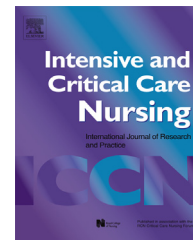




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ORIGINAL ARTICLE

Sources of knowledge used by intensive care nurses in Norway: An exploratory study



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Accepted 1 December 2013

KEYWORDS

Evidence-based practice;
Focus groups;
Intensive care;
Knowledge;
Nursing

Summary This study explored the sources of knowledge that intensive care nurses used in their daily nursing practice. It used a qualitative design based on four focus group interviews with 20 intensive care nurses, from four intensive care units in Norway. Data were analysed using systematic text condensation. The following condensed meaning units were identified: research, theoretical knowledge, experiential knowledge, work place culture, clinical expertise and patient participation. This study illustrates the complexity and variety of the knowledge bases of intensive care nurses. Despite some variation in nurses' familiarity with research literature, nursing interventions found by research to be useful were given priority, and research affected daily practice through changes in guidelines and procedures.

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Implications for Clinical Practice

- This study indicates that there is a complex and multifaceted knowledge base for intensive care nursing practice, which should be recognised when initiatives for implementing evidence-based practice (EBP) are developed. Hence, this study suggests that further efforts should be made to ensure that nursing practice is based on the best available evidence. Educating ICU nurses in EBP is essential to achieve this.
- Research findings were stressed by the ICU nurses in this study as important, and as being more important today than some years ago, but they also described uncertainty about whether research conducted within the nursing profession was used as a basis for actual nursing practice, indicating a need for both the educational system and organisational management to assist them in applying nursing research in practice.
- Personal and cultural differences might influence nursing decisions, suggesting that attention needs to be paid to the social and cultural aspects of ICU units when research findings and EBP are implemented.

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Introduction

Evidence is one of the most fashionable concepts in health care (Rycroft-Malone et al., 2004) and health care environments increasingly demand nurses to be able to solve patient problems by utilising the best available evidence (Shorten et al., 2001). Despite some criticism of evidence-based practice (EBP) (Porter and O'Halloran, 2008), there is a strong international desire for EBP in nursing (Forsman et al., 2010; Sherriff et al., 2007).

Evidence-based practice is defined in different ways. Sackett et al.'s (1996, p. 71) definition of EBP in medicine states that EBP is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients". According to this definition practising EBP means "integrating individual, clinical expertise with the best available external clinical evidence from systematic research" (Sackett et al., 1996, p. 71). Evidence-based practice has also been described as the optimal use of research evidence in nursing (van Achterberg et al., 2008). Others have emphasised the process of making clinical decisions using the best available research evidence, clinical expertise and patient preferences within the context of available resources (DiCenso et al., 1998). Evidence-based practice has evolved in definition and scope, and requires that decisions about health care are based on the most current, valid and relevant evidence available. The decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources (Dawes et al., 2005). In Norway, EBP has sometimes been considered synonymous to knowledge-based practice (Nortvedt et al., 2007). The Norwegian Nurses Organisation (NNO) states that "nursing practice shall be knowledge-based and shall be founded on research and empirical knowledge as well as on the patient's/user's choices and value preferences" (NNO, 2008, p. 12).

Recently, there has been significant growth in the field of knowledge utilisation in nursing (Scott et al., 2010). The literature includes research on how knowledge is built up and expanded in the health care system. For example, studies show that social interactions and experience are two important sources of practice knowledge for nurses (Estabrooks et al., 2005; Marshall et al., 2011; Thompson et al., 2008), and that, when faced with uncertainty, nurses tend to rely on these sources of information, rather than evidence-based resources, for their clinical decision-making (McCaughan et al., 2005). Regardless of efforts to implement EBP in nursing, and nurses' positive attitudes concerning the use of scientific evidence to guide practice (Adib-Hajbaghery, 2009; Majid et al., 2011), both individual and organisational barriers to research utilisation and EBP have been described (Brown et al., 2009; Estabrooks et al., 2003, 2007). In a previous study, we explored the knowledge nurses used in their clinical practice of primary care and found that although they used different sources of knowledge, they seldom used research (Berland et al., 2012). Other studies have also found that few nurses use research in their clinical practice (Adib-Hajbaghery, 2009; Bonner and Sando, 2008; Boström et al., 2006).

Fewer studies have examined the knowledge upon which nurses in intensive care units (ICUs) base their clinical practice. Aitken et al. (2008) described decision-making in ICU settings as a highly complex process. Marshall et al. (2011) found that nurses preferred to rely on information obtained from colleagues and that this was considered both the most useful and accessible source of knowledge in the clinical setting of ICUs, while text and electronic information were seen as less accessible. However, little is known, and further research is recommended. Therefore, the objective of this study was to explore the sources of knowledge used by ICU nurses, as described by the nurses themselves.

Methods

A qualitative exploratory design was used, with focus group interviews.

The study was approved by the Norwegian Social Science Data Service (No.: 25853), and was conducted according to the Declaration of Helsinki. Leaders in the administrations of the involved hospitals all gave informed written consent. Prior to participation, all participants received verbal and written information regarding the aims of the study and how the results were to be presented, and were told that participation was voluntary. Anonymity and confidentiality were guaranteed.

Participants were recruited from ICUs located on the west coast of Norway. Four different ICUs, located at three different hospitals, were chosen. The hospitals varied in size; none was a university hospital. The selection criteria for participation in the study were being an ICU nurse and working at the bedside of patients in an ICU. This excluded ICU nurses in primarily administrative or management roles and nurses who were working outside ICUs. The ward management distributed information to ICU nurses who fulfilled the criteria, and made appointments for the interviews for those who wanted to participate.

The participants in this study consisted of 17 female and three male ICU nurses. All participants had completed 18 months of postgraduate education to specialise as ICU nurses. Their experience levels as ICU nurses varied from three months to more than 30 years, with a mean of 10 years.

The data collection was conducted during the spring of 2011. Four focus group interviews, one in each ICU, were conducted. The number of participants in each interview was respectively 7, 5, 6 and 2. The hospitals provided conference rooms, and the interviews lasted between 1.5 and 2 hours, which is a common duration for focus group interviews (Kitzinger, 1995).

The interviews were led by the first author, who is an ICU nurse. This was based on recommendations that the moderator must have adequate background knowledge on the topic of discussion and be familiar with 'inside language', jargon and key issues (Krueger and Casey, 2009). An assistant moderator was also present and took notes on nonverbal communication. The moderator facilitated the discussion so that appropriate themes were discussed, and ensured that all participants were heard. Emphasis was placed on asking simple, open-ended and clear questions (Krueger and

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