Handling a challenging context: experiences of facilitating evidence-based elderly care

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Aim To explore improvement facilitators' experiences of handling their commission to implement evidence-based practice in elderly care for frail older persons.
Background Improvement facilitators were put in place across Sweden in a time-limited project by the government, with one part of the project being to evaluate the model before establishing this facilitation of evidence-based practice in elderly care.
Method Two focus groups were interviewed twice. Each group comprised three respondents. The interviews were analysed using qualitative content analysis.
Findings A main theme, 'Moving forward by adjusting to the circumstances', described how the improvement facilitators handle their commitment. Five subthemes emerged: identifying barriers, keeping focus, maintaining motivation, building bridges and finding balance.
Conclusion The improvement facilitators' commitment is ambiguous because of unclear leadership of, and responsibility for the national investment. They have to handle leaders' different approaches and justify the need for evidence-based practice. The improvement facilitators did not reflect on the impact of programme adaptations on evidence-based practice.
Implications for nursing management The findings emphasise the need for collaboration between the improvement facilitator and the nurse manager. To fully implement evidence-based practice, negotiations with current practitioners for adaptation to local conditions are necessary. Furthermore, the value of improving organisational performance needs to be rigorously communicated throughout the organisation.

Keywords: elderly care, evidence-based practice, facilitators, nurse management, quality register

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Introduction

Evidence-based practice (EBP) for frail older persons entails integrating the best research evidence with clinical expertise and with the older person's health condition, preferences and actions (DiCenso *et al.* 2005). Facilitating refers to the process that enables the implementation of evidence into practice. Thus, a

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facilitator is an individual with appropriate skills and knowledge who can help individuals, teams and organisations to apply evidence in their daily practice (Harvey *et al.* 2002, Rycroft-Malone *et al.* 2004).

A few years ago, the Swedish government established that evidence-based practice is not employed to a significant extent in health and social services (National Board of Health & Welfare 2008). One strategy with regard to this situation was to recruit improvement facilitators in an effort to develop coordinated health and social care for older people with complex health conditions (Swedish Association of Local Authorities and Regions 2012). The improvement facilitators' duty is to facilitate EBP in the public sector, and they should drive, inspire and facilitate changes that make a difference (Swedish Association of Local Authorities and Regions 2012). Improvement facilitators are established in all counties in Sweden. They are agents of change and play a key role locally as they drive and support performance. However, the national investment is a time-limited project, and one aspect of the project is to evaluate the direction, methods and expected results before this model of facilitating EBP in elderly care is established permanently. A first step might be to describe the role of improvement facilitators from their point of view.

Evidence-based practice is dependent on the health-care context and on the available health-care resources (DiCenso *et al.* 2005). Rycroft-Malone *et al.* (2004) suggest that knowledge derived from a variety of sources that has been tested and found credible should be considered as evidence in EBP. This definition includes sources of information other than research evidence alone and so extends the meaning of EBP. The idea of the national investment in improving elderly care is to stimulate research and knowledge development, as well as to disseminate and implement new knowledge according to the extended definition of EBP (Swedish Association of Local Authorities and Regions 2012). The improvement facilitators play an important role in this dissemination and implementation (Rycroft-Malone *et al.* 2004).

Several implementation theories and frameworks encompass the role of individuals or groups of individuals in facilitating and supporting EBP. According to Rogers' (1995) theory of diffusion of innovations, opinion leaders are individuals who are influential in disseminating positive or negative information about an innovation. In general, the opinion leaders are local, respected sources of influence who are trusted among their peer group and are accomplished in role-modelling (Rogers 1995). In the Promoting Action on Research Implementation in Health Services (PARIHS) framework, facilitation is one part and refers to a process of enabling implementation into practice (Harvey *et al.* 2002). The Ottawa Model of Research Use (OMRU) describes facilitators as individuals or groups that are voluntarily or formally employed to be responsible for implementing a research innovation (Rycroft-Malone & Bucknall 2010). In addition, Stetler's model from the 1970s includes facilitators as a strategy for implementation (Stetler *et al.* 2003). This model emphasises the need for the facilitator to have an appropriate level of education and a supportive context (Tsai 2003) in the work of implementing EBP.

Being a facilitator has been described as challenging, complex and requiring versatility (Eriksson *et al.* 2013), and previous studies have confirmed the importance of key persons in implementation processes (Fitzgerald *et al.* 2002, Grimshaw *et al.* 2006). However, the role of improvement facilitators in elderly care is unclear and needs to be further illuminated. Therefore, the aim of this study was to explore the improvement facilitators' experiences of handling their commission to implement EBP in elderly care.

Methods

Study design

The study design was inductive and included focus group interviews with persons working as improvement facilitators. Focus group interviews were chosen because of the fact that the method emphasises the interaction between respondents with a common frame of reference (McLafferty 2004). This method gave the authors an opportunity to elicit data on how a group of improvement facilitators described the improvement facilitator role and their commission to implement EBP in elderly care.

Setting and participants

Elderly care in this study includes both health care and social service for older persons. In the county of Skåne in the south of Sweden (population 1 263 088), six improvement facilitators with the responsibility for knowledge development in elderly care are employed. Each improvement facilitator has responsibility for several of the 33 municipalities in the county. Their mission is to support nurse managers and staff in two working areas: first, the development of dementia care at the highest national level; second,

the implementation of risk analysis and registration in three national quality registers. A national Swedish quality register is defined as follows: 'A national quality register contains individualised data concerning patient problems, medical interventions and outcomes after treatment, within all health care production' (Swedish Association of Local Authorities and Regions n.d.). The three national quality registers are the Senior Alerts Register, the Palliative Register and the Behavioural and Psychological Symptoms of Dementia (BPSD) Register. At the national level, government, through the Swedish Association of Local Authorities and Regions (SALAR), made time-limited performance payments (2012–14) to the municipalities in line with the number of registrations in these registers (Skane Municipal Association n.d).

All of the six improvement facilitators who were invited to participate in the study accepted the invitation. Their mean age was 45 years and their experience as improvement facilitators ranged between 3 months and 1.5 years (Table 1). All except one had previous work experience in elderly care, as well as in leadership and/or project management. The improvement facilitators were invited by e-mail containing information about the study; and after they had accepted, a time for the first focus group interview was scheduled. Before the interview started, the aim was once again presented, the voluntary nature of the study was emphasised and an assurance that all data would be treated confidentially was given. According to Swedish law, no ethical approval was needed from the Regional Ethics Committee because studies about staff's work do not include confidential or sensitive information.

Table 1
Characteristics of the improvement facilitators in the study ($n = 6$)

	Improvement facilitators
Age mean (range)	45 (38–55) years
Gender men/women	2/4
Educational level	
University	5
Master's 2-year advanced level	1
Master's 1-year advanced level	1
Bachelor's, basic level	1
High school	1
Educational topics	
Health care and social service	6
Pedagogy	2
Psychology/sociology	2
Leadership/project management	2
Improvement knowledge	2
Health economy/health-care administration	2
Previous work experience	
Health care and/or social service for older people	5
Leadership and/or project management	6

Data collection

Two focus groups, each group comprising three respondents, were interviewed twice between October 2012 and January 2013. The time between the first and second interviews was 7 weeks (group 1) and 11 weeks (group 2). The interviews were conducted at the university, with the second and third authors as moderator and observer, respectively. An interview guide was developed for the first group interview based on the facilitation concept (Rycroft-Malone 2004). The moderator started the discussion in the first interview by asking the respondents to narrate their first expectations of the role of improvement facilitator and to state why they had applied for this position. The focus was then on exploring how prepared the improvement facilitators were for the role, what strategies were significant and what results they expected to achieve.

The interview guide for the second group interview was based on information from the first interview and started by asking the respondents to reflect on the concept of EBP. In addition, the types of tasks or implementation projects they were working on, their use of implementation strategies and the clarity of their role and commission were discussed. Additional questions were asked to deepen or clarify the information. All interviews were digitally recorded and transcribed verbatim, and each interview lasted 90–120 minutes. Immediately after each interview, the observer made field notes, including a summary of the areas discussed, the order of speakers and the group dynamics, to ensure the quality of each group session (Kreuger & Casey 2009).

Data analysis

The content analysis (Krippendorff 2004) of the data was performed by the first author (AN) in collaboration with the third author (CWH). First, the two authors read the transcribed discussions several times to obtain an overview of the content. Second, the authors identified as meaning units all discussions related to the aim. Third, they labelled the meaning units with a code that described their content. In this step, the data were still close to the text. Fourth, the authors abstracted and interpreted the codes' underlying meaning in order to achieve a deeper understanding of the content of the discussions. From this step of the analysis (Baxter 1991), five subthemes emerged. The subthemes were merged into an interpreted whole and one main theme was generated.

The first and third authors then discussed the content and the interpretations of both the subthemes and

the overarching theme with the second author (GA), who had been one of the interviewers. In addition, the informants in the focus group had an opportunity to offer comments on the findings to the third author. The informants verified the findings and no changes were made. Finally, to illustrate the findings, quotations from the focus group discussions were selected for inclusion in the Findings section.

In Sweden, the leaders in elderly care in the municipalities have their professional background in nursing or in social work. Despite this variation we use the term 'nurse manager' in order to make the text more consistent.

Findings

The findings explore the improvement facilitators' experiences expressed by the main theme of 'Moving forward by adjusting to the circumstances' generated by the five subthemes: identifying barriers, keeping focus, maintaining motivation, building bridges and finding balance.

Moving forward by adjusting to the circumstances

The improvement facilitators' experiences were described as 'two sides of a coin'. On the one side, they described their commitment to improving quality in elderly care. On the other side, their role of facilitator was a pioneering one and they had to struggle to legitimise themselves. They mostly met with interest from the leaders and staff in the municipalities they were responsible for, as long as the national investment was performed according to the organisational focus and qualifications. The improvement facilitators had to justify the need for EBP without any support. To be an improvement facilitator entailed handling a challenging context.

Identifying barriers

The improvement facilitators identified and reflected on barriers both within their own organisation and within the target organisations. They discussed the unclear leadership of the national investment and their dependency on nurse managers' willingness to invest in and set up clear strategies. The improvement facilitator role required several additional skills not needed in their previous work. Their ability to only advise, not decide, was described as an obstacle in the implementation process. However, the most commonly identified barrier was the complexity in the organisation of elderly care. They discussed how the process of decision-making in the elderly care units was sometimes unwieldy, and they emphasised the lack of communication between leaders at different levels in the organisations. Another barrier discussed was the absence of evaluation and goal-setting in elderly care units. The discussions disclosed that attitudes and qualifications in the municipal organisations were determining conditions with regard to performing quality registration. The improvement facilitators reported that the nurse managers have varied approaches to the quality registers. Some of the leaders agreed to perform registration, but not every leader could see the value of the national investment in registration in the quality registers, and for access to those units a gatekeeper was needed. The improvement facilitators discussed their concern regarding the sustainability of quality registration related to the time-limited payments for the registration. They also reflected on the need of supporting motivation other than money to make the work sustainable.

Focus group 2, interview 1

> 'Actually, I think our assignment is a bit narrowly restricted to the registers. We're supposed to try to further develop this evidence-based practice stuff'.
>
> [Respondent (R) 1]

> 'Surely it's partly because we get our assignments through SKL, and it's SKL that provides these performance-based compensations and owns the issue'.
>
> (R2)

> 'I tend to agree that it is really an impediment'.
>
> (R3)

> 'Of course it can be an impediment, but the ones I tend to come into contact with most are actually the leadership. A lot of department heads are so busy they have very little of a development orientation, and measuring is just not part of their world. They call in new staff and work on bringing in new users'.
>
> (R1)

> 'The variation in their approaches to the job can be surprising'.
>
> (R2)

Keeping focus

The improvement facilitators reflected on keeping a focus on the goal of national investment and using a

systematic approach to achieve improved service quality for the frail older person. They commented that they maintained their focus on the older person, as they had been closely involved in elderly care shortly before they became improvement facilitators. However, they perceived that the nurse managers in elderly care overlooked this perspective. The informants discussed their struggle to keep the two perspectives in mind because there were so many other elements that could be improved on and highlighted. In addition, they discussed the systematic work to implement quality registration as a routine measure in the organisation. They emphasised the value of using quality registers for performance interventions in order to achieve evidence-base practice. To facilitate the goal of national investment, they had been inviting leaders to meetings where person-centred care and improvement tools were discussed.

Focus group 1, interview 1

> 'Everything we do is supposed to be for the good of the elderly patient, but our work is on a slightly different plane and we have to continuously remind ourselves that we are trying to help this or that particular person, even though we have no contact with them. I notice that when you start communicating on that level in organisations, that focus, that perspective, is not always self-evident'.
>
> (R1)

> 'It doesn't seem that real'.
>
> [Interviewer (I)]

> 'It easily turns into a lot of bureaucratic jargon. I have to pinch myself sometimes. I try to bring it into discussions and meetings – 'Excuse me, who are we actually here for?' Sometimes you feel there is a tendency to forget the patient-focused perspective'.
>
> (R1)

Maintaining motivation

The improvement facilitators indicated that they were generally met by positive attitudes at the different elderly care units. However, they reflected on the importance of maintaining motivation — the nurse managers', the staff's and their own — to accomplish EBP. To support motivation in the organisations, the improvement facilitators put the specific elderly care unit within a larger perspective. They often did this by presenting results from quality registration in other municipal organisations, at the same time as they kept in mind the particular organisation's current knowledge and performance. The informants also discussed their efforts to become less needed by the municipalities. One way was to share their knowledge regarding improvement work in order to empower the municipal leaders to face future interventions. Another way was to provide hands-on tutoring regarding how to perform quality improvement. In addition, the improvement facilitators reported that working with engaged co-workers supported participation, self-determination and motivation in the organisations. The discussions revealed a great willingness to make improvements in the organisations. In order to maintain their own motivation, the informants emphasised feedback from leaders and staff they work with. It was also important to support each other and share knowledge and acknowledgements.

Focus group 1, interview 2

> 'It depends on what the municipalities put on the table, and whether we actually comply, you might say, with everything'.
>
> (I)

> 'We have to adapt it. It may be a matter of providing support for the establishment of a structure, everything from implementing a steering group to being a part of the group, so they're on the right track when it's set up. Helping them so they can help themselves, in a way'.
>
> (R2)

> 'In some cases, our main role is to be a sounding board'.
>
> (R1)

> 'Yes'.
>
> (R2)

> 'They would really like to know what it's like in other municipalities'.
>
> (R3)

Building bridges

The improvement facilitators indicated that building bridges concerned promoting quality and collaboration within and between the municipal organisations. They reflected on the need to transform the concept of EBP in order to close the gap between theory and practice. The concept of EBP was sometimes difficult for nurse managers and staff to understand. Thus, the improvement facilitators needed to make the concept

understandable and useful. To do so, they introduced EBP by incorporating research, the older persons' experiences and the staff's experiences related to the particular practice into the current improvement work. They also reported that the implementation of EBP is dependent on the frontline staff in the elderly care units, and emphasised the importance of not neglecting the existing knowledge of leaders and staff. Therefore, evidence has to accord with the context, with value and usability being aspects in facilitating the implementation. The improvement facilitators supported a dialogue between leaders, to increase their awareness of the value of a shared approach to EBP. They stressed that the authorisation given to their role in the national investment facilitated collaboration with leaders and staff at different levels in elderly care. To achieve collaboration and give the leaders a shared picture of the value of EBP, the improvement facilitators put forward good examples from elderly care in other municipalities.

Focus group 2, interview 2

> 'It's part and parcel of organisational culture – the organisation's attitudes to research and development, how well trained the organisation is in adjusting to new theories or orientations'.
>
> (R3)

> 'There has to be pressure from somewhere to get organisations to align their operations with research and proven experience'.
>
> (R2)

> 'I don't believe people ask for something they don't even know exists'.
>
> (R1)

> 'Exactly!'
>
> (R3)

> 'There's where I believe we have an important role – to give a concrete example – to make sure the debate stays on a level that is easy to understand'.
>
> (R1)

> 'When you're working in an outreach context, you try to put the concept in concrete terms, so to speak'.
>
> (I)

> 'Yeah, you can't just waltz into a department and announce that everybody suddenly has to switch over to evidence-based practice'.
>
> (R1)

> 'You certainly can't'.
>
> (I)

> 'You can't do that. You'd just lose 'em in an instant, you would'.
>
> (R1)

> 'So, it's gotta be about concrete tasks'.
>
> (R2)

Finding balance

The improvement facilitators reported that they experience the national investment as ambiguous, and they emphasised the need for balance between the national commitment and the organisational preconditions. They discussed the nurse manager's expectations which mostly was limited to the benefit of the implementation of national investment in accordance with their own elderly care unit [i.e. with regard to costs, process analysis, information technology (IT) and evaluation]. To balance the top-down perspective on quality registration, the improvement facilitators highlighted the frail older person's perspective. They also stressed the need for having an instinctive feeling about when to contact the nurse managers. The improvement facilitators discussed how their previous experience of authority as a leader and/or project manager helped them in balancing their workload and rejecting commissions of no relevance to the national investment. They also described the lack of balance between the time required for the national investment and the time required for their own supervision and support from other improvement facilitators. Again, their previous working experience supports them in setting priorities.

Focus group 2, interview 2

> 'I feel that on certain things, like I said, I get support from you, but I also feel I have quite a lot of support from how I did things before and being good at dealing with people'.
>
> (R3)

> 'I believe you need a pretty strong sense of self in this job, because you get thrown among so many people and situations. If you don't have that, I think you can feel pretty lost. That's how I see it'.
>
> (R2)

> 'You have your experience to fall back on'.
>
> (R1)

Discussion

To the best of our knowledge, this is the first study illuminating the improvement facilitators' experiences of a Swedish national programme for evidence-based elderly care. The main theme, 'Moving forward by adjusting to the circumstances', describes how the improvement facilitators handle their commitment. The national investment was described as 'two sides of a coin'. On one side, they were committed to handling their task and, on the other side, it was pioneering work and they had to justify EBP to the elderly care units. However, as long as they adjusted the national investment to the context, they were mostly met by interest. The five subthemes – identifying barriers, keeping focus, maintaining motivation, building bridges and finding balance – determined the content of the overarching theme.

The findings show that there was no predefined model of how the process was to work or how the improvement facilitators were to approach the municipalities. As a result, the improvement facilitators had to handle each new situation individually. According to Stetler's model, a package of tools and resources for facilitators should include a supportive context with mentors and consultants (Tsai 2003) as well as other organisational resources, such as staff time available for project work (Stetler *et al.* 2003). The PARIHS framework goes further, suggesting the need for an appropriate training programme (Kitson *et al.* 2008). However, in view of the nurse managers' various approaches to EBP, the improvement facilitators in the present study were forced to adopt the learning-by-doing approach. Thus, the lack of a formulated working model and support may have resulted in barriers that were unnecessary and could have been prevented. The facilitator role that supports practitioners in making improvements is not consistently or clearly described in the literature. During the last 20 years several studies in Europe and North America have attempted to understand the role of facilitators – a role that can involve different tasks, from setting up meetings and recording minutes to guiding activities directed towards health-care improvement (Godfrey *et al.* 2014).

The findings highlight the importance of committed collaboration between the improvement facilitator and the nurse managers throughout the implementation process. Further, the leaders need to have knowledge about EBP and the value of using quality registers as improvement tools. However, the role of nurse managers in relation to EBP is still not fully researched (Sandström *et al.* 2011). Hauck *et al.* (2013) supports the findings in this study in emphasising the value of a leadership that promotes education and opportunities to transform research into practice. Such promotion calls for a clear vision and the making available of enough resources to improve clinical performance. (Rosengren *et al.* 2012) .

The improvement facilitators referred to the nurse managers' different approaches to improving quality in elderly care on the basis of the national quality registers. They reported that some leaders do not see the value of the quality registers or their connection to evidence-based elderly care. This is an unexpected finding, as Sweden currently has about 90 national quality registers, mostly web-based. Swedish Association of Local Authorities and Regions n.d. These registers require significant resources, and they are monitored and approved for financial support annually by a national executive committee (Swedish Association of Local Authorities and Regions n.d.). Critical opinion regarding the registers suggests that they mean increased governmental control and decreased professional autonomy in securing quality and appropriate performance in elderly care. Furthermore, the national quality registers have been introduced without a neutral and rigorous presentation to the municipalities (Bejerot & Hasselbladh 2011). This may be one of the reasons why some leaders decide not to use them.

The improvement facilitators used good examples from other organisations that had used the quality registers in their work. Putting the current organisation into a bigger context is thus one way of building a bridge between theory and practice. The use of national quality registers has resulted in improved health care for patients with both long-term and acute conditions (Petersson *et al.* 2007, Hallgren Elfgren *et al.* 2013) and may indicate the need to disseminate good examples more widely and to continue research into the benefits of the quality registers in elderly care. Gunningberg *et al.* (2010) emphasise the importance of incorporating nursing outcomes in national quality registers for benchmarking between county councils, and such an approach would facilitate nurse managers' work in improving quality. This practice is in line with previous literature describing the use of quality registers for benchmarking in order to improve organisational performance (van der Veer *et al.* 2010).

The improvement facilitators discussed the question of knowing when to contact the nurse managers. One of the reasons factors is the workload in the organisation. This finding is strengthened by previous research

regarding an organisation's dependence on sufficient personnel resources to be able to use the national quality registers (Adolfsson & Rosenblad 2011). The impact of context when implementing EBP is widely known (Grol & Wensing 2004, Rycroft-Malone *et al.* 2004, Hutchinson & Johnston 2006, Rycroft-Malone 2012). The present study has revealed the improvement facilitators' differing approaches when encountering the nurse managers and the ways their role varies, from giving practical support to coaching already skilled leaders. These findings are in line with the findings of Harvey *et al.* (2002), who describe a facilitator's skills as including the ability to adjust to different contexts and situations. The PARIHS framework suggests several elements of leadership that increase the likelihood of success for implementation. Transformational approach, role clarity, effective teamwork, effective organisational structures, democratic decision-making and an enabling approach to learning, teaching and managing should all be present (McCormack *et al.* 2002). However, at times the improvement facilitators have to explain the concept of EBP, and they need to keep the explanation simple for the concept to be usable by the nurse managers and staff.

The findings revealed that adaptation of evidence-based methods to current practice is necessary for the success of the improvement facilitators' work. An intervention cannot always be implemented fully because local conditions may require some programme adaptation (Carroll *et al.* 2007). The term *fidelity* is often defined as the degree to which a particular programme follows an original programme model (i.e. the model that the programme developers intended should be used) (Dusenbury *et al.* 2003, Hasson *et al.* 2012). However, when evidence-based methods are adapted to a specific practice, the aspect of fidelity is too often neglected. Several studies have demonstrated that programmes with high fidelity have better outcomes than programmes with lower fidelity (Dusenbury *et al.* 2003, Carroll *et al.* 2007, Hasson *et al.* 2012). Other authors argue that local adaptations improve the fit of the intervention to the local context, and successful interventions are dependent on adaptations (Rogers 1995, Carroll *et al.* 2007, Hasson *et al.* 2012). This perspective is in line with theories on organisational change and motivation, showing that employees are more likely to change behaviour when they are motivated to do so (Ryan & Deci 2000). Nygårdh *et al.* (2014) found that taking a clinically relevant perspective with regard to improving performance increased staff motivation.

To summarise, implementation in practice will happen when the intervention fits the organisation (i.e. when the direction of change is in accordance with organisational and personal goals), when the employees have sufficient competence for the tasks and when the results are valued by others in the organisation (Hasson *et al.* 2012). However, the improvement facilitators in this study did not reflect on any adaptations that had been made or on the effect of such adaptations on evidence-based methods.

Methodological considerations

Research findings should always involve the maximum possible trustworthiness (Lincoln & Guba 1985). Therefore, some aspects of the focus group methodology deserve attention when interpreting the findings of the present study. A purposeful sample was recruited that comprised all six improvement facilitators in the county of Skåne. In line with the suggestion of Kreuger and Casey (2009), they were a homogeneous group of people with something in common: in this case the experience of being improvement facilitators. The ideal group size has been debated and there is little consensus as to what is appropriate. A review of the literature indicated that the number of focus group participants can vary from 4 to 20 (McLafferty 2004). As each of the two groups in the present study had three members, there may have been a risk of fewer generated concepts (McLafferty 2004). However, fewer people in a group may increase the likelihood of interaction, and the discussions in this study yielded rich, in-depth information, reflecting the full range of experiences in connection with the improvement facilitator role. Group discussions can lead to group consensus, which may influence the creation of particular ideas (Kreuger & Casey 2009). To minimise this risk, the moderator encouraged the quietest participants by using probing questions. To ensure credibility, the four focus group interviews were held at the same location, with the same moderator and observer. Furthermore, to strengthen the dependability of the data, the first author, who was not involved in the focus group interviews, immersed herself in the data analysis process. The three authors compared and discussed new interpretations and insights until they reached agreement on the categorising. In general, researchers conducting qualitative studies do not have a view to generalising their findings, but instead seek to explore a topic in depth (Lincoln & Guba 1985). In this instance, however, the authors suggest that these findings can be transferred to similar facilitator roles in elderly care.

Conclusions

The main finding concerning the improvement facilitators' experience, 'moving forward by adjusting to the circumstances', points to the ambiguity of their role in accomplishing EBP in elderly care. They have to handle unclear leadership of, and responsibility for the national investment. The findings reveal how the improvement facilitators use different strategies to justify and simplify the concept of EBP for nurse managers and staff. The improvement facilitators described the need to engage with the leaders and staff in relation to their current needs and situation. However, they did not reflect on the significance of fidelity and the impact of any adaptations on the performance of EBP. In summary, implementing the national quality registers in order to accomplish evidence-based elderly care needs collaboration with supportive nurse managers and competent and supported improvement facilitators for adaptation to the specific context.

Implications for nursing management

To fully implement EBP, a nurse manager should support the improvement facilitator's negotiation with practitioners in order to achieve successful adaptation to local conditions. The findings emphasise the need for nurse managers as transformational leaders who facilitate learning and evaluation in the implementation of EBP within the particular organisational structure. There is need to support the staff by role modelling, clear strategies, continued education regarding EBP and the use of the quality registers. The value of improving organisational performance must be rigorously communicated throughout the organisation.

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Ethical approval

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