjects must have experiences with the phenomenon of study and represent the population. The population was the whole compilation of personalities who possess certain shared features as established principles, which is then used to select samples for the study (Davidsen, 2013). In this study, the population was nurses who had experience in implementing EBP practice in a hospital setting. This study used purposive sampling strategy (Converse, 2012) and snowballing technique to recruit participants. Purposeful sampling helped me to identify individuals who had the experiences of the details of the phenomenon of study (Converse, 2012).

In phenomenology, the intention of sample selection was not to establish validity but to ensure that a thorough and exhaustive appreciation of the phenomenon through the participants (Converse, 2012). In purposeful sampling, the rule for selection was decided ahead of extracting the sample. The snowballing technique was used to find participants, who had similar experiences in translating evidence irrespective of where the participant had the experience. The below three criteria guided the selection of the subjects:

- Participants were qualified nurses who were licensed to work as Registered Nurse and with varying ranges of experience and roles. By default, all participants had to have some degree of English proficiency to be employed as a nurse in UAE and so the data collection was in English.
- Participants were nurses working in a hospital setting.
- Participants had the opportunity to experience implementing EBP.

To ensure that potential participants were recruited voluntarily from hospitals, flyers (Appendix A) were posted around hospitals to recruit interested nurses who met the criteria to participate. The CEOs/Directors of Nursing of different hospitals in Dubai were approached to allow the display of the flyers (Appendix B) in locations where potential participants would see them and before the research began a Letter of Cooperation was sought (Appendix D). I sent emails to CEOs and directors of nursing explaining the study and the criteria for selecting participants. The flyers outlined the scope and purpose of the investigation and nurses who collected the flyers were requested to circulate them to other nurses who might be inclined to participate.

The sample size in a phenomenological study must meet certain criteria: adequate in numbers to understand the phenomenon and small in numbers to allow precise circumstantial consideration of the data (Converse, 2012; van Manen, 1990). The aim was to ensure that sample size helped accomplish both the intensity and the extensiveness of the phenomenon strengthened by the perception of the researcher (Converse, 2012). Matua (2015) explained that the purpose of qualitative research is to find equilibrium between the personal understandings from the experiences and the depiction of the life

experience of the participants. That is, the number of samples was not as significant as the need to capture the completeness and distinctness of the phenomenon accurately and sufficiently (Converse, 2012).

In my study, the sample size was dependent on three factors; the level of saturation, the homogeneity and variety of experiences (van Manan, 1990). The degree of saturation was significant in deciding the suitable sample size in a qualitative study. Saturation was considered to be the level of data during the collection of data where additional data is no more necessary to uncover the details of the phenomenon. In this dissertation, it was planned to include 10 to 15 participants who had experience in implementing EBP. I was able to meet the phenomenological principles including the saturation of data with 12 participants (Converse, 2012; Matua, 2015). Hence the participants of the current study were 12 nurses who had experience implementing evidence to practice.

Instrumentation

The principal aim of phenomenology is to bring to light the real perception of the participants (Matua, 2015). Data collection was derived from the description of experiences and the narratives that expressed the substance of the understanding that resulted in a thick description of nurse's experiences (van Manen, 1990). I conducted semi-structured interviews, as this would allow me to modify the questions to the understanding of the subjects regarding the topic of discussion.

Data Collection Instruments

Extensive interviews were considered to be the principal method of gathering data for a phenomenological study (Converse, 2012; Davidsen, 2013; Heinonen, 2015). According to Converse (2012), in a phenomenological research study, the person or investigator functions as the primary data collection apparatus. The human instrument need to remove biases and preconceived thoughts about the phenomenon to disconnect from the study and concentrate on data collection approaches (Converse, 2012). The key participant's interview was used to collect data that have distinct experience or insights of the phenomenon of study (Heinonen, 2015a). The research interview attempted to explain and discover applications of major subjects in the life and domain of the participants (Heinonen, 2015b). Interviews provided flexibility, helped to build trust, and established rapport to obtain information from the respondents (Converse, 2012; Davidsen, 2013; Heinonen, 2015a; and Heinonen, 2015b).

According to van Manen (1990, p. 101), “all phenomenological human research efforts are an exploration into the structure of the human life world, the lived world as experienced in everyday situations and relations.” Life reality encompasses of temporalities that effect experience or perception and includes lived time, corporeality, spatiality and relationality (van Manen, 1990). Lived time is the personal reflection of past and future experience and its influence on the present. Corporeality refers to one's physical body, spatiality relates to the surrounding environment, and relationality describes the relationship with others within one's personal space (van Manen).

The interview questions were prepared beforehand based on van Manen's four existential and was open-ended (Appendix G). Predetermined questions enabled standardization of the sequence of the questions and wording during the interview for all subjects (Converse, 2012). Uniform and open interview questions were more organized, efficient, and useful for reducing bias (Heinonen, 2015a). Further, this supported the participants to answer interview questions openly using their own words (Davidsen, 2013; Heinonen). Subject's response to open-ended questions allowed me to gather details of their personal opinions and values that defined the experiences of the participants. Further, the availability of predefined questions helped me cover topics that were necessary for the study. I recorded all interviews and then transcribed verbatim. I continuously wrote field notes during the interviews taking into account personal expressions and body language or other contributing factors (Matua, 2015). In the phenomenological method, the researcher collects not only the data but also becomes a companion functioning along with the subjects as co-investigators (Converse, 2012; Matua, 2015). The following were the open-ended questions used in the research:

1. What are your experiences of implementing the EBP in a clinical environment? (Temporality)
2. What is it like for you when deciding, planning and implementing EBP? (Corporeality).
3. What is it like for you when implementing EBP to care patients, interacting with other peers and other health care providers? (Corporeality, Spatiality, and Relationality).

4. What is it like for you when relating to others the experience of implementing EBP? (Relationality)

I used additional open-ended questions as a guide for interviews that was from my prior experience, pertinent literature and the aim of the study. The questions included:

- What are the facilitators and barriers that you faced while implementing EBP?
- How did you make the choices that you made about this experience?

Interpretative hermeneutic phenomenology supported the use of open-ended questions to allow the participants to provide response respond spontaneously to promote intensity and abundance in their expression of the phenomenon (Converse, 2012; Davidsen, 2013).

Data Collection Protocol

An interview protocol (Appendix F) guided the interview process (Matua, 2015). A single lead question was used to begin the interview as recommended by van Manen (1990). The principal question was:

How would you describe your experience to understand and implement the EBP in your clinical practice?

After this initial question the following important principles guided effective interviewing (van Manen, 1990):

1. Be patient and quiet as required, carefully listen and maintain a calm attitude to help the participants to uncover their experience.
2. Rehearse effective communication skills by carefully listening, clarifying and paraphrasing what was heard.

3. Focus on the principal research question; deliberate in what way the particulars of the participants' response will promote the achievement of the purpose of the study.
4. Clarify with participants the reasons they explained important concepts in the manner they did to gain more insights of the participant experience. These insights are crucial to reveal the rationale of the participants lived experience to expose the phenomenology (van Manen, 1990).

I used the hermeneutic circle in which the researcher moved between portion of the transcript and the complete transcript, to determine the reality by discerning the phenomena and understanding them (Heinonen, 2015a). The hermeneutic circle illustrated a demonstration of phenomenological reflection where by the understanding and explanation of data is gathered moving between the parts and the whole (Heinonen, 2015a).

Pilot Study

The pilot interview was conducted on two participants. The pilot study helped to ascertain the effectiveness of interview for data collection for the study, and to review the interview questions. I did not make any changes to the original interview questions following the pilot study because I was able to collect relevant the data using the planned interview questions (Converse, 2012). I followed the all steps for recruiting participants and for data collection as planned during the pilot study. Further, the pilot study provided me an opportunity as a researcher to rehearse the interview activity before formal research interviews and the efficiency of recording of the data. Similar to the research

interviews, I ensured that the privacy of all participants was maintained. In addition, all data collected during the pilot study was held confidential with the researcher.

Data Collection

The methods for data collection included semi-structured interviews that were conducted one to one on 12 participants. This was an attempt to explore the “human life world, the lived world as experienced in everyday situations and relations” (van Manen, 1990, p.101). This section describes the recruitment of participants for interviews, the consent process, the interviews, the assessment of data sufficiency, and the data management.

Recruitment and consent. After the flyers were displayed in various locations, as planned, the first two participants who volunteered to participate were identified as the pilot study participants. All nurses who volunteered including the pilot study participants were invited to participate in the study through an initial phone conversation if they meet the inclusion criteria (Appendix D). During the telephone call, the participants were given a short overview and general details of the study such that it helped participants make decisions regarding their willingness to participate in the study. All participants were also informed of the need to sign a consent form. During this call, I discussed with the participants to decide on the venue and date of interviews according to the participant’s convenience. I used this phone conversation to interact with the participants with an effort to build rapport and to make them comfortable.

To summarize, the following steps helped to ensure that the participants freely and voluntarily consented to participate in the study:

1. In this study, the principles and techniques of the Internal Review Board (IRB) were followed and informed consent was taken from the participants. The IRB approval was taken from Walden University, and the IRB approval number is 04-06-17-0236951.
2. The participants' recruitment was done through the display of flyers that attracted participants to volunteer.
3. The participants signed a voluntary consent form that highlighted the rights of the participants to depart from the study at any period and the reassurance of privacy.
4. All participants were given opportunity to clarify any queries regarding the details of study and were asked to review and sign the consent form before involving in the study.
5. Before interviews, rules of confidentiality were discussed with participants.
6. The interviews were conducted in different location away from the workplace of the participants to ensure their privacy and support comfort.
7. All audio records and the transcripts of the interviews were stored in folders in a password-protected computer. All transcripts were de-identified and all hardcopies were secured in a locked cupboard with access only to me during the study.
8. Fictitious labels or names were used in the analysis, story depiction, and elucidation of the data in the report.

9. The hard copy of the research description and publication of dissertation did not enclose the real name or whereabouts of the participants including any quotations.

Conducting interviews. The primary objective of the research was to gain a clear understanding of the participants' perception and experiences. With an attempt to get a rich explanation of the phenomena, I collected nurses' experiences and stories through in-depth semi-structured interviews. Interviews were conducted in private rooms so that there were no distractions during the interviews. All interviews were conducted from April 16, 2017 to June 4, 2017, and each of the interviews lasted for an average of one hour. All interviews took place in English, and I recorded all conversations and simultaneously collected memos of the interviews. During the interview session, I explained about the study details and the participants received and signed a consent form with information related to the research study. The information with the consent leaflet delineated the details of the study including the purpose of study, description of the research methodology, and the researcher's convenience and the contact details to clarify any doubts.

It was important to maintain rapport to encourage nurses to describe their experience. So I spent some time before the beginning of the interview and chatted with the nurses informally to make them comfortable. After building rapport, I started the interview with the predetermined lead question that was open-ended so that nurses were able to voice their experiences freely. During the interviews, nurses were encouraged to give examples of their experiences in implementing EBP. I offered clinical examples

from my practices to help the participants to recollect any experiences that were relevant to the phenomena. Some of these questions included “Have you had any experience implementing EBP where you had difficulty implementing the changes?”

Though all aspects of the predetermined questions were covered during the interview, it did not take place in any particular sequence. As the topic of the phenomenon evolved, the participants were prompted to talk specifically about that experience. This was done so that there was no disruption in the nurses’ thought process and to encourage them to express their experiences freely. Throughout the interview, when the nurse completed explaining a particular aspect of her experience, I rephrased the experience in my own words to ensure that I captured the essentials of what the nurse had expressed to me. Once the participant confirmed that my understanding was right, we moved on to the next topic. At the end of the interview, the participants were given time to add any relevant information that they wanted to discuss.

Throughout the interviews, I remained patient and allowed the participants to express freely their responses and develop into a conversation. However, as topic and responses become apparent, I restated the summary of the responses so that the participants could confirm if the information was gathered correctly. This also served another purpose, as the participants were able to reflect again on the response and also felt comfortable with me as the researcher. Figure 1 is an example of a portion of the conversation during the interview with the participant, Linda

Linda:	EBP is always good – for that we are working according to policy. We go through the evidence and putting it into practice. ... we are seeing that there are a lot of changes and differences to the patient care. ....
Researcher:	For you evidence means you find out what is the best from the literature and change it into policy. And then according to that policy...
Linda:	We are putting it into practice. Clinically we are going to the patient and doing exactly what is that practice.
Researcher:	And then you evaluate before and after whether you have achieved a difference or not. That is what you consider as EBP in your opinion.

Figure 1. Sample excerpt of interview with a participant, Linda.

Linda went on to explain how her experience was implementing EBP. From here we (researcher and Linda) were able to progress into in-depth details of the Linda's experiences. Such instances were significant as it led to further revealing expression and allowed Linda and me to associate and comprehend the description of the experience. Thus the interview proceeded through the process of active listening, probing, reaffirming, précising, endorsing and acknowledging what was being discussed.

Data sufficiency: Reaching data sufficiency is a significant and crucial decision in phenomenology. It is, in fact, a personal conclusion. Data sufficiency is decided when a researcher is able to determine that enough data had been collected and there were no more additional findings compared with the objectives of the research. Thus the number

of participants was decided grounded on number necessary to enlighten all the crucial details of the phenomenon of study completely (Sargeant, 2012).

I started the data collection with 10 to 15 participants in mind. As I approached the 10th participants, I realized that no new themes were evolving and so no new codes. The current research required a significant review of the participants' experience, and so I continued data collection to ensure that I was sure of the data saturation. As suggested by Sargeant (2012) and O'Reilly & Parker (2012), the point when no new concepts evolved during the interviews, I considered this as a point of saturation or data sufficiency. Thus, when I reached 12 interviews, I was certain that I had reached the point when data saturation had occurred.

In addition, to ensure that accurate and adequate data was collected, I initiated the analysis of the data as soon as the first data was collected. The interviews were transcribed and read to identify themes. The member checking during the interviews further strengthened the fact that accurate data was collected from the participants of the study. Further, throughout the data collection and data analysis, I was conscious to ensure that the information was both "rich" in regard to character and "thick" in terms of the amount (Burmeister & Aitken, 2012; Fusch & Ness, 2015).

Data management. During the data collection, I did double recording strategy to make sure that no data was lost; one recording was in the personal computer and the second by an audio recording in a mobile phone. The recording devices were placed such that the both data from the researcher and the participant were collected. Immediately following the interviews, the audio recording was stored in a folder on the laptop and

then uploaded on to the NVivo 11 software (QSR International). NVivo 11 program is a software used for uploading data and organize themes into different components to understand the meaning of the statement to support qualitative analysis. A copy of the audio recording was also secured in a cloud service called Dropbox. All electronic data were kept secured in folders that were password protected computer. Electronic records both in Dropbox and on the computer hard drive were saved in a password protected folder. All audio records were transcribed verbatim and the soft copies of the transcripts were also stored in three different places; one copy on the computer, one in the NVivo 11 program and another copy in the Dropbox. The hard copies of transcripts and other details such as consent forms were kept in a locked cupboard in the researcher's home.

The interviews were transcribed within 48 hours after the interviews, which resulted in a total of 199 pages. All the participants were assigned pseudonyms to protect their confidentiality. The actual names and the pseudonyms were recorded in an excel sheet which was stored in the in protected folders in the computer. Interviews continued, as the previous interview was being transcribed and analyzed. The total number of words, total transcription pages and interview durations are outlined in Table 1.

Ethics

IRB approval for this study was requested and approved from Walden University's Institutional Review Board on the April 6, 2017 (approval number 04-06-17-0236951.). I took the following measures to make sure that participants' freely and voluntarily consent and participate in the study.

Table 1

Details of Interview Transcripts

SN	Participant names (pseudonyms)	Interview duration (minutes)	Transcription word count	Transcription total page
1	Jodi	44	6,739	19
2	Jill	38	4,819	12
3	Cindy	46	3,869	11
4	Cathy	41	4,328	13
5	Nora	66	4,327	13
6	Ashlie	55	4,513	14
7	Jackie	66	7,036	26
8	Kim	62	6,374	25
9	Eva	37	5,740	16
10	Linda	68	4,400	15
11	Shine	55	4,986	15
12	Val	54	5,471	20
	Total	632 minutes	62,602 words	199 pages
	Average	53 minutes	5,217 words	17 pages

- All participants were given an information sheet with details of this research before the study.
- In addition, sufficient time was provided to all interested participants to clarify any doubts with regard to the study.
- A voluntary consent form was made available to all participants with detailed explanation of the study and explained to the participants before the consent was sought.

- All participants were informed of their rights to leave the study whenever they wish to and were assured of complete privacy.
- The interview transcripts were given pseudonym to de-identify them.
- All audio recording and the transcripts were saved on a folder in a password-protected computer. The hardcopies of transcripts was saved in a cupboard, which could be accessed only by me.

Data Analysis Plan

The process of analysis took place throughout the study. The analysis of data started when the interviews were in progress, during the transcriptions and following the transcriptions through reading, rereading, writing, rewriting, and elucidation of transcripts (Davidsen, 2013). Participants who met the inclusion criteria and volunteered for the study were included in the study (Creswell, 2013; Finlay, 2013). Data analysis for qualitative research was founded on constructing the collected data into the comprehensible material (Emmel, 2013). During the interviews, I frequently checked with the participants to ensure that accurate description of the participant experience was captured, which is known as member checking. During the member checking the participants had the opportunity to acknowledge or change the details recorded (van Manen, 1990).

Transcription of data. The audio recording of interviews was transcribed immediately within 48 hours following the interviews. After the interviews were converted to text, the texts were analyzed for any inaccuracies by comparing the audio recording and the writing. After transcription, the audiotapes were stored for

confidentiality of the participants. After transcription, the data was imported into the NVivo 11 software.

Developing themes. The first reading of the data took place during the initial transcription of the interviews. Through thorough and detailed reviews of the data, I was able to identify the themes (Harper, 2015). van Manen (1990) called this as segregating thematic accounts, which created an opportunity for the researcher to retain the emerged themes. Three methods to the identification of the themes of a phenomenon was highlighted by van Manen:

1. a holistic or general approach,
2. a discriminatory or emphasizing approach, and
3. a thorough or sentence by sentence plan.

The holistic method is used to review the complete manuscript in its entirety and evaluating the text to find meaning. The discriminatory approach is about choosing or highlighting words, phrases, and sentences that seem as important element to the experience. In a detailed approach, the researcher reviews every statement or a group of declarations examining what it uncovers about the phenomena of study.

I reviewed the written data to understand the descriptions of nurses regarding time, body, space and human relations as experienced by the nurses when implementing the evidence to practice (Matua, 2015; Tuohy et al., 2013). According to van Manan (1990), the themes that emerged are explored within the four existential; that is spatiality (personal space), corporeality (personal body), temporality (personal time) and relationality or communality (personal human relation). Specifically, the analysis of the

data took into consideration the nurse's expression of the phenomena in terms of the lived space, personal time, body personification, and interpersonal relationship; and their experience of the phenomena (Tuohy et al.; van Manen). During all readings, I wrote a journal that highlighted the interview process and the themes that emerged from the data. Substantial accounts of the participants' transcripts were recognized and categorized under thematic headings and coded. The current process of coding or sectioning offered more transparency of the data.

Interpretation took place through reading and re-reading participants' relevant comments, reviewing the literature, studying and reorganizing the sequence of the topics to seize the understanding of the experiences as appreciated and perceived by each participant. Codes or themes were structured based on circumstances and significance. Essentially, all themes were generated with value, significance, and rationality centered on research questions (Emmel, 2013). Creating language alterations permitted the investigator to understand and decipher the data using the transcribing logs and passages (van Manen). van Manen called the act of reviewing the thematic explanation as for the grasp of phenomenological description.

Issues of Trustworthiness

Accurate representation of findings was fundamental to qualitative research as the researcher will be involved in every phase of the investigation procedure; research strategizing, interviewing, transcribing the data, data analysis, and preparing the findings of the study (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). To accurately represent the conclusion of the study there was a need to ensure that trustworthiness or

credibility, reviewability or auditability, and fittingness or appropriateness (LoBiondo-Wood & Haber, 2013). Trustworthiness or credibility is the acknowledgment of the actuality of the conclusions by subjects and experts in the field (LoBiondo-Wood & Haber, 2013). Validating of the data was established through the perceptions of the participants, who confirmed the existence of the phenomenon in their experience. Methods for ensuring credibility in this study was achieved through the following methods (Fridman & Frederickson, 2014):

1. I recorded and wrote a dialectic journal that complemented the interviews during the interviews.
2. Analyzed the data by repeatedly paying attention and listening to the tapes, by appraising and frequently reviewing the texts, and by documenting and examining the data until fullness or completeness was reached.
3. Checked with nurses who participated in the study to confirm the findings of the study.

Reviewability or Auditability offers for technical thoroughness, responsibility, and consistency. I maintained an audit trail that helped me to track the development of the research study from start to end (Palinkas et al., 2015). Audit trails during the study allowed me to conserve the veracity, validity, and reliability of the data (Emmel, 2013). All information regarding the hard copies of data, audio materials, the field notes and the journals, and the methods used for capturing the data were included in the audit trail (Creswell, 2013; Emmel, 2013). This facilitated to maintain a clear track of how I progressed throughout the study as well as aid in providing the justification and the

interpretation of the data (Emmel, 2013). Other researchers and committee members also reviewed the study. The description of the finding was clearly outlined such that the reader can almost literally visualize or understand the exact meaning of the data (LoBiondo-Wood & Haber, 2013). According to van Manen (1990), this is the "phenomenological nod" from the readers when they can identify with the experience of the participants (p. 27).

Summary

The goal of this study was to reveal the nature of the change nurses experienced and the associated influence of personal values, beliefs, and the social processes in implementing EBP. The nature of participants' experience revealed the association nurses created from their experience and understanding while implementing EBP. Through the process of hermeneutic phenomenology, I intended to analyze the phenomenon and understand how an individual nurse experiences the change process and how this influences the enactment of current role at the bedside.

This chapter portrayed the theoretical and chronological foundations of hermeneutic phenomenology and its importance to the participants in the study. It summarized the research design, the role of the researcher, methodology, data collection, dealing with ethical concerns and the data analysis. The primary goal was to specify how the collective nursing experience would be collected. Further, the effort in this chapter was also to highlight how any issues with trustworthiness and data collection were dealt with. Overall the finding may provide information that may support the process of evidence translation, promote practice reforms, and advances in the quality of nursing

care. Chapter 4 outlines the overall results of the study and will further discuss the research setting, demographics of the participants, and the methods of collecting data. The chapter concludes with an analysis of the data and description of the developed themes.

Chapter 4: Analysis

Introduction

The purpose of my study was to explore evidence translation among nurses using hermeneutic phenomenology. The research questions of this study were as follows:

1. What are the personal experiences of nurses engaged in implementing EBP in hospital settings?
2. What factors in the nurses' personal values, competence and social systems influenced the decision-making and the practice of EBP in the clinical setting?

This chapter includes objectives of the study, findings of the pilot study, settings of data collection, demographic details of the participants, details of data collection, and data analysis. In the following section, I is the presentation of the results of the study as themes derived from the personal experiences of 12 nurses who were involved in translation of evidence into practice. Then, I highlight, the core essence of the study is highlighted as a result of the existential investigation and phenomenological reflection.

My overall aim in this phenomenological study was to reveal and interpret the nurses' lived experiences of the complex phenomenon of implementing EBP in a hospital setting. I used the following open-ended questions were used in the research:

- What are your experiences of applying the EBP into clinical practice? (temporality)
- What is it like for you when deciding, planning and implementing EBP? (corporeality)

- What is it like for you when implementing EBP to care, patients, interacting with other peers and other health care providers? (corporeality, spatiality, and relationality)
- What is it like for you when relating to others the experience of implementing EBP? (relationality)

I followed the stories of the participants to gain understanding of the phenomenon as themes and dimensions emerged that transcended their experiences. Common themes that evolved from the participant stories created a whole that described the aspects of the phenomena and answered the following question: how would you characterize your experience to understand and implement the EBP in your clinical practice?

Pilot Study

The pilot study consisted of interviews of two participants. The results of the pilot study were crucial because they helped to ascertain the effectiveness of the interview questions. I did not modify the interview questions following the pilot study. The results of the pilot study also helped to me gain confidence and a clear understanding as a researcher to carry out other interviews. Similar to the participants of the study, I ensured that the privacy of pilot study participants and all details of the pilot study were held confidential throughout the study.

Setting

Once a participant showed interest to participate, I finalized the venue for the interview according to the convenience of the participants. I conducted all interviews in private rooms either in participants' homes or in a library, to avoid interruptions and to

clearly record the interviews. Almost all interviews lasted for an average of one hour. Before all interviews, I spent time with the participants to build rapport and to make the subjects comfortable. Before signing the consent form, I provided adequate opportunity for the participants to clarify all doubts. I recorded all interviews in two audio recording devices so that no information was lost in the recording; one audio recorder was placed close to the participant and the other close to the researcher.

Demographics

In this section, I focus on the background information of the participants. All participants involved in the study were nurses employed at various levels and roles in the nursing departments of hospitals. The total number of participants for the study was 12, and all were female nurses from ages 34 to 58 years. I have assigned pseudonyms to all participants to protect their confidentiality (Table 2). Of the 12 nurses, three (25%) participants had diplomas in nursing degrees, four (33.3%) nurses had a bachelor of nursing degrees, and five (41.7%) of the nurses had a masters degree (Table 3). All participants were full time employed and had experience in implementing EBP. Of the 12 participants, four (33.3%) were staff nurses; two (16.7%) were staff nurses and team leads, three (25%) alternate in-charges, two (16.7%) were charge nurses, and one was a nurse manager (Table 3).

With regard to the number of years of experience of the participants, five of 12 (41.7%) participants had a range of 11 to 20 years of experience, and four (33.3%) nurses in the range of 21 to 30 years of experience (Table 3). Furthermore, as reported by

participants, nine (75%) of 12 participants had more than 5 years of experience involved in implementing EBP.

Table 2

Pseudonyms of the Participants

Participants	Pseudonyms
Participant 1	Jodi
Participant 2	Jill
Participant 3	Cindy
Participant 4	Cathy
Participant 5	Nora
Participant 6	Ashlie
Participant 7	Jackie
Participant 8	Kim
Participant 9	Eva
Participant 10	Linda
Participant 11	Shine
Participant 12	Val

Table 3

Demographic Details of the Participants

Variables	*n*
Education level	
Diploma in nursing	3
Bachelor degree in nursing	4
Master degree	5
Current position	
Staff nurse	4
Staff nurse and team lead	2
Alternate in-charge nurse	3
Charge nurse	2
Nurses manager	1
Nursing experience (years)	
0 to 10	1
11 to 20	5
21 to 30	4
31 to 40	2
Experience in evidence translation (years)	
0 to 5	3
6 to 10	5
11 to 15	2
16 to 20	2

Data Collection

The steps of the phenomenological methodology include identifying the nature of lived experience through the literature review of the phenomenon; conducting an

existential investigation through data collection and bracketing of researcher's knowledge; phenomenological reflection and phenomenological writing (van Manen, 1990). One means of performing the second step is data collection and bracketing my experiences (van Manen). The data collection took place from April 16, 2017 to June 4, 2017 for the 12 participants who volunteered to participate in the study. The participants of the study were recruited by displaying flyers in hospitals and through snowballing technique. Nurses who volunteered to contribute in the study were invited to participate in the study through an initial phone conversation to check if they met the inclusion criteria. The data collection was done through semi-structured in-depth interviews. Semi structured interviews helped enhance the participation of the nurses and to clarify their doubts, thus helping to uncover the participants' philosophies and thoughts.

After spending time to build rapport and make participants comfortable, the interviews began with an open-ended predetermined lead question for the participants to talk about their perceptions of EBP. As the topic of the phenomenon evolved, the participants were prompted to talk specifically about certain experiences. Perceptions are the results of experience with the phenomenon, which could subsequently affect behavior. Hence participants were encouraged to discuss their experience of implementation in hospitals and to reflect on their actual practice.

In line with a semi-structured approach, the contents of the interviews were in no particular sequence. When a particular topic was not addressed spontaneously, I prompted participants to address it. Throughout the interviews, I rephrased the contents of the thoughts that the nurses shared with me so that I could confirm the accuracy of the

content. I used communication techniques such as open-ended questions, rephrasing, summarizing and probing as a means to capture issues in greater depth. At the end of all interviews, I provided each participant the opportunity to add to any additional thoughts or views. I transcribed the audiotaped interviews within 48 hours for thematic analysis.

Throughout the process of interviewing, I kept two reflective research journals: a personal log or a reflective journal, and an analytical record or a bracketing log. The personal log was used to record, on a daily basis, the field notes of my experiences and reflections on the study. The recorded notes were written during and directly after each interview. I specifically allocated time to record these notes when the interview was fresh in my mind. I recorded general notes, the setting and the context of each interview, notes on the participants' appearance and nonverbal communication during the interactions, noteworthy points of the interview, my impressions of how the interview progressed as well as the preliminary interpretations of the data. I maintained a log of the theoretical, and other important methodological activities throughout the interviews and during the analysis phase.

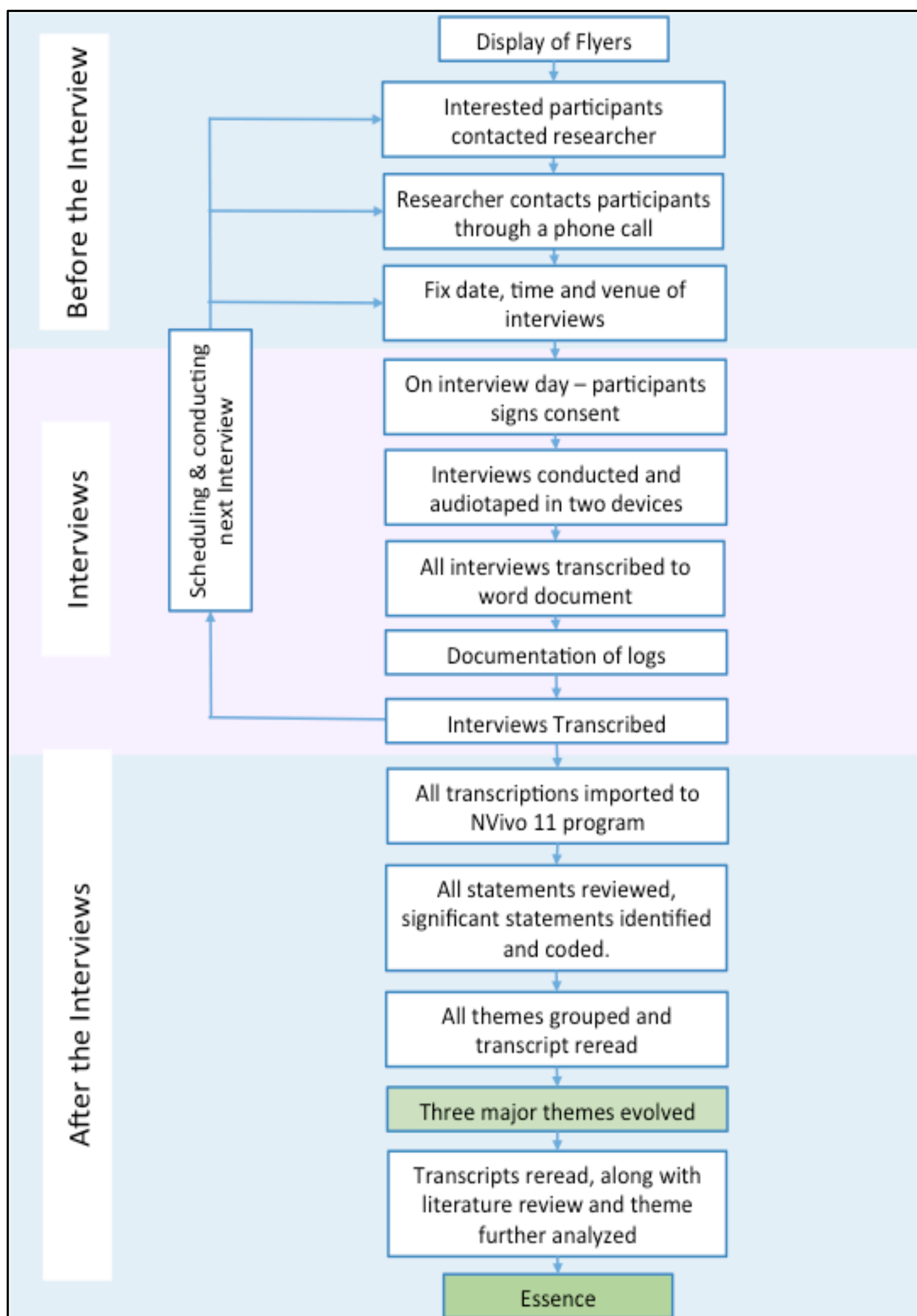

Figure 2. Steps of data analysis

Data Analysis

The interviews were transcribed immediately and completed within 48 hours after the interviews. Next, all transcripts were uploaded to NVivo 11 software, and all analyses were carried out in NVivo 11 program. The analysis of data was conducted after the transcription by reading, reviewing, writing, rewriting and elucidation. The interviews continued with the ongoing transcription and data analysis of earlier interviews creating a continuous process (Figure 2). Thus, the data analysis process included phenomenological reflection and phenomenological writing, the third and fourth step recommended by van Manen (1990). This method allowed uncovering the nature of the nurses' experiences.

Phenomenological Reflections

I conducted thematic analysis to determine the existential themes. In fact, the phenomenological reflection along with phenomenological writing started with data collection. The interpretation and descriptions of the findings evolved as the themes emerged from the analysis, and from the logs that included the languages and feeling in the responses of the participants.

Conducting thematic analysis. The thematic analysis involved three methods that were highlighted by van Manen (1990), which includes holistic, discriminatory approach, and a thorough or sentence-by-sentence analysis. First, all transcripts were interpreted as a whole in its entirety to gain a holistic understanding. Then, I used the discriminatory approach to review all transcripts and highlighted texts, expressions, and judgments that gave meaning to the phenomenon of study. Thirdly, I again read the

transcript line-by-line concentrating on the connotations hidden in the text. To understand the expressions of the participants, the interviews were coded under the four existential; lived space or spatiality, lived body or corporeality, lived time or temporality, lived human relation or relationality (van Manen, 1990). That is, I recognized important responses from the transcripts of the participants and classified under thematic headings, the four essentials.

After I completed coding of all the participants' transcripts, 48 themes were coded, citing the participants' important accounts that emerged from the analysis. Subsequently, I analyzed the 48 codes and identified relationships between the codes using my understanding that I derived from the literature review and grouped the themes. The clustering resulted in 25 thematic clusters that incorporated thematic headings and sub headings. Accordingly, I marked representative themes, prepared syntactical conversions and gathered thematic portrayals from the data (van Manen, 1990).

In the next step, I interpreted the data by reviewing all transcripts again, now using the themes that evolved as headings and reassembling participants significant narrations listed under these thematic headings (Table 4). Interpretation of the findings was undertaken by reading, reviewing, writing, rewriting and elucidating the meanings, then going back to the literature, reflecting and reordering of the themes to capture the essence of the experiences of the participants.

Table 4

Themes Identified and Sample Quotes

Themes	Sample Quotes from Participant Transcripts
Meaning of EBP	EBP always scientific. It is the practice, which is according to the scientific way or results. It is about putting into practice, day to day, because nursing is a daily practice and daily seeing the improvement of the patient.
Attitude towards EBP	It was my personal commitment to gain and impart it (knowledge) to my junior. ...we need to go for it (EBP) because it is with evidence - we get the best practice. The organizations also must believe in EBP. If they don't believe, I do not think they would even cascade it down.
Personal Experience	I don't call it a struggle it was a challenge to implement because the people are basically resistant to change. Change is not easy but after the changes in the unit we feel that they are more empowered.
Empowerment	It has really impacted a lot because it improves my skills and it gives me a guide of how to be more, like, what we call it, it gives me the confidence for my practice. The way I'm giving nursing care or management to my patient, it improves a lot as well. We mainly feel empowered as if I am great nurse and that I am not as simple nurse. I am really doing something great.

Identification of emergent themes. van Manen (1990) specified that the motivation to "isolating thematic statements" was to enable the researcher to "hold on to"

the emerging themes (p. 93). As suggested by van Manen, I did “linguistic transformations” to enable me to understand and decipher the data by recording notes, logs, reading, reviewing and going back to the literature (p. 95). Once all transcripts were coded, I compared all codes across all participants in the NVivo 11 program. During the comparison, I made a note of similar associations and combined them, maintaining each participant’s significant phrases. The emerged interpretations unique to one participant were additionally added to this file, and those that were similar were merged, creating the first list of themes through comparison. These topics were typically much shorter phrases that captured the meaning of the participants’ comments in a few words. In naming themes, I attempted to capture the essence of the participants’ meaning, on both in the semantic level and interpretive level.

Themes were separated from each other by examining the context of the participants' story, and how participants phrased what they expressed. Thus an iterative process emerged with naming themes, moving back and forth from my words to participant words and from individual participants to all participants’ voices. This was the phenomenological depiction using certain story representing the essence of the phenomenon of study with the spirit of faithfulness and truthfulness (van Manen, 1990). The 25 thematic groups were restructured again illuminating the three broad themes (Figure 3). I engaged in the process of imaginative variation to explore all possible meanings of a theme. This part of the process clarified my thinking about some of the themes, so I was sure that the theme was something unique to the experience of nurses who were involved in the translation of evidence.

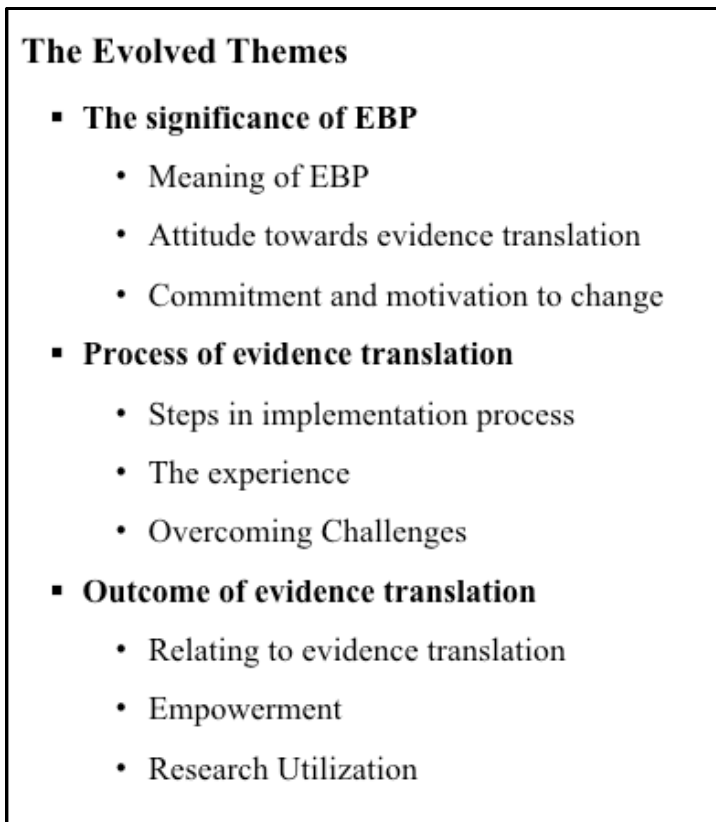

Figure 3. Themes from data analysis

Interpreting Lived Experiences

As themes emerged, I started the writing with the help of personal logs and reflective notes. The description painted a concentrated, coordinated presentation of the participants' lived experiences. To promote the analysis, I first conceived a summary using the narrative circumstances of each participant. Next, I described the experience that helped me to realize the essence of participants' experiences. The emerged themes I wrote down on paper to understand and connect ideas and themes that was similar and combined it. Here I started to write down the interpretation and included quotes that made the story clear. To include the quotes, I questioned myself, "is this necessary to

conserve the essence of this person's experience?" Thus, the data were reduced to the substance of each participant's experience with the phenomenon and the accurate quotations were incorporated to fashion and back the interpretation.

Once I created the preliminary script of the interpretation the principles of horizontalization was used to advance essential themes. According to van Manen (1990), the themes are the limits or horizons or visions of the phenomenon believed by the participants. Following the identification of the initial descriptions of the themes, I prepared the conclusive themes by describing the themes in words with an intention of highlighting the participants' understandings. This allowed me to reflectively present the finding in a manner that it engaged the readers' self-examination with the phenomenon (van Manen, 1990). The whole process was insightful and I attempted to gain perspective of the features of the phenomenon. When more themes emerged I compared it with the original themes and combined them with the help of the findings of the literature review.

Evidence of Trustworthiness

The study used the qualitative phenomenological research design as it better suited the purpose of the research study. The data collection occurred through semi-structured interviews to allow greater consideration into the lived experiences of the participants. The validity of the data was established through the perceptions of the participants, who confirmed the existence of the phenomenon in their experience. Credibility was achieved through documenting dialectic logs that complemented the interviews, analyzed the data repeatedly paying attention to the texts and member checking with the participants.

I maintained an audit trail that tracked the development of the research study from start to end. All hard copies of data, audio materials, the field notes and the journals, and the methods were included in the audit trail (Emmel, 2013). The report of the findings outlined the steps of data collection, management, and analysis such that the reader can understand the exact meaning of the data (LoBiondo- Wood & Haber, 2013). According to van Manen (1990), this is the "phenomenological nod" from the readers when they can identify with the experience of the participants (p. 27).

Results

The fundamental themes were illuminated from the text of the 12 participants in the research study. That is, the themes in this study were the expressive parts of the participants' experience that portrayed the understanding as a whole. The careful evaluation of the themes that emerged from the participant stories helped to understand the nurses' experiences regarding the phenomenon. The patterns or themes that developed from the thematic analysis were combined and cataloged together to give further meaning. The resultant meaning was the "aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is" (van Manen, 1990, p. 107). The following three themes emerged and discussed in the details:

1. The significance of EBP,
2. Process of evidence translation
3. Outcome of evidence translation

Theme 1: Significance of EBP

The first theme that emerged from the interview data was the belief that the participants had with regard to EBP and what it means to them. All participants expressed positive statements about EBP and considered EBP important to patient care. Overall three main subthemes evolved from the transcripts, the meaning of EBP, the attitude towards EBP and the commitment and motivation to implement EBP.

Meaning of EBP. During the interviews, all the participants were keen to express their understanding of the concept EBP. This was important as this provided an insight of how nurses in the study defined EBP. Some of the shared understanding of the participants with regard to the meaning of EBP was that EBP helped to standardize and organize patient care, improved patient outcomes and patient safety, enhanced the confidence and commitment of nurses, and promoted the expertise of the nurses as it was based on scientific evidence. Three participants of 12 included all four terms in their definition for EBP. In addition, participants expressed that EBP is derived through a review of literature and was the outcome of rigorous scientific research. Linda described EBP as bringing about "a lot of changes and differences to the patient care" and "EBP is always scientific." She defined that "the practice (EBP) is according to scientific ways or results. It (EBP) is always put into practice day to day because nursing is a daily practice and daily we want to see the improvement to patient." She further added:

> It (EBP) really improves your self-confidence. I am motivated and satisfied that we are up to date and up to the level. It (EBP) helps to provide same care to all patients also - patient come from there to here (from other countries) or here to

there (to other countries) also that gives satisfaction to the patient and the confidence to come to us.

Jill emphasized the need for the nurses to go through "journals, abstracts and nurses should increase their knowledge." Cindy was a nurse manager who was very keen and passionate to explain what EBP meant to her. Her responses were specific and highlighted the importance of reviewing the literature to identify evidence and the need to ensure that the evidence was patient focused and outcome oriented. She explained that:

> We were able to change the practice with, of course showing lot of studies, lot of evidences, and lot of people who have used this before. …. When you show all the evidences and why you want to do this and then you have a justification or a reason for implementing this. .. if the changes are for patients, the core of our job is our patients and when patients are getting benefited, everybody started to think on that ground and that's how it (evidence translation) started to happen…

Some participants highlighted that evidence need to be translated to practice. Cindy considered that EBP is knowledge that need to be translated to practice and explained that:

> To choose an evidence-based practice, it is again knowledge. In the clinical setting, I definitely believe that knowledge is the key; this is very important what I have gone through over the period of time in my experience.

Nora explained that evidence is derived from research and needed to be integrated into practice. She said EBP helped to update nurses' knowledge and considered knowledge is power. She explained:

> You have the knowledge from the research and that you have to integrate to clinical expertise and review how it can improve the patient care and how it can improve the outcome of the patient care. It (EBP) has to be there in order to be updated ourselves and the clinical care, in order to - we have to be updated in order to bring the change. …It (EBP) is a really a fantastic approach that could redesign the care that we render to patients. I feel knowledge is power but if we keep the knowledge in the store and nothing is done into the clinical practice then it is a waste of time and energy and everything - if we can use that knowledge into practice it is a bliss to all.

Other participants expressed their understanding about EBP in terms of patient outcome, staff development, patient safety, patient outcomes, and confidence. Cathy, an in-charge nurse, highlighted that as the in-charge of her unit she is keen that all nurses followed standardized care and that implementing EBP helped her with this. Jodi explained that "EBP make your work more organized and more systematic, yeah more systematic." Shine highlighted that "EBP is when there is a result and the result is obvious and improves patient safety… by practicing it basically it will promote patient safety by improving patient care." For Val, "EBP is how you implement a procedure about your patient - e.g. bedsore, changing a patient's position. It is a collective way of doing… First of all they (nurse) should have an understanding of why they are doing it (patient care)." Cathy explained that she is more interested to know that all patients are receiving the same standards of care.

Comparing this to the PARIHS framework, the first element evidence, included three sub-elements; research, clinical experience and patient preferences/experience (Gozdzik, 2013; Kitson et al., 1998; Rycroft-Malone et al.). In the PARIHS framework, the evidence is defined as the knowledge generated by meticulous and methodical examination; the judgment of the clinician; and the preferences of the patient (Shifaza et al., 2014; Stevens, 2013). According to Melnyk et al. (2014), EBP is a continuous process to find solutions to problems in patient care or clinical settings using scientific research, matched with patients' inclinations and beliefs, and confirmed through clinicians' expertise. In the description of the meaning of EBP, though participants had a general understanding of EBP but it was not precise to research based definitions of EBP. The explanation of participants showed that they considered EBP outcome of could be research and there is a need to do a literature review to understand if the evidence could be applied to current practice. However, the participants' definition about evidence did not include the need for acceptance of the evidence by experts and taking into consideration of patient's preferences.

Some of the participants expressed that there was need to review the literature to convince the doctors and the leaders the need for the change, but there was no clarity as to the necessity of the acknowledgment from experts. Secondly, there was no recognition that EBP should also meet the patient's preferences. The essence gleaned from the interviews was that all the participants considered that evidence was derived from research studies but did not include the need for the input of clinicians' expertise and the patient's values. However, some of the participants considered that keeping the patient

and the family happy was important for them to as nurses. Clinical judgment by experts in the field is essential to ascertain the significance, of the application of care plans and conclusions in particular patient care situations.

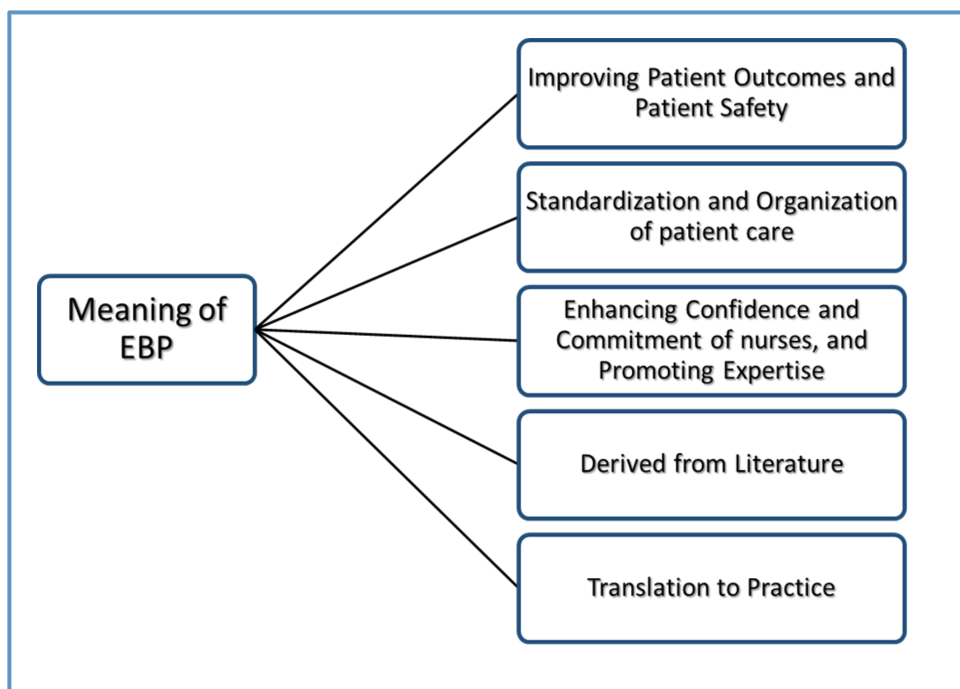

Figure 4. Common expressions of participants when defining EBP

Some common concepts described by the participants included the recognition that EBP was a problem-solving process, evidence is derived from reviewing research study, a method that intended to improve or standardize patient care, and a development of expertise (Figure 4).

Attitude towards evidence translation. The other sub-theme that evolved from the transcripts was the attitude that participants had towards the translation of evidence to practice. Jodi stated, “I want to impart it (EBP) to my juniors.” Here the nurse recognized

that it was her duty to enable other nurses to implement evidence to practice. Linda, expressed that:

> To bring about a change in the attitude and behavior is a big achievement. I learnt how important EBP is and what things we need. How beneficial it is…. we need to go for it (evidence translation) because it is with evidence - we get the best practice with it.

Val explained, "it (EBP) made so much change in our practice and is beneficial to the patients." She continued to express that the benefits outweighed the problems involved in the implementation and that evidence translation was essential for the nursing profession, as nurses are always closer to patients.

> Evidence-based practices a very good process especially in nursing. Actually we are going through many kind of patients, many problems to deal with the patients. So when we identify some problems we have to study about a problem, search and discuss with those who are aware of this problem, discuss with the administration and slowly implement the new practices.

Cindy was keen to explain how some of the health care providers were not committed to making EBP. She commented, "people are very comfortable with using the same thing, but there is no evidence of what they were doing." She went on to elaborate that "I don't believe in something, which was traditionally done by the people for 20 years and they thought it was alright … Why don't we follow people who are more intellectual?"

Commitment and motivation to change. Another subtheme that emerged was the commitment and motivation of the participants to enact the evidence based change process. Nurses who had administrative responsibilities expressed different the reasons why they were committed to the translation of evidence. One in-charge nurse revealed that it would help in ensuring that there will be "same quality of care if you are introducing an EBP in a particular unit," "we can evaluate the result and the staff also', and "because everybody is updated with everything." There is a clear expression of the need for standardization of patient care quality.

Another nurse in-charge highlighted "…why don't we think about doing something which is always right." Here the participant perceived that it was her obligation and duty to render best to their patients and it was her driving force to continually develop practice. Each nurse presented compelling stories from their experiences describing clinical practice issues that affected them both personally and professionally, which compelled them into taking action for their patients. Such commitment provided the impetus to question existing practice, and to take ownership of their practice to improve outcomes:

> ...there is a lot to be done. There is a lot of EBP and nursing care that has to be bring to the bedside nursing which is not yet been done...nurses are very traditional and they stick to what they did for 100 years before. …the organizations also must believe in EBP. If they are doesn't believe I do not think they would even cascade it down… (Cindy)

This participant elaborated personal obligation to evidence translation and there is a need to be transparent for effective translation:

> ...I am always open to that (evidence translation). I would say why not, let us start to do something different. …that will help the patient to recover fast and of course we feel so happy too…

Other participants took an altruistic view to their commitment to EBP. Cathy, an in-charge nurse had the following to share about her commitment to evidence translation. For her it is important to give the best to our patients.

> We should give our best for our patient, office work or other work can be repeated but life, we are always accountable to human life, every life is important …
>
> "….we persisted for a long and found benefit.."
>
> "…..always want to do what is best for my patient and I want all my colleagues to do that is best for my patient. Our responsibility is patient safety."

Another nurse Ashlie explained:

> …if someone is not seeing what I am doing but I am committed to make the right change that makes me to do things. ….as a professional nurse, I wanted to improve the nursing care and the patient health is better.

All nurses expressed that EBP is very crucial for patient care and highlighted that EBP must be scientifically based and derived from literature search. Being committed to implementing EBP and possessing a positive attitude to evidence translation will help nurses to actively involve in implementing EBP. All participants expressed a positive attitude toward implementing EBP and recognized the importance of evidence translation

for the quality of care. The nurse participants increased confidence was a result of increased knowledge and skills related to EBP; improved capacity to implement changes to practice in their unit; enhanced ability to discuss EBP with their peers and colleagues; capability to present their EBP projects at professional conferences; and the desire to mentor others in EBP. They expressed a commitment to ensure that their patients get the best possible care available.

Nurses had positive attitudes toward EBP and wished to gain more knowledge and skills. Each nurse participant interviewed expressed an increased or newfound confidence when they experienced success in implementing EBP. All of the participants believed that adopting evidence to practice provided them with the knowledge, tools, and skills necessary for a successful transition from traditional nursing practice to one of evidence-based. They expressed that there is a need to be positive and be committed to the results of change and not get got caught the barriers that hinder the implementation process. They were willing to take extra effort to approach physicians to ensure that the project is implemented.

Theme 2: Process of Evidence Translation

The second theme that evolved from the interview transcripts was "the process of evidence translation". Some sub-themes emerged that added to the findings of the study were the following:

1. Steps in implementation process
2. Barriers faced
3. Overcoming Challenges.

Steps in the implementation process. All of the participants were particular to elaborate the steps that were involved in the implementation process of the evidence. The participants were enthusiastic when discussing about this theme, as they were very keen to describe how they participated in the change process. Most participants presented a clear description of the how the process was implemented in their hospitals. Accordingly, the steps of implementation were problem identification and problem solving, evaluation of evidence, reviewing literature, the involvement of leadership, team involvement from the beginning, preparation of guidelines or policies, education of staff and communication and monitoring. One of the participants explained that the evidence translation was initiated when they faced a problem related to Ventilator Associated Pneumonia (VAP). According to Linda explained, "the whole unit including the doctors decided to implement VAP bundle… We had prepared a bundle for that with the tools … it was consulted with many people." Shine described that:

> The initiative could be from any person - when we find a problem, we can approach others - colleagues or in-charge to know how we can improve it. Finally, we together will decide to make a checklist then we will decide on how many samples are need to know the improvement and monthly we will audit.

All participants expressed the importance of staff education in implementing EBP. Cindy elaborated that "education is the light to any darkness. People should be educated and trained on the soft skills and other skills such as evidence-based practice." Some participants highlighted that the evidence translation would be effective if the

change is adopted into to a policy or a clinical guideline. Another participant, Val explained the process of translation of evidence in the following words:

> When I have to make a decision, I have to take the approval of my superior. I can give suggestions - we are always welcomed. They will take our suggestions and we can put forward to higher authorities…
>
> There should be workshop, there should mentorship, and there should more updating of knowledge. They should have to be encouraged. They have to do willingly and they should have the knowledge to do it properly.
>
> we conduct two kinds of audits; one unit wise or organizations audits. Then, if any hassles or anything is there we can….., we can always tell them.

When responding to their experiences implementing EBP, all participants viewed evidence translation as a hospital wide comprehensive project implementation and expressed as being a part of a big project. As a result, they had a rich description how they implement the change as a project. When asked about the evidence translation in their daily practice such as clinical decision-making, they did not relate to such an experience. Those nurses who have involved in the translation of evidence can be useful resources for implementing EBP in future. So knowing and understanding the steps involved in implementing evidence is desirable in nurses as this will provide them the necessary skill to engage in such activities.

The experience All of the participants were vivacious and enthusiastic when describing their experience implementing EBP. Some of the words that were used to describe their experience during the initial phase of implementation were “difficult,” “not

smooth," "challenging," "tough," "frustrated," and "not easy." Cindy explained about the initial experience as:

> I don't call it a struggle it was a challenge to use to implement because the people are basically resistant to change. Initial days, yes it was not easy because people are very comfortable by doing what they do always… the first challenge was to change that mind set. All that attitude towards change and that was one of the challenges.

Val explained that it "was really interesting but when we implemented initially it was not smooth as you are deviating from your old practices. …. it takes time." She further added, that "the process is very difficult but the outcome is beautiful." Kim explained,

> Of course, it was a challenging implementing. Why, because when people are in a track, nobody likes change. So when implementing change of course, there will be like that resistance and you know, finding mistakes with all sort of things while we are implementing, trying to find all negative points that one rather than coming to the most aspects. So, that was a challenge actually we faced.

When the evidence is translated and adapted to the clinical setting, the experience changed when all staff involved were able to experience the success. The participants expressed this as "happy," "felt confident," "satisfaction," "beneficial," and "interesting." Some of the excerpts were:

> "It was really interesting."
>
> "I feel confident definitely if it is helpful for the patients."

"you can't even explain in words what satisfaction you get"

"In reality, I observed all this benefits."

"I will have satisfaction and the patient satisfaction and a professional I will feel satisfied."

"You feel that you have done improvement to your patient, some thing I have done and it improves the health condition or satisfaction."

"I felt very confident that we are like looking for a complete patient care rather than like any body's beneficial."

All participants expressed their feelings of success relating to implementing evidence, a sense of urgency and the need to change. Another universal theme among the nurse participants was their commitment to continual development and improvement of their nursing practice. All of the participants were interested in further development of their practice for professional advancement with the overall goal of improvement in practice to provide better patient care with improved outcomes based on the principles of EBP.

Overcoming challenges. When discussing their experience of implementing EBP, the most cited issues by all the participants were the lack of collaboration among nurses and physicians. The doctors and senior nurses were two groups of providers who were reluctant to get on board of the change process. The most common barriers that they faced were that resistance from physicians, resistance from senior nursing colleagues, lack of competencies in newer nurses, lack of time, and lack of resources. Some comments about the participation of doctors for EBP implementation were:

"Physicians are very challenging very challenging, may be you have its percentage only with them that they can follow what you will present to them."

"They (Physicians and senior nurses) think that they are bigger and they don't want to listen to nurses. That is a challenge."

"The physicians always think that they're always head of nursing but is not like that."

"The most difficult people to change are also the physicians. So you have to convince them that we are going to a change and it will good for the patient."

"Particularly physicians usually they will resist."

"Most of them were interested but few were not bothered if you want you can do it. Others were very helpful; they were trying to make their colleagues understand."

With regard to the issues related to nurses all participants expressed that:

"Most challenges we faced were the senior most nurses who were in the industry for 10 or 15 years."

"The seniors will not accept…..I am in a comfortable zone and someone is coming and telling me to change."

"Some senior nurses were not agreeing because they felt this was an extra work for them specially documentation."

According to the participants, younger and new nurses were more flexible and easy to get on board the change, but the main problems with such nurses were that they were less experienced. Participants also related that nurses who had higher qualification

were more likely to participate in the EBP change project. About younger nurses, the participants expressed that they were easy to adapt to changes, but the challenges were related to the lack of experience and skill that affected the change process. Hence younger nurses needed constant support. Jodi explained, "if you are a newbie and then you are recently joined the mainly young age - recently joined there they will not believe you immediately." Jodi elaborated "for younger nurses; it is easy because they are very open-minded there are very open minded they want to learn they want to see what was here…" On the other hand, for younger nurses, it is "difficult for them to grasp because they do not have previous experience."

Participants also highlighted that nurses who are with higher education and those who are involved in their periodic updates are more interested in engaging in a change process (Val and Cindy). Other barrier that was cited by the participants was lack of time for involving in evidence translation and lack of support from higher authority and lack of research utilization capabilities in nurses.

When questioned about what strategies they used to overcome the challenges related to resistance from physicians and nurses the participants considered building relationship, education, early and active involvement of all concerned as a team, leadership buy in, having facilitators in the clinical areas, and continuous monitoring as that they employed. All of the participants highlighted that support from organization was crucial for implement EBP. Changes at the level of the organization and its commitment to improve patient care that is evidence supported practice that are crucial to ensure that evidence is translated into patient care. Organization as an entity can be a powerful

means to improve evidence translation. Nurse's commitment to change can be easily thwarted by the increasing pressures they face in terms of time constraints, pressures from peers, administration, and seniors and physicians. The participants expressed that relying on individual provider behavior change without a systems approach would fail.

Table 5

Themes and Some Comments Related to the Outcome of EBP Implementation

Theme	Comment
1. Standardized patient care	Same care to all patients.
2. Improved patient safety	It's (EBP) for patient safety.
3. Better care outcomes including reduced hospital stay	It helped us a lot because it reduces code blue calls (Jodi).
4. Reduced patient complications and errors	Helped the patient outcome, it (EBP) reduced medication error and incidents (Nora).
	Ultimate goal of all (EBP) is patient safety and patient satisfaction (Jill).
5. Reduced costs	We can save the hospital costs (Val).
	The hospital expense will decrease (Ashlie).
6. Enhanced staff knowledge and competencies	It (EBP) is about updating our nurse's knowledge. It provides better outcome for the patients (Nora)
7. Increased satisfaction of nurses	I (the nurse) feel happy and satisfied and feel that we are doing something good (Eva)

Participants expressed that involving all concerned into the process of change from the beginning of the planning process ensured that participated more willingly.

They also expressed that team cohesiveness is another way of building confidence in the nurse in implementing EBP. One participant conveyed that having facilitators in the clinical areas could support the early uptake of evidence among the health care providers. Team cohesiveness is another way of building confidence in the nurse in implementing EBP (Dogherty et al., 2013). There is a need to create a culture of team cohesiveness, which enhances the upholding or health care providers to support evidence translation.

Theme 3: Outcome of Evidence Translation

A universal focus of all the nurse participants interviewed was their expressed goal to improve outcomes for their patients. Common themes that emerged related to the results of implementing EBP were standardized patient care; improved patient safety; better care outcomes including reduced hospital stay; reduced patient complications, and errors; increased patient satisfaction; lower costs; enhance staff knowledge and competencies; and increased satisfaction of nurses (Table 5).

Relating to evidence translation. Some nurses highlighted that when they are involved in a satisfactory evidence translation process, they were keen to relate their experience to others. Jodi expressed that “sharing of the experience (implementing evidence) from others will be helpful.” Another participant revealed that when in “one ward if there is an improvement then it can be introduced to other areas also” and “as soon as you did something in there is an improvement we are happy to announce for other friends so happy.” Val went on to explain that “you feel proud when you get a good outcome, so the positive things we share with others” and that “we have invited other organization leaders and they used to send their representatives to the classes.” She

mentioned, “it is very nice to share with others.” Cindy explained, “We call and tell the others that why we are doing it and it has to be done. This is what I strongly feel.” Some of the participants were keen to include the need to share their experience implementing to others.

All of the participants considered that it was wrong not to incorporate EBP into nursing practice, and speculated that if all nurses knew about EBP, they would be compelled by a sense of duty to include it into their practice. Each of the participants expressed a moral imperative for nurses to reflect on their practice, to question existing interventions, and to examine the best approach to practice for optimizing outcomes. Nurses who commit are more motivated to participate in the implementation. Nurses’ attitudes concerning the benefits of EBP to advance patient care and results play a significant role in encouraging nurses to acquire indispensable skills to involve in EBP.

Empowerment. All participants explained that being involved in the translation of evidence improved their skill and confidence in delivering patient care. Being a part of the implementation process motivated the nurses and pushed them to do more for their patients. It improved the nurses' passion for the work they do (Table 6). This particular topic was the most passionately expressed by all the nurse participants. Many of the nurses became emotional while discussing the fulfillment and excitement they experienced through the implementation process, and the empowerment associated with EBP. Every nurse participant stated they felt empowered by participating in the EBP. Many nurses expressed a real passion for nursing and felt that EBP introduced an new dimension to their practice as they felt empowered to effect change.

Table 6

Comments Related to Feeling of Confidence and Empowerment

Jodi	It helps a lot with our practices as nurses, it helps us a lot and the doctors became confident as well as we practice this.
Linda	Really improves your self-confidence. I am motivated and satisfied that we are up to date and up to the level
Shine	I am basically I'm very happy and gives you motivation or any kind of push for you to do more or do more.
Val	Nursing is a different role not like any other job. You are dealing with human beings. So definitely your job satisfaction, your care all this - outcome for the patient at the end when they say a thank you to you it really good.
Jill	We mainly feel empowered as if I am great nurse and that I am not as simple nurse. I am really doing something great.
Cindy	If the patient is happy, and the patient is convinced and he gives you appreciation. It keeps me motivated
Cathy	I feel confident and empowered and my skill also will be better
	Nurses are educated they are motivated and confidant
Nora	I felt really motivated when that change came because I always had in my mind that what was going was not correct.
Ashlie	As a professional we will be more and we will feel more satisfied but they then slowly accepted.
Kim	I felt very confident that we are like looking for a complete patient care.

Research utilization in nurses. When making decisions related to the most suitable evidence for the present clinical scenario, they used different means of

identifying and selecting the best fit. Seven out of the 12 participants highlighted that they would do a literature review on the topics of interest to identify the best evidence to deal with the concerned problems that they faced in practice. Cindy explained that she would use the evidence from the literature to convince leadership and other health professional about the importance of change. She also mentioned the importance of training nurses on how to do a literature search, and to conduct research. She added, "education is the light to any darkness. People should be educated and trained on the soft skills and other skills such as evidence-based practice."

Jackie explained it is an individual nurse's responsibility to improve those capabilities to implement EBP by continuously reviewing literature. She highlighted that it is important for the nurses to attend symposiums, conferences and use the resources available in the library. Every nurse interviewed commented on their constant desire for knowledge and their ongoing quest to answer the 'why' in their nursing practice. Several nurses felt their inquisitive nature attracted them to EBP as a means to respond that burning clinical question (i.e., answer the 'why').

Nurses are placed at a crucial position near the patients in the health care delivery chain and positive attitude and commitment for EBP are crucial. Some participants were willing to commit to extra effort to do the best for the patients and considered that it was their obligation to mentors other younger nurses to implement the best care to the patients. Many of the nurse participants mentioned that it was their duty not to harm, and viewed that not practicing evidence based nursing represented negligence in nurses.

Nurses who recognize the importance, purpose, and process of evidence translation are best assets to assist with EBP implementation.

Participants explained nurses must be educated regarding the identification the best evidence, continuously updating nurses' knowledge through literature reviews and the steps of implementing EBP was important. Further, an environment that supports cordiality and team spirit will be very effective in overcoming this challenge. Cindy explained that "knowing the outcomes of the change process not only provides us with the details of how the change is undertaken - but it also helps the nurse to celebrate their successes which will contribute to implementing evidence."

There was a strong sense among the participants that nurses are influential leaders and can influence the change in the clinical setting. All nurses interviewed stated that they felt empowered by participation in the EBP. Nurses are central to any changes that are implemented in the clinical setting irrespective of their specialty and they are crucial in achieving the planned results in patient care. Nurse leaders in practice, research, and education must address this research practice gap so all nurses are supported and encouraged to incorporated the best evidence to patient care is safe and efficient.

Phenomenological Dimension and Description

The purpose of the phenomenological consideration was to comprehend the implication of the experiences of nurses who were involved in implementing EBP. From the themes that emerged from the interviews of nurses who participated in the evidence translation process the following portrayal developed. Nurses believed that EBP is

important for patient care, quality of care, and patient safety. All nurses considered that it was their ethical obligation to practice nursing care that was best for the patient.

Nurses considered that knowledge regarding how to conduct a literature review, identifying the most suitable evidence for a clinical situation, and to implement the evidence. There was a common experience that research skill for nurses is essential for the translation of evidence. Further, nurses expressed pride and confidence in being involved in evidence translation projects and participated in a research investigation that supported EBP. Nurses revealed that some of the barriers of EBP were lack of support from physicians and senior nurses, lack of time and other organizational processes. Overall the nurses found meaning in being part of the implementation process where they felt that they are doing the best for their patients.

Summary

Several factors affect the translation of evidence to practice for nursing in the clinical setting. The EBP presents a method to accomplish care goals and helps improve quality and patient safety. Despite the growing research that identifies the best evidence there are still gaps in knowledge transfer. The aim of this phenomenological study was to reveal and interpret the nurse's lived experiences of the complex phenomenon of implementing EBP in a hospital setting. It was an attempt to understand the nature of experiences nurses undergo in the change process and the associated influence of personal values, beliefs, and the social processes in implementing EBP.

In Chapter 4, I presented details of the methods of the study, the data analysis and the conclusions derived from the data analysis. The information that was derived from

literature presented in Chapter 2 and the outline of methods of recruiting and data collection presented in Chapter 3 supported the analysis and finding of the study. Themes that evolved from the study included the meaningful parts of the nurses' experience painting a picture of the whole. They are the "aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is" (van Manen, 1990, p. 107). The fundamental themes emerged from the experiences of 12 nurses who participated in implementing EBP. The themes evolved from the study were the significance of EBP to nurses, the process of evidence translation, and the outcome of evidence translation. Overall all participants expressed inherent desire to ensure that patient care is the best and that patients are safe. Additional support from the health care community, health care organization and administrator are important for the seamless translation of evidence. In the next chapter, Chapter 5 provides further details related to finding of the study, which include interpretation of the study, limitations, recommendations, implications and conclusions of the study.

Chapter 5: Results

Introduction

EBP is a process of using the best possible evidence from scientific studies to support clinical decisions. The result of my literature review suggested that evidence derived from research often does not reach patient care due to many elements that impede the implementation of evidence in everyday practice (Dudley-Brown, 2012; Hebden & Murphy, 2013; White, 2012). The purpose of this phenomenological study was to describe and interpret the lived experience of nurses who were involved in implementing EBP. Specifically, my intension was to reveal the nature of nurses' experiences to understand and implement EBP effectively. Nurses are the largest workforce in health care and the best resources to find ways to augment the translation of research evidence to clinical care (Yost et al., 2014).

I chose phenomenology as the research methodology for this study because it allowed the discovery of the essence within the context of the lived world experiences of nurses involved in implementing EBP. Hermeneutic interpretative phenomenology enabled me to examine of the nurses' lived experiences by highlighting insights of their reactions and philosophies from their perception (Matua & Van, 2015). It is a distinctive methodology because it is not meant to create generalizations of the outcome of the study; rather, it is intended to provide insights into the phenomenon of study. Nurses communicated their understanding of their experiences that helped to fashion meaning or value to these experiences. This methodology fit the investigation of phenomenon

relevant to the nurses as they experienced the change process in implementing EBP along with their lived experiences.

Interpretation of the Findings

The findings of the study highlighted that EBP is still an evolving concept in the UAE. This research study was the first study that investigated the experiences of nurses implementing EBP in the clinical setting using phenomenology as the methodology. The results of this study highlighted three major themes and nine sub-themes, which include the following:

1. Significance of EBP (subthemes were meaning of EBP, attitude towards evidence translation and commitment and motivation to change)
2. Process in evidence translation (subthemes were steps in implementation process meaning of EBP, the experience, and overcoming challenges)
3. Outcome of evidence translation (subthemes were relating to evidence translation, empowerment and research use among in nurses)

The first theme of the study was the significance that the nurses associated with evidence translation. Three different sub-themes of the reality of the phenomenon evolved within this theme. The participants of the study expressed different meanings to the concept EBP based on their experience. The common understanding of the participants regarding evidence was that it was the result of scientific studies but did not include the other two elements; clinician’s expertise and patients’ values as per the currently recognized definition of EBP (Shifaza et al., 2014; Stevens, 2013). This indicated that though the nurses had a basic understanding of EBP, there was still a need

to enhance the comprehensive theoretical understanding of the concept. The second subtheme was attitude towards evidence translation. Nurses considered that evidence translation was fundamental and central to their practice. Finally, all participants of the study expressed commitment and were motivated regarding the evidence-based change.

Therefore, the first theme confirmed the importance that nurses placed on evidence translation. It signified that the participants had some understanding of EBP, which could be the foundation on which further development of nurses understanding about the phenomenon. Thus this finding denotes the need to improve the knowledge of nurses regarding EBP including knowledge of theories on evidence translation, tools, and frameworks.

The second theme, the process of evidence translation, focused on steps in evidence translation process, the experience of the change and the difficulties that they faced when implementing EBP. All participants explained the steps of the implementation when explaining how they implemented EBP. The findings highlighted that the participants considered evidence translation as large-scale projects that included departmental or hospital wide implementation. The participants did not relate experiences of evidence translation in their daily care decisions. The participants recollected the steps of the process of translation as they experienced it but there was no understanding of current scientific methods of implementing evidence. Participants’ evidence translation experience is useful as they are good foundation for the future implementation of EBP. The second subtheme “the experience” highlighted that when participants experienced success in implementing evidence, this triggered a sense of urgency and the need to

change. Further, the nurse participants were commitment to continually develop and improve their practice through personal professional development.

The third theme of the study highlighted that the participants considered that it was wrong not to incorporate EBP into nursing practice. All participants explained that being involved in the translation of evidence improved their skill and confidence in delivering patient care. The contentment and enthusiasm that the participants experienced when translating evidence empowered the participants to commit to improve patient care. Participants considered that nurses are best placed to support EBP and that nurses must be educated to identify the best evidence and the steps of implementing EBP. An environment that supported team spirit was important. Nursing leaders must address the research practice gap to support nurses to incorporate evidence to patient care.

Comparison with Recent Literature

In Chapter 2, I presented a literature review to position the study within the current research studies involving evidence translation. Here I endeavor to develop importance around the themes identified in this study utilizing relative literature. The review of literature indicated that there were limited studies that used qualitative methods (Bohman et al., 2012; Upton et al., 2014). Among the qualitative studies there are few that have evaluated the lived experience of nurses involved in EBP practice using phenomenological method (Fridman & Frederickson, 2014; Spiri & Macphee, 2013). However the themes that emerged from this study were, actually, consistent with results of studies that were reviewed in review of literature.

The first theme identified in this study was the meaning that the participants had related to EBP. The participants in the study had some understanding of what is EBP and considered evidence translation important for care delivery. Further, the findings reiterated current research-based conclusions that nurses were committed and had a positive attitude to evidence translation (Upton et al., 2014). Some study findings had identified similar finding where nurses had high cognizance and appreciation for translation of research into practice (Athanasakis, 2013; Bohman et al., 2012; Eaton et al., 2015; Fridman & Frederickson, 2014; Mohsen et al., 2016; Stokke et al., 2014). Some studies acknowledged that even practitioners had positive attitudes towards EBP, the translation of research to practice did not mostly happen (Black et al., 2015; Hussein, & Hussein, 2013; Mohsen et al., 2016; Weng et al., 2013).

As identified in number of studies (Baird & Miller, 2015; Maaskant et al., 2013; Mallion & Brooke; 2016), participants highlighted that the ability to correlate research findings to decision-making in patient care and the willingness and inclination to improve current practice were crucial factors for knowledge translation. In the current study, though the nurses had increased commitment to implementing evidence, their definition for EBP did not include the other aspects such as acceptance by the expertise and patients' preferences. The participants did not express the knowledge of tools or theories that were used for translation of evidence.

The second theme that evolved in the current study was "process of evidence translation" described "the steps that involved in the translation of evidence" as sub theme. Similar to this sub-theme, a study conducted by Eaton et al. (2015), recognized

that it was imperative to embed scientific evidence in hospital policies and procedures and that senior nurses are to develop such policies and procedures. Studies identified that checking on practices in the clinical settings; discussions with colleagues and opinion from patients are other supporting factors for adoption of research results (Irwin et al., 2013).

The findings of this study suggested that there were a number of barriers that hindered the translation of evidence. Nurses identified that lack of time and lack of knowledge regarding the principles of conducting research studies, literature reviews and data analysis were some of the barrier in the individual characteristics of nurses. Number of studies had identified that lack of theoretical knowledge in nurses and the skill to engage in effective research-based practice were barriers to evidence translation (Barría-Pailaquilén, 2013; Eaton et al., 2015; Thorsteinsson, 2013; Spiri & Macphee, 2013; Warren et al., 2016; Weng et al., 2016). Other studies reported such as no backing from organization for research utilization, and the lack of capabilities of nurses to conduct research as barriers to implementation of research findings (Akerjordet et al., 2012; Heinonen, 2015a et al., 2015; Tan, Sahin, & Özdemir, 2012; Ubbink et al., 2013).

The third theme in this study was regarding the outcome of evidence translation and research utilization among nurses. The findings of the study highlighted that nurses who were more qualified such as BSN and masters trained were more inclined to participate in evidence translation readily. This finding is similar to the findings of other studies where education preparation of the nurses was considered to be necessary for the research implementation (Bohman et al., 2012). The conclusions of the study also found

that the research knowledge in nurses as a vital source to support research translation. An organization that inculcates a research culture is the best means to help with implementing EBP.

According to Boström et al. (2012), management is an important dynamics for the uptake of EBP. In the current study, it was confirmed that supportive leadership helped in the examining other sources, applying evidence into practice, and appraising practice. Similarly to this study, it was found that supportive leadership both nursing and others were necessary for the translation of evidence in a setup. It is important to encourage and develop strong motivational leadership at the clinical unit level as this is considered to inspire nurses in their work (Bostrom et al., 2013). Shifaza et al. (2014) suggested that nurse administrators could promote the advancement of EBP by incorporating time and resources necessary for nurses to improve their capabilities connected to EBP. Educating nurses on research methods, statistical principles, and conducting literature reviews are important (Athanasakis, 2013). The adoption of current evidence into clinical practice supports the development of the expertise of nurses and helps to deliver the best patient care (Athanasakis, 2013).

Findings and Theoretical Framework

The current study aimed to explore the phenomenon of evidence translation among nurses using hermeneutic phenomenology. Insights derived from nurses' lived experience of knowledge translation was intended to provide information that could add to the body of knowledge related to the utilization of evidence. The collective nursing experience expressed by the participants helped to define the significance of translation to

promote practice reforms and stimulate advances in the quality of nursing care (Titler, 2014). This section presents an interpretation of the findings of the study in the context of the theoretical and conceptual framework (Figure 5).

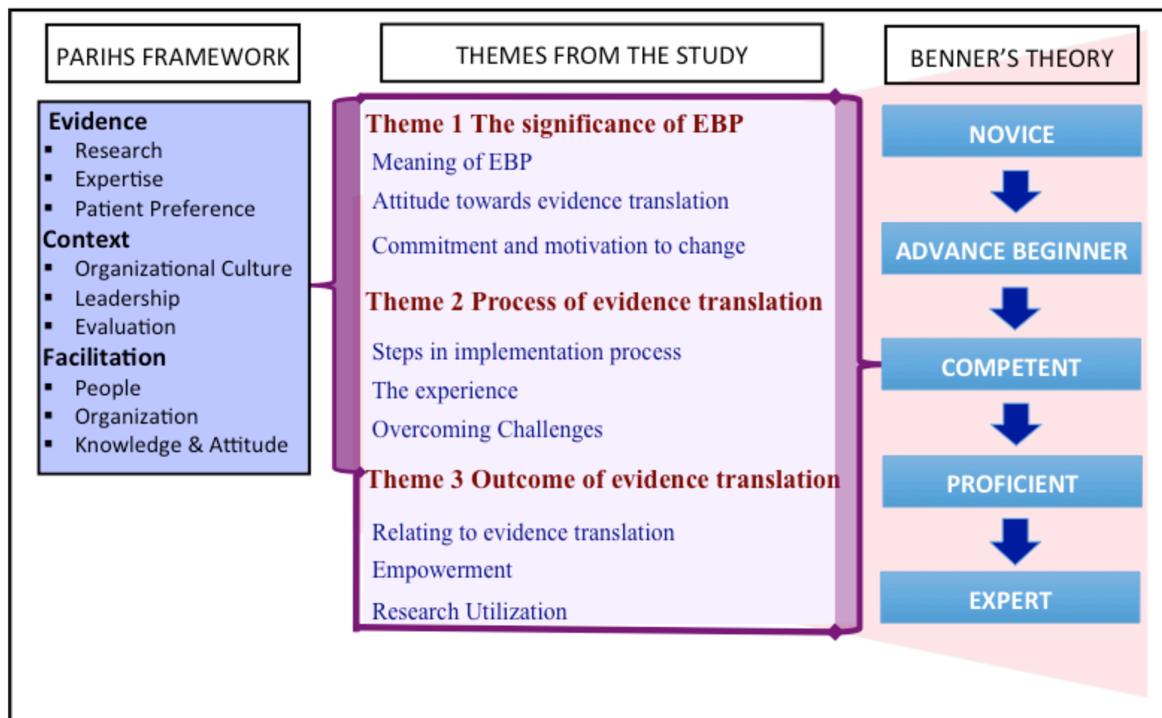

Figure 5. Findings of the study and theoretical frameworks

PARIHS framework was used in this study as an analytic framework that provided focus and constructions for discussing the analysis of implementing EBP. The model presented a simple structure that involves three elements, which include evidence, context, and facilitation. Knowledge of what is evidence is crucial for the deliberate attempt to translate evidence to practice. Though all participants were keen to define evidence, they did not possess a comprehensive understanding of the concept, hence is an area for improvement. The participants expressed that organizational context and leadership in the clinical setting was important for translation. The interviews of the

participants also emphasized the importance of facilitators for translation. PARIHS framework is a simple yet powerful tool that could help in the interpretation of evidence and specifically related to the themes 1 and 2 of this study.

Benner's novice to expert theory was also used in this study to gain focus on skills acquisition related to knowledge translation in nurses. The findings of this study confirmed that the three elements highlighted in the PARIHS framework were essential in the translation of evidence to practice. Further, the study also proved that evidence translation was an essential competency for practicing nurses and this skill is acquired within the circumstantial experiences (Benner, 1984). According to the participants of the study, to develop the evidence translation, there is a need to educate nurses on how to conduct a literature review, and gaining knowledge of how to do research studies. Further, nurses reported that their experience implementing EBP in the clinical environment provided the necessary understanding and confidence to make clinical judgments and decisions. The didactic knowledge in this study starts with gaining insight into what is EBP and learn the skill in utilizing tools that could support translation to practice. Benner theory related to all three themes of the study and themes reflected the incremental nature of the theory, novice to expert.

Limitations of the Study

The participants of the study was expected to include 10 to 15 nurses as participants, but the final sample size was 12 participants as I was able to reach saturation (Converse, 2012). Participants were nurses who work in hospitals and included staff nurses, charge nurses and nurse managers who have had experience implementing

evidence to practice. The sample size and the sampling technique were the limitation of this study as there is a question of the generalizability of the findings. I used systematic sampling method that supported selection of participants who volunteered for the study and met the inclusion criteria. In addition, I employed member checking when collecting data, developed a semi-structured interviews with predetermined questions, and maintained an accurate audit trail and documentation throughout the study. As I am a nurse administrator, the research study was susceptive to investigator bias. Hence I used the process of bracketing to reduce researcher bias. Further, a phenomenological study intends to present the current understanding of a phenomenon to increase knowledge, inspire additional investigation, support individual consideration, and present insights for other research (van Manen, 1990).

Recommendations

The aim of this study was to explain and understand nurses' experiences of the phenomenon of implementation of EBP in a hospital setting. A hermeneutic interpretative phenomenological approach was used to uncover the phenomena. This approach was both a research method and a means to seek, explore and understand the individual experiences of existence and expose the underlying extracts related to this understanding (van Manen, 1990). I have presented the recommendation of the study under four headings; nursing practice, nursing education, nursing research, and leadership.

Nursing Practice

It is necessary to develop the knowledge and skill of staff nurses to facilitate the efficient translation of evidence to patient care. The clinical setting must have procedures

and protocols that could help nurses to find, validate, and associate the best and contemporary evidence by regulating and incorporating throughout the hospital. It is also recommended to build a culture of EBP in a clinical environment that encourages the implementation of the best evidence to patients, based on patient preferences and values. Building evidence translation resources such as role models and mentors in clinical setting is crucial in meeting continued application of research evidence.

Nursing Education

There is a need to provide job-based education for nurses that promote the nurses' commitment to change and the implementation of research. Educators can assist nurses to cultivate a positive self-image by providing working experience that promotes confidence that allows nurses to provide new and necessary services to patients (Shifaza et al., 2014). In addition, it is also important to include research and research translation in the curriculum in nursing schools. EBP should be considered as an essential competency that nurses needs to develop right from the time the nurse in the school and consolidate through clinical experiences. EBP competency must be regarded as a mandatory skill, which must be developed for nurses who are novices. Nursing programs may need to adopt critical thinking, models for knowledge implementation and theories of change in their curriculum.

Nursing Research

There is a scarcity of research studies conducted by nurses in the Middle East as a result the research skills and ability to publish findings of the study is limited. Nurses must be supported in conducting small research studies in the clinical settings and to get

involved with research related activities. Nurses must be supported to articulate important clinical queries, search for relevant literature, evaluate and summarize the collected information, apply evidence to practice and appraise the performance.

Leadership for Evidence Based Practice

Assistance, backing, and appreciation from the management and administration were considered to facilitate research utilization. Directors of nursing have a critical role in leading nurses in supporting and implementing EBP, their opinions, understanding, and abilities toward EBP are fundamental. Organization must employ strong nurse leaders who are committed to EBP. Strategies must recruit strong leadership in health care, particularly those with the capability and competency to promote and encourage nurses in practicing EBP in the clinical setting. According to Grimshaw et al. (2012), factors that increased commitment to EBP in clinicians enhanced implementation outcome such as academic associations; functional differentiation; evaluation, access to resources; education; a learning environment; organizational readiness for change; supportive leadership style; decision-making structure; and autonomy (Eaton et al., 2015; Gozdzik, 2013; Irwin et al., 2013; Powrie et al., 2014). Leaders who have clear and genuine goals are essential for the facilitation of research translation as they are influential and proactively engage in gaining feedback and exhibit positive leadership approaches (Eaton et al.).

Implications

The findings of the study are indicative of various implications for further research, education, and clinical practice. The results of this study showed nurses

recognized the importance of EBP and were keen to implement EBP. Alternatively, the knowledge regarding EBP among the nurses was limited including the awareness of the theories of evidence translation, frameworks, tools, and steps in translation. Educational programs that focus on evidence-based knowledge and skill development are necessary and should be tested through further research study. Research is essential to ascertain the most successful educational strategies that can be adopted.

Further, it is suggested that future studies should evaluate nurses' clinical decision-making skills as a means to implement EBP and to develop tools that could support nurses' clinical decision-making abilities. Researchers can additionally prepare evaluation instruments to measure the use evidence in personal decisions of nurses.

It is important to train nurses on how to do research studies and to implement evidence into practice and promote their critical thinking skills. Nurses must be given in-service training to understand the soundness and value of research articles (Shifaza et al., 2014). Developing useful methods to search and find best current evidence and educating nurses on how to use these resources to translate evidence to patient care is essential. Such education must also include means to develop skill to conduct literature review and included in nursing schools. More studies on evidence translation are required that study patient's experience being part of a new evidence translation project.

Conclusions

The aim of the current phenomenological study was to explore the perceptions and lived experiences of nurses who were involved in implementing EBP in a clinical setting in hospitals. This study was an attempt to reveal and interpret the nature of

experiences nurses undergo in the change process and the associated influence of personal values, beliefs, and the social processes in implementing EBP. The ability of the nurses to make decisions related to implementing evidence is reliant on the clinical expertise of the nurse (Canadian Nurses Association, 2015). The review of the literature identified that the capability to correlate research findings to decision-making in patient care and the willingness and inclination to improve current practice were crucial factors for knowledge translation.

The findings of this study highlighted that EBP is an evolving concept in the UAE. The results of this study resulted in three major themes and nine sub-themes, which include:

1. Significance of EBP (sub-themes are meaning of EBP, attitude towards evidence translation and commitment and motivation to change)
2. The process in evidence translation (sub-themes are steps in implementation process meaning of EBP, the experience, and overcoming challenges)
3. The outcome of evidence translation (sub-themes are relating to evidence translation, empowerment and research utilization in nurses)

While this study had been conducted in UAE, the general findings and implications contribute to our understanding of EBP by nurses and add to the limited international research literature on this topic. In particular, the study highlighted the importance of qualitative research to fill the gap between data from interviews and a way of discovering specific and relevant information. The use the qualitative method allowed for new information to be accessed, which provided the opportunity for a more

comprehensive interpretation. At the theoretical level, the study endorses the use of the PARIHS framework as a simple tool to support evidence translation and Benner's theory as a framework to develop nurses' competencies.

The positive social change implication of this study is the recommendation to leaders in health care, nursing, educators, and researchers to recognize the need for building EBP capabilities among nurses. Organizations must include current theories, frameworks, and tools of evidence translation to cultivate a culture of EBP as a foundation for patient care. In the current study, the nurses had a basic understanding about EBP, but there is still need to enhance the theoretical knowledge of the concept.

The implication of the finding is the need to improve the knowledge of nurses regarding EBP including knowledge of theories on evidence translation, tools, and frameworks. Nurses are crucially placed in the health care delivery system, so are the best resources in the clinical setting as they can adopt knowledge of EBP in the construction and approaches of nursing delivery. Effective methodologies can be assimilated into an individual nurse's method of providing patient care (Mick, 2017). In particular, abilities such as the practice of evidence to deal with clinical questions, examine the evidence, critique the practicality, appraise the vigor, and hold an optimistic attitude to the prospects of and add to problem-solving (Canada, 2016; Grimshaw et al., 2012).

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Appendix A: Flyer for Recruiting Participants for the Study

DEAR NURSES,

A Unique Opportunity to participate in a Study that will inform your practice

You are invited to participate in a study on utilization of evidence based practice (EBP).

Participation Criteria:

- ✓ You are nurse working in a hospital.
- ✓ You have participated in implementing an EBP.

Aim of study:

To understand personal and organizational factors that influence nurses to participate in the change process.

Who is doing this study?

The study is conducted by Ms. Monnie Abraham (monnie.abraham@waldenu.edu) as part of her completion of PhD Dissertation from Walden University.

What should expect?

Once you choose to participate

- ✓ First you will be contacted via email
- ✓ You will be interviewed approximately 1 hour at your convenience

All communication will be kept confidential

What will happen to the results of the study?

The results of the study will be reviewed by the university, and published and may be presented at professional conferences.

If you are interested please contact Ms. Monnie Abraham in the above email or call +971 50 4245627.

Appendix B: Request for Participation

Dear Fellow Nurse,

You have a unique opportunity to participate in a study about utilizing research-based evidence to clinical practice. The main focus of the study is nurses who have experienced implementing EBP in their practice. I am a Ph.D. student at Walden University in the Health Services program and ask for your participation in this study. I expect that the interview will last around one hour. I can be reached at Monnie.abraham@waldenu.edu. My faculty chair and advisor is Dr. Robert E. Hoye Ph.D., FAAMA.

There are no specific risks to you as a participant, and I would like to inform you that your involvement is voluntary. There will not be any payment for participation except that the information that you are contributing will useful and valuable. All attempts will be taken to ensure that confidentiality is maintained always. All your personal information and the information from your interview will be held confidentially and kept locked at all times. The findings and the interpretation of the data will be reported only in collective form.

Thanks for your response,

Monnie Abraham

Ph.D. Candidate

Appendix C: Permission to Display Flyers to Recruit Participants

Date:

Ms. _____________________,

__________________________,

__________________ Hospital.

RE: Permission to display Flyers to recruit Participants

Dear Ms.

I am forwarding this email to ask permission to display flyers for a research study at your institution to recruit participants for a research study. I am registered in the Ph.D. in Health Services from Walden University in the USA, and I am in the process of completing my Dissertation. The study is titled "A Phenomenological Inquiry of Nurses' Lived Experience Implementing Evidence to Practice."

I request that your permission to let me display flyers in your organization to recruit participants who may voluntarily agree to participate in the study. Due to the nature of the study, I hope to recruit nurses who have had experience in implementing evidence-based practice. Interested nurses, who agree to participate, will be given a consent form to sign and revert to the researcher at the commencement of the study.

The interviews will be scheduled at a place and time convenient for the participant out of duty hours in any location comfortable to them outside the hospital premises. The interview should take about an hour and the collected data will be held confidential. Any published details of this study will a result of a combined analysis and

will be held completely confidential. There will not be any costs incurred in the study either by the organization or the individual participants.

Your agreement to conduct this study will be greatly valued. I would be happy to clarify any queries that you may have at any time. You can connect with me at my email: monnie.abraham@waldenu.edu.

If you approve, kindly sign the enclosed Letter of Cooperation and return it to me.

Sincerely,

Enclosures:

Letter of Cooperation format

Appendix D: Letter of Cooperation

---------------------------,

Name of Hospital

Contact Information

Date

Dear___________________________,

I give you authorization for you to display flyers to recruit participants for the study entitled "A Phenomenological Inquiry of Nurses' Lived Experience Implementing Evidence to Practice" within the _____________ hospital. Individual nurses participation in this study is voluntary and at their own choice.

We recognize that our organization's accountabilities include: allowing the display of flyer to recruit participants.

I affirm that I am authorized to approve the display of flyer for research in this setting and that this meets the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Authorization Official

Contact Information

Appendix E: Protocol for Initial Phone Contact With Research Participants

1. Clarify what the participant's participation in the study comprises, that I am looking for their portrayal of their experiences being involved in implementing EBP.
2. Describe that strict confidentiality will always be conserved.
3. The interview will likely last for one hour.
4. During the interviews the researcher will frequently check with the participants to ensure that accurate descriptions of the participant experience are captured that is know as member checking.
5. Explain the potential benefits of the study that it will reveal the association influence of personal values, beliefs, and the social processes in implementing EBP.
6. The interview will be conducted face-to-face.
7. Send an email with an invitation and the informed consent form

Appendix F: Interview Protocol

Introductory Protocol

I appreciate you for agreeing to interview with me today. My name is Monnie Abraham, and I am a Ph.D. student in health sciences at Walden University. This interview is part of the data collection for my dissertation and wants to comprehend your experience while implementing EBP or translation of evidence into your practice. The aim of this project is to help me appreciate the nature of the change nurses experience and the associated influence of personal values, beliefs, and the social processes in implementing EBP. Results of the study may help inform the policies and procedures, the building of organizational process, and educational programs, which could promote evidence translation.

To facilitate my note taking, I will be audio taping our discussions today. For your information, only I will have access to the audio tapes which will be ultimately damaged after transcription.

This interview will last for one hour. During this time, some questions will have to be covered. If there is no adequate time, you may be interjected to cover all required details.

Introduction

You have been chosen to interview with us today as you have been recognized as having had experience in implementing EBP. Our research project as a whole concentrates on the development of knowledge translation, with specific concentration in understanding how nurses in hospitals engage in EBP. The study is not about evaluating

your skills or experiences but focused on gaining information about the processes of knowledge translation.

Biographical information

1. What is your present position?_______________________.
2. Where do you work? Hospital/ clinic/ primary health center
3. What is your highest degree? _______________________________________
4. What is your field of study? ____
5. How long have you been a nurse?
6. How many years have you been involved in implementing EBP?
7. What is your ethnicity?
8. What is your gender?
9. Are you married or single?
10. How old are you?_____________

Appendix G: Interview Questions

Lead Interview question: How would you describe your experience learning to understand and implement the EBP in clinical practice?

1. What were your experience of implementing the evidence-based practice in patient care? (Temporality).
2. What is it like for you when deciding, planning and implementing EBP? (Corporeality).
3. What is it like for you when implementing EBP to care patients, interacting with other peers and other health care providers? (Corporeality, Spatiality and Relationality).
4. What is it like for you when relating to others the experience of implementing EBP? (Relationality)

Other questions include:

1. What were the facilitators and barriers you faced when implementing the EBP?
2. How did you make the choices you make in relation to implementing EBP?
3. Briefly describe your role and how you involve in implementing EBP.

   Probes: How were you involved in EBP?

   How did you get involved?
4. What motivated you to implement EBP in your everyday practice?
5. What was the strategy at your organization for improving the implementation of EBP?

Probes: Was it working - why or why not?

6. What resources were available to nurses for implementing EBP?
7. How did you go about enlisting support in implementing the latest EBP in your clinical work?

   Probe: Did you face any challenges?
8. What kinds of monitoring techniques you used the most when monitoring the effects of evidence translation?

   Probe: What kinds of assessment most accurately captured evidence translation?
9. What were some of the major challenges your department faced in attempting to implement EBP?

   Probes: How can barriers be overcome?

   How can opportunities be maximized?
10. What types of educational preparation or professional development opportunities did you see enhance your capabilities to implement EBP

    Probes: What motivated you to participate in professional development

activities to enhance your competencies?