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Constructing situated evidence-based practice in acute frailty care: A grounded theory.

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ABSTRACT

Objective: To develop a substantive grounded theory that explains how nurses in acute frailty units construct, negotiate, and enact evidence-based practice (EBP) in everyday care.
Methods: A constructivist grounded theory design guided 21 interviews and 36 h of focused observation in an English acute frailty unit. Analysis used initial and focused coding, theoretical coding, and memoing, supported by supplementary situational mapping to sensitise contextual relations. Constant comparison informed category development and specification of the core process.
Results: The basic social process, constructing situated EBP, comprised four linked practices: negotiating professional boundaries, integrating patient and family preferences, mediating organisational pressures, and sustaining professional identity. Credible proposals gained traction through strategic timing, relational framing, use of visible warrants such as validated tools and audit indicators, and the adoption of locally recognised institutional language. These brief, distributed moves functioned as micro-facilitation, enabling bedside nurses to align patient goals with organisational imperatives and to document rationales that colleagues could accept under constraint.
Conclusions: The theory explains how nurses translate shared evidence into situated action within fast-paced multidisciplinary forums. It extends implementation accounts by specifying micro-facilitation as routine interactional work rather than a discrete role, and by showing how proposals that link patient priorities to organisationally legible indicators support safe, acceptable decisions under flow pressure. The model is transferable to high-tempo services managing multimorbidity where teams rely on a small set of legitimising tools and rapid deliberation.

Introduction

Evidence-based practice (EBP) is widely described as the conscientious integration of the best available research evidence with clinical expertise and patient preferences to guide decisions that improve care quality and outcomes.[1,2] Despite sustained policy advocacy, routine enactment of EBP across acute nursing settings frequently diverges from formal expectations due to contextual contingencies that shape what becomes feasible at the bedside.[3] Scholarship often frames EBP as individual competencies or organisational capabilities,[4,5] which can flatten the relational and political textures of clinical work and obscure how clinicians mobilise evidence within hierarchies, resource constraints, and contested meanings of quality and risk.[6] Sociological and organisational perspectives have shown that nurses and other healthcare professionals accomplish care through situated coordination, soft intelligence, and boundary work that rarely map neatly onto linear models of knowledge use.[7,8] This study examines the translation work of EBP rather than the production of evidence through evidence-based research, maintaining a focus on how guideline recommendations are mobilised, negotiated, and adapted in practice.

Abbreviations: 4AT, 4 'A's Test; CFS, Clinical Frailty Scale; COREQ, Consolidated Criteria for Reporting Qualitative Research; EBP, Evidence-Based Practice; FM, Frailty Matron; iPARIHS, Integrated Promoting Action on Research Implementation in Health Services framework; MDT, Multidisciplinary Team; SNs, Staff Nurses; SSNs, Senior Staff Nurses; WMs, Ward Managers

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Acute frailty units provide a distinctive arena for studying how evidence is negotiated because teams deliver rapid assessments and time-sensitive decisions for older adults living with multimorbidity, polypharmacy, cognitive impairment, and social vulnerability.[9] The complexity and pace of frailty care expose limitations of single disease guidelines and require clinicians to weigh competing risks while aligning plans with what matters to patients and families.[10,11] Research on comprehensive geriatric assessment demonstrates benefits for older adults, yet translation depends on team processes, local resources, and coordination across services that vary within and between hospitals.[12,13] Day-to-day decision making in these settings frequently draws on collectively held 'mindlines', informal exchanges, and experiential judgements that calibrate formal evidence to shifting conditions of staffing, flow, and patient priorities.[14]

Growing work on implementation and complexity argues that evidence use is shaped by context, mechanisms, and social relations rather than by linear pipelines from research to practice.[15,16] Nurses often work within hierarchies that differentially recognise knowledge claims, which makes the presentation and timing of evidence as consequential as the content itself during multidisciplinary deliberations.[17] Teams, tribes, and professional subcultures influence whose voices are amplified and whose experiential claims require external legitimation through guidelines or metrics.[18] Attention to social position remains important, as it can structure access to influence and credibility for nurses without altering the evidentiary standards that apply to all patients.[16,17]

Prior studies have explored barriers and facilitators to evidence uptake, yet fewer have theorised the everyday negotiations through which nurses align guidelines with patient values and organisational constraints in real time.[15] Studies of technology adoption, quality improvement, and soft intelligence similarly highlight the importance of sense-making, boundary negotiation, and relational labour, but rarely specify how these dynamics unfold in frailty units where acuity, throughput pressures, and multimorbidity are routine.[21] Positioning the work as processual rather than linear aligns with accounts of complexity in health services and with calls to move beyond adoption narratives toward explanations of adaptation, non-adoption, and reconfiguration. This study aimed to explain how nurses working in acute frailty units construct, negotiate, and enact EBP within everyday clinical care.

Methods

Design and theoretical framework

We adopted a constructivist grounded theory approach as articulated by Charmaz.[18] Constructivist grounded theory was chosen because it positions knowledge as co-constructed between researcher and participant, acknowledging the interpretive nature of both data collection and analysis.[19] Rather than seeking to uncover an objective reality, this approach attends to the multiple realities that emerge through social interaction, which is particularly suited to exploring complex processes such as EBP within acute frailty settings.[19] Understanding of grounded theory has evolved from the original work of Glaser and Strauss, who conceptualised the method as a systematic approach to generating theory inductively from data.[19] Charmaz subsequently adapted the methodology by rejecting the assumption of objective discovery and emphasising instead the co-construction of meaning between researcher and participant, thereby situating knowledge as interpretive and contextually contingent.[18] This study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ),[20] (supplementary File 1).

Study setting

The study was conducted in an acute hospital located in England. This hospital provides specialist services for older adults and has a dedicated acute frailty unit integrated within its emergency care and geriatric medicine departments. The setting was chosen for its organisational commitment to frailty care and its diverse nursing workforce, which offered a rich environment for exploring how EBP is negotiated and enacted in everyday clinical work. The acute frailty unit operates as a multidisciplinary space where nurses collaborate closely with geriatricians, physiotherapists, occupational therapists, and social workers. Clinical care focuses on rapid comprehensive assessment and tailored intervention for frail older adults, many of whom present with multiple, interacting health and social needs. Patients admitted to the unit typically displayed high levels of complexity, including multimorbidity, polypharmacy, frequent delirium or cognitive decline, and significant psychosocial vulnerabilities such as isolation or lack of informal carers, which created conditions where standardised guidelines often proved difficult to apply in isolation. Routine tools included the 4 'A's Test (4AT) delirium screen and the Clinical Frailty Scale (CFS), which shaped everyday talk and documentation, though they were not study measures.

Participants and recruitment

Participants were recruited through purposive sampling strategies designed to ensure diversity in clinical role, experience, and professional background. The sample included staff nurses (SNs), senior staff nurses (SSNs), ward managers (WMs), and a frailty matron (FM), all currently working within the acute frailty unit and with at least six months of experience to ensure familiarity with unit practices and team dynamics. The frailty matron is a senior nursing leadership role responsible for frailty service coordination and clinical governance.

Initial recruitment was facilitated through information sessions and departmental meetings, where the study aims, and expectations were outlined. Interested nurses were invited to contact the researcher directly to maintain confidentiality and voluntary participation. Snowball sampling was subsequently used to expand the participant pool by encouraging enrolled nurses to suggest colleagues who might provide additional perspectives. All participants, including WMs and the FM, were registered nurses, which ensured that all perspectives represented nursing practice across frontline and leadership roles. Participant demographic characteristics are summarised in the Results section (section 3.1).

Data collection

Data were collected over six months (April-September 2023) through semi-structured interviews, supplemented by field observations and memo writing. Interviews were the primary data source, chosen for their flexibility in capturing detailed narratives about the social processes shaping nurses' engagement with EBP. Each participant took part in two interview rounds. The first interviews focused on gaining a broad understanding of participants' experiences with EBP in the acute frailty unit, while the second interviews explored emerging themes in greater depth and offered participants opportunities to reflect on and expand their earlier accounts. Interviews were conducted face-to-face in private rooms within the hospital premises to ensure a comfortable and confidential setting. The interviews were conducted by the lead author, a qualitative researcher, and were guided by an aide-memoire that outlined key topic areas but allowed flexibility to follow participants' narratives (Table 1).

Each participant completed two audio-recorded interviews lasting between 60–120 min, contributing a total of 2–4 h of interview

Table 1
Interview Aide-Memoire

Topic area	Key questions	Probes
Understanding of EBP	How do you understand evidence-based practice in your clinical work?	Can you describe a moment when your understanding of EBP changed? What influenced that change?
Negotiation of evidence	Can you describe a situation where you had to negotiate the use of evidence with colleagues or patients?	What made that negotiation easy or difficult? How did others respond to your suggestions?
Organisational influences	What organisational factors help or hinder your ability to use evidence in patient care?	Can you give an example of a time when organisational policies supported or challenged your use of evidence?
Professional identity	How does your background or experience influence the way you engage with evidence-based practice?	In what ways do you think your role or background shapes how colleagues listen to or accept your views?
Multidisciplinary interactions	How do relationships with other healthcare professionals affect your use of evidence?	Can you recall a time when working with another professional either strengthened or weakened your ability to apply evidence?

data across the study period. The aide-memoire was refined after initial interviews to probe emerging processes, for example sponsorship, institutional language, and use of dashboards. Interviews were transcribed verbatim shortly after completion to facilitate timely analysis.

We also conducted 36 h of focused observation across multidisciplinary board rounds, bedside handovers, and rapid discharge planning meetings. Observation was nonparticipant, verbal notice was given at the start of each forum, and staff consent was reconfirmed during sessions that included brief patient or family interactions, with no patient identifiers recorded. Observational notes (Supplementary File 2) were compared constantly with interview accounts to corroborate and contrast processes, for example, how guidelines were invoked in real time. Contextual documents such as staffing rotas, bed-flow dashboards, and discharge targets were reviewed to sensitise analysis to institutional logics, although they were not treated as a separate dataset. Memo writing occurred throughout data collection and analysis, supporting reflexivity and aiding in the development of categories and theoretical insights. Memos captured evolving interpretations, analytic decisions, and reflections on the research process.

Data analysis

Data were managed manually and in NVivo 12 to support systematic retrieval and auditability. Data analysis drew on constructivist grounded theory principles within Charmaz's analytic tradition [18]. Interview transcripts, field notes derived from thirty-six hours of focused observation, and contemporaneous analytic memos were examined alongside ongoing data collection. NVivo 12 supported systematic organisation and retrieval, although the analytic process remained iterative, interpretive, and theoretically driven rather than procedural. Constant comparison guided movement across transcript segments, observational extracts, time points, and participant groups. This approach allowed testing and refinement of emerging insights and ensured that early interpretations remained grounded in the data.

Initial coding began with line-by-line analysis, using action-oriented gerunds to remain close to participants' meanings and to foreground what nurses were doing as they mobilised evidence in real time. Observation data were integrated from the outset to check alignment between reported and enacted practice. Early analytic comparisons identified patterned links between bedside noticing, tool scores, and rapid presentation of evidence during multidisciplinary discussions. These analytic leads were recorded in memos and informed subsequent theoretically focused observation. At this stage, one hundred and thirty-two open codes were generated, representing interactional strategies, contextual contingencies, and ethical and emotional considerations associated with evidence work in frailty care.

Focused coding synthesised the most analytically meaningful codes into higher-order categories. Twenty categories were developed through iterative comparison across role seniority and training background. Memo writing supported this process by documenting interpretive shifts, analytic dilemmas, and questions about meaning, context, and process. Memos (Supplementary File 3), also recorded reflexive considerations, given the lead researcher's prior professional experience in frailty care. Negative and deviant cases were actively pursued to test the durability of early interpretations, particularly in relation to credibility, sponsorship, and institutional fluency.

Theoretical coding then examined relationships across categories, specifying the mechanisms that linked them and clarifying conditions under which particular practices secured influence. This phase highlighted how nurses legitimised proposals through strategic timing, visible warrants, and alignment with organisational logics while continuing to prioritise patient values. Abductive reasoning strengthened theoretical development, as unexpected observations prompted further interrogation of transcripts and targeted sampling to incorporate the perspectives of internationally educated and junior nurses whose contributions sometimes faced closer scrutiny.

Situational analysis mapping acted as a supplementary sensitising tool that deepened attention to context rather than forming a separate analytic system. Messy maps catalogued human and non-human elements that shaped decision-making environments, including dashboards, staffing patterns, and discharge pressures. Ordered maps organised these elements into social and organisational arenas, clarifying where evidentiary negotiations occurred and how accountability structures influenced decision pathways. Relational maps traced how credibility, voice, and institutional language interacted with material resources such as scoring instruments and flow monitors. These maps guided analytic decisions and informed theoretical sampling by highlighting when and where particular interactional strategies gained traction. They also drew attention to the positional dynamics experienced by internationally educated nurses, leading to targeted observation of their contributions during high-tempo board rounds. In this way, situational analysis directly shaped category specification and theory building by revealing how the four practices operated within material and organisational constraints.

Fig. 1 illustrates the integrated analytic trajectory, showing how grounded theory coding and situational mapping cycles converged through comparison, memo writing, and abductive return to the field. Saturation was reached when no further properties of the categories emerged and when relationships across categories retained coherence across interviews, observations, and memos. The substantive theory is presented in Fig. 2 and summarised in Table 2, which outlines the basic social process, 'Constructing Situated Evidence-Based Practice', and its four interrelated sub-processes.

An analytic matrix was developed during the later stages of analysis to consolidate how contextual conditions, interactional strategies, and observed consequences informed category refinement and

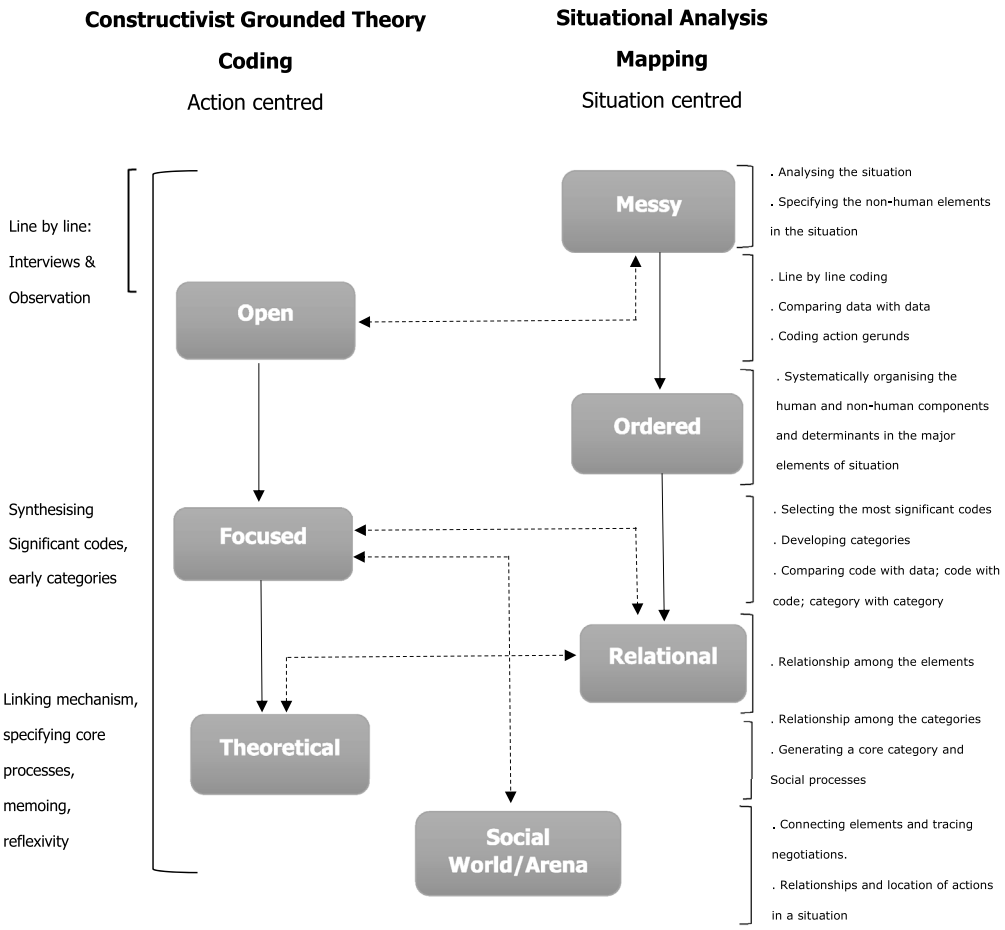

Fig. 1. Analysis process.

theoretical integration. This matrix is presented in Table 4 to support transparency and provide a clear link between data patterns and theoretical proposition.

Rigour and reflexivity

The quality and trustworthiness of this grounded theory study were guided by the evaluative criteria proposed by Thornberg & Charmaz,[21,22] We addressed Charmaz's criteria of credibility, originality, resonance, and usefulness through audit trails, iterative memoing, peer debriefs, participant feedback, and thick description. Credibility is the plausibility and trustworthiness of findings, and the extent to which the theory offers new insights, resonance as the degree to which the findings reflect participants' lived experiences, and usefulness as the applicability of findings to practice and further research.[21] Credibility was supported through regular research meetings where coding decisions, category development, and theoretical constructions were openly discussed. This collective engagement helped to refine interpretations and minimise the influence of individual bias. Memo writing was integrated throughout data collection and analysis, allowing for ongoing reflection on methodological decisions and the researcher's position within the study. The lead researcher, a registered nurse with prior experience in acute frailty care, maintained a reflexive stance, recognising both the advantages and challenges this insider knowledge presented. Reflexive memos documented how the lead researcher's insider knowledge shaped access and interpretation, and peer debriefs with co-authors were used to surface and bracket assumptions. An audit trail of coding decisions, map iterations, and memo timestamps supported transparency and dependability. Thick description of setting, workforce mix, and care processes is provided to enable reader assessment of transferability to other acute frailty and similar high tempo units.

Theoretical sampling moves were made during analysis to seek participants who varied by role seniority and country of initial qualification in order to elaborate properties of boundary negotiation and identity work. Originality was demonstrated through the development of a substantive theory that provides a novel understanding of how nurses construct EBP within the complex environment of acute frailty units. Resonance was sought through participant validation strategies, whereby summaries of preliminary findings were shared with a subset of participants to ensure that interpretations reflected their experiences accurately. Feedback from this process was incorporated into the final analysis to strengthen the authenticity and relevance of the findings. Usefulness was established by ensuring that the developed theory offers practical insights for clinical nursing practice.

Ethical considerations

Ethics approval was obtained from the University Research Ethics Committee (Reference ID: #001,284). Additional approval was secured from the Research and Development Units of the participating hospital site, ensuring compliance with institutional governance protocols.

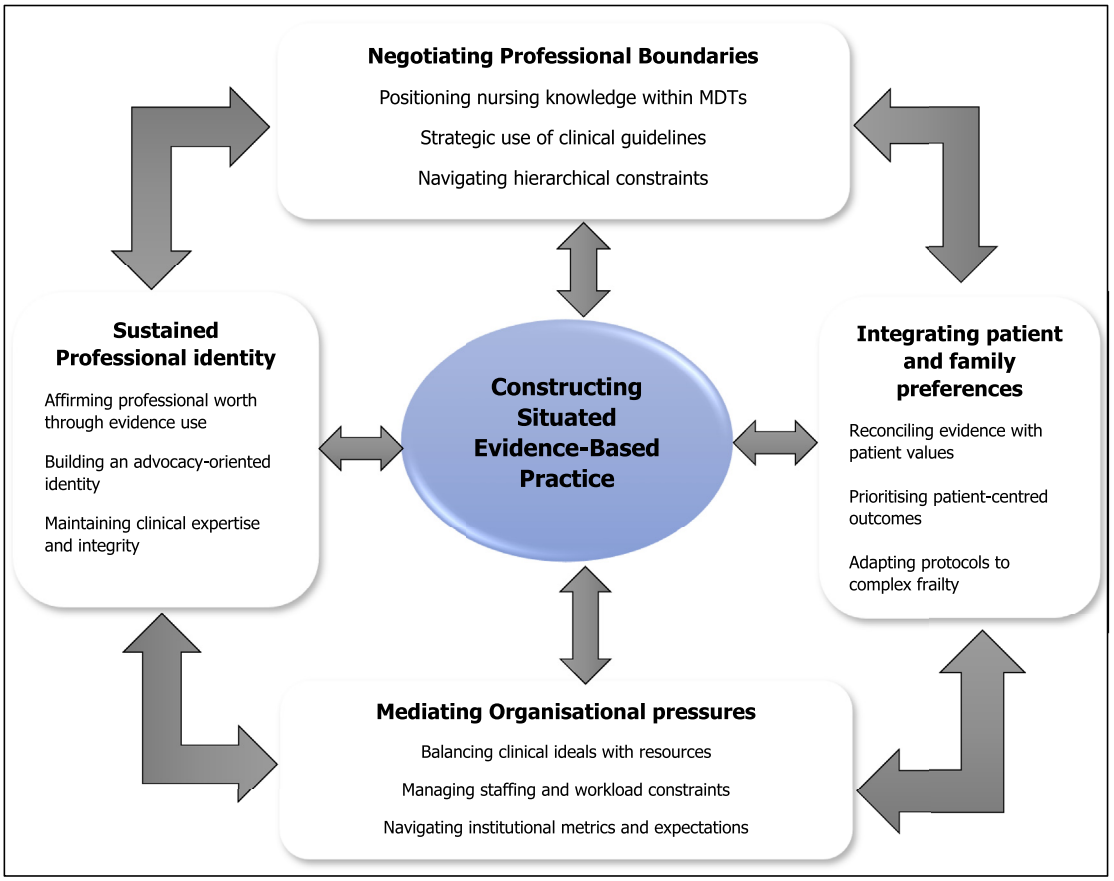

Fig. 2. Grounded theory of "constructing situated evidence-based practice".

Results

Participants' characteristics

A total of 21 registered nurses participated in the study, representing a range of clinical roles within the acute frailty unit, including SNs, SSNs, WMs, and a FM. Participants had between two and twenty-eight years of professional experience, and held academic qualifications ranging from diploma to master's level. Table 3 presents cohort-level demographic characteristics to maintain confidentiality while demonstrating the breadth and diversity of the sample.

Variation across roles, experience, and training backgrounds created the contrasts needed for constant comparison and informed theoretical sampling. As a recap, analysis yielded a core social process, "constructing situated EBP," expressed through four interrelated practices: negotiating professional boundaries, integrating patient

Table 2
Basic social process and sub-processes.

Basic Social Process	
Constructing Situated Evidence-Based Practice	
Sub-categories	**Key elements**
Negotiating professional boundaries	○ Positioning nursing knowledge within MDTs ○ Strategic use of guidelines ○ Navigating hierarchical constraints
Integrating patient and family preferences	○ Reconciling evidence with patient values ○ Prioritising patient-centred outcomes ○ Adapting protocols to complex frailty
Mediating organisational pressures	○ Balancing clinical ideals and resources ○ Managing workload constraints ○ Navigating institutional metrics
Sustaining professional identity	○ Affirming professional worth through use of evidence ○ Building an advocacy-oriented identity ○ Maintaining clinical expertise ○ Social position and credibility

Table 3
Demographic characteristics of participants (aggregate data).

Characteristic	N (%)
Role	
Staff nurses (SNs)	10 (47.6%)
Senior staff nurses (SSNs)	6 (28.6%)
Ward managers (WMs)	3 (14.3%)
Frailty matrons (FM)	2 (9.5%)
Gender	
Female	15 (71.4%)
Male	6 (28.6%)
Years of experience	
Range	2-28 years
Median	8 years
Academic qualification	
Diploma	2 (9.5%)
BSc	15 (71.4%)
MSc	4 (19.0%)
Ethnicity	
White British/Irish	12 (57.1%)
Black African/Caribbean	5 (23.8%)
Asian (Indian/Filipino)	3 (14.3%)
Other	1 (4.8%)

Note: SN = staff nurse; SSN = senior staff nurse; WM = ward manager

and family preferences, mediating organisational pressures, and sustaining professional identity. The following sections present each practice in turn.

Negotiating professional boundaries

Participants engaged in deliberate boundary work to render nursing assessments visible and credible within multidisciplinary forums. This work proceeded through positioning nursing knowledge, selective citation of guidelines, and tactful navigation of hierarchical relations, with each move shaping opportunities to influence decisions. These practices were not occasional tactics but routine ways of working that accumulated into recognisable patterns of interprofessional influence and professional legitimacy.

Positioning nursing knowledge

Participants described making nursing judgements legible to colleagues by framing bedside observations through recognised evidence.

> "When you speak up in those meetings, you need to have the evidence ready, because otherwise, your input gets brushed aside [. . .] you have to show that your observations are grounded in something more than experience, that they are backed by data and studies that matter to patient outcomes" (Interview, P03, Senior Staff Nurse).

This articulation captured a central mechanism of influence in board rounds and handovers, where raw experiential noticing rarely shifted plans unless it was fastened to a recognised evidentiary anchor such as a validated tool, a documented trend, or a recent audit. Nurses who prepared short, data-based narratives reported greater uptake of their recommendations, suggesting that credibility derived from the fusion of situated insight and portable proof.

> "A senior staff nurse summarised an overnight fall risk trend drawn from the notes and then cited a falls guideline to request a physiotherapy review before discharge. . ." (Observation, board round).

This observed interaction illustrated how translation of bedside pattern recognition into a concise, evidence-linked proposal enabled rapid alignment with medical decision making without extensive debate. The fall risk trend provided the trajectory, the guideline provided the warrant, and the specific request provided a feasible next step.

> "Positioning relies on a choreography of timing and format, with evidence offered as a bridge between bedside observations and medical expectations" (Analytic memo, Week 4).

Moments of maximal receptivity were cultivated through brevity, ordering of points, and alignment with meeting norms. The cumulative effect was to secure space for nursing expertise in care planning while setting up pathways for later advocacy on patient-defined goals.

Strategic use of guidelines

Participants described selective citation of guidelines to lend authority to proposals while retaining flexibility to tailor recommendations to the individual case.

> ". . .I do not quote guidelines to tick boxes. I bring them when I know they will back up what I am recommending [. . .] it gives weight to what you say, especially when the atmosphere is tense and others are more focused on discharge rates or bed availability" (Interview, P10, Senior Staff Nurse).

This comment illuminated guidelines as rhetorical and relational resources as much as technical ones. Selectivity functioned as a sign of judgement, signalling that participants could discern which parts of a guideline were germane to the immediate problem. The effect was to convert a potentially competing priority, such as bed pressure, into a consideration that could be negotiated within legitimate professional boundaries rather than through status alone.

> "A staff nurse used the Clinical Frailty Scale score to challenge a 'medically fit' label and asked for a pharmacy review of medication burden before discharge; the team agreed to check anticholinergic load and adjusted the plan" (Observation, bedside handover).

This observed sequence showed how a score, when paired with a specific and workable ask, could reopen a seemingly closed decision. The knowledge object did not end the conversation; it created an opening in which the team could pivot to a safer and still efficient alternative.

> "Guidelines operate as social currency; citation not only informs but legitimates the speaker as a knowledgeable practitioner who can be trusted with complex judgement" (Analytic memo).

Currency was earned through judicious rather than rigid use, which communicated both competence and respect for situational nuance. The cumulative effect was that guidelines served as both a "shield and a sword", enabling nurses to advance context sensitive plans while signalling accountability to organisational and professional norms.

Navigating hierarchies

Participants emphasised the importance of framing recommendations to invite uptake, with careful timing and tone to avoid triggering defensive responses.

> "You have to read the room. Some doctors welcome input [. . .] others see it as a challenge. Framing evidence as a suggestion rather than a correction often works better; you are bringing something valuable grounded in evidence and the patient's needs" (Interview, P04, Ward Manager).

This account highlighted relational intelligence as a companion to evidentiary work. Influence depended not only on what was said but on how and when it was offered, especially in time pressed meetings where face saving mattered.

> "The frailty matron acknowledged bed pressures, presented a one-page functional summary, and proposed a 24 h mobility plan. . .the consultant accepted the plan and linked it to safer discharge" (Observation, rapid discharge meeting).

This observed script began with alignment to shared organisational realities, moved to concise evidence that reframed the clinical picture, and ended with a time-limited proposal that respected flow. The sequence translated potential conflict into collaboration.

> "Hierarchy is managed through sequencing. . .affirmation of shared goals, concise evidence presentation, then a specific and time-bound proposal" (Analytic memo).

This memo crystallised the mechanism by which hierarchy was navigated rather than confronted. The cumulative effect was the normalisation of nurse led shaping of care plans without escalating interprofessional tensions, thereby sustaining future opportunities to speak and be heard.

Integrating patient and family preferences

Integration of "patient and family preferences" involved reconciling recommendations with personal goals, aligning outcomes to what mattered to the individual, and adapting to multimorbidity and fluctuating risk.

Reconciling evidence with values

Participants articulated the ethical and clinical need to align recommendations with what patients considered acceptable and meaningful.

> "...you can have all the evidence in the world about what is best clinically, but if the patient refuses because they value independence or fear the process, you need to listen...evidence has to serve the person, not override them" (Interview, P12, Staff Nurse).

This stance shifted the criterion of success from protocol completion to achievement of valued capabilities, which required explicit discussion of trade-offs rather than unilateral instruction.

> "After discussing risks of a brief inpatient stay for delirium, a senior nurse proposed a same day community package aligned with the patient's wish to go home; the family agreed and the consultant documented the shared plan" (Observation, family meeting).

This scene illustrated how negotiated care preserved both safety and autonomy by redistributing risk through community support and follow-up rather than insisting on a standard inpatient pathway.

> "Negotiation often reframes risk from probability to tolerability, anchored in the person's stated goals and context" (Analytic memo).

This memo made sense of why some plans that looked riskier on paper were accepted as safer in context. The cumulative effect was an approach to evidence use that remained clinically responsible while maintaining moral legitimacy for patients and families.

Prioritising patient-centred outcomes

Participants reported that patient centred outcomes provided a practical compass for ordering tasks and allocating scarce time.

> "...we might aim for early mobilisation, but if a patient's main goal is to regain enough strength to return home and tend to their garden, that is what matters. The evidence informs options, but the outcome has to fit their life" (Interview, P05, Frailty Matron).

This focus transformed daily planning from a list of generic tasks to a sequence of targeted rehearsals for home life, which supported both clinical recovery and patient confidence.

> "The therapy team re-ordered the day to secure stair practice before imaging because the patient identified managing stairs at home as the critical outcome for discharge" (Observation, therapy huddle).

This example showed how one clarified aim could reorganise a shift so that the most consequential capability was addressed first, preventing a late discovery of functional barriers.

> "Patient-stated outcomes operate as a decision compass that re-ranks tasks when time is short, and resources are thin" (Analytic memo).

The cumulative effect was smoother board rounds and fewer last minute plan changes, since teams shared a common reference point for judging readiness. Cases where no explicit outcome was articulated often produced scattered activity with less impact on discharge.

Adapting to complexity

Participants highlighted continuous adaptation in the face of multimorbidity, fluctuating cognition, and social vulnerability that complicated standard protocols.

> "...frailty is never straightforward; you are dealing with dementia, heart failure, arthritis, and isolation all at once. Guidelines help, but they do not tell you how to prioritise when everything is interconnected" (Interview, P17, Ward Manager).

This acknowledgement framed adaptation as a hallmark of expert practice rather than deviation, with iterative recalibration based on changing signs and contexts.

> "A senior nurse summarised competing risks of deconditioning versus delirium from a move to an unfamiliar ward; the team kept the patient in the same bay and scheduled targeted mobilisation with family support" (Observation, weekend board round).

This decision demonstrated principled flexibility, protecting orientation while still addressing mobility, and showed how adaptation could conserve gains in one domain without inviting deterioration in another.

> "Adaptation is enacted as micro-triage across evidence, goals, and available resources, with small course corrections that accrue over the admission" (Analytic memo).

The cumulative effect across cases was a pattern of small adjustments that yielded safer discharges and lower rates of plan reversal.

Mediating organisational pressures

Mediating organisational logics of throughput involved balancing ideals with resource realities, managing workload while maintaining safety, and translating patient-centred risks into arguments that were recognisable to decision makers. Cross-case comparison showed that teams with explicit rationales for adaptations retained credibility with senior managers, which later afforded flexibility during peak pressures.

Balancing ideals and resources

Participants described disciplined flexibility when comprehensive assessments were unattainable within shift constraints.

> "...the textbooks tell you to do comprehensive assessments, but when you have seven or eight patients and the team is short-staffed, you adapt. You focus on the essentials. Evidence still guides you, but it has to fit the reality you are working in" (Interview, P14, Senior Staff Nurse).

This orientation foregrounded prioritisation rather than abandonment, with temporary narrowing of scope justified and recorded for later completion.

> "During the morning safety brief the nurse in charge agreed a shortened assessment bundle for two new admissions and secured early therapy input for the highest risk patient, documenting the rationale on the ward dashboard" (Observation, morning safety brief).

This scene showed that accountability did not require rigid adherence to an ideal template; transparency about choices preserved trust and allowed the most consequential work to proceed first.

"Pragmatism here is principled; choices are documented, rationales are stated, and risk is redistributed transparently across the team" (Analytic memo).

The cumulative effect was preservation of safety standards without paralysing flow when capacity was strained. Cases without documentation occasionally drew retrospective criticism, indicating that transparency was as important as the adaptation itself.

Managing workload constraints

Participants emphasised ambient learning and rapid dissemination of updates as practical responses to limited protected time.

"...there is no protected time to read the latest research. Most of what I use comes from experience, handover discussions, and quick updates during training days. You grab what you can and weave it into the care you are already giving" (Interview, P01, Staff Nurse).

This mode of knowledge work converted small fragments of information into immediate changes through corridor consults, shift huddles, and micro-teaching.

"A senior staff nurse relayed a brief update from a pressure injury webinar to set turning schedules for two high-risk patients; the team adjusted plans within minutes" (Observation, corridor consult).

This example showed how timeliness and proximity to action mattered as much as content depth for influencing care. The webinar snippet did not await a formal session; it became part of the shift's choreography.

"Learning travels via short interactions that convert information into action, reinforcing shared standards under pressure" (Analytic memo).

This memo illuminated the diffusion mechanism characteristic of high-tempo environments. The cumulative effect was a living practice of evidence use that did not depend on periodic training alone.

Navigating institutional metrics

Participants described translating individual risk into organisationally legible arguments that balanced targets with safety.

"...you are always conscious of the clock and there is pressure to move people through quickly, but that can clash with what evidence says about safe discharge for frail patients. We navigate that carefully to avoid compromising care while still meeting the targets expected of us" (Interview, P18, Frailty Matron).

This navigation relied on reframing decisions in terms that hospital flow leaders recognised, such as falls probability, reattendance risk, or functional readiness.

"During the afternoon board round the ward manager acknowledged four-hour breaches, proposed two step-down transfers on functional grounds, and argued for one patient to remain overnight citing falls risk and lack of home support; senior decision-makers accepted the mixed plan" (Observation, afternoon board round).

This outcome illustrated strategic compromise, as organisational aims were partly satisfied while clinically unsafe moves were deferred, and the rationale was recorded for transparency.

"Metrics are negotiated through clinical arguments that translate person-centred risks into organisationally recognisable justifications" (Analytic memo).

This memo clarified how shared vocabularies bridged clinical and managerial perspectives. The cumulative effect was maintenance of trust between ward leadership and hospital flow teams, which in turn supported future flexibility when needed.

Sustaining professional identity

Use of evidence was linked to the development and maintenance of a durable professional identity. This identity work both resulted from and enabled boundary negotiation and organisational mediation, creating a reinforcing cycle of credibility, voice, and advocacy. Comparative analysis indicated that identity consolidation was most evident where recognition from colleagues followed visible, evidence linked contributions, which then emboldened further participation.

Affirming professional worth

Participants associated confident evidence use with enhanced recognition and willingness to contribute to multidisciplinary forums.

"...when you are confident in the evidence you are applying, it shows...you are more assertive in discussions...you are shaping the care plan actively. That shift builds your professional credibility within the team" (Interview, P07, Senior Staff Nurse).

This self-perception was mirrored externally when consultants or therapists acknowledged clinical reasoning, which served as public validation.

"After a staff nurse presented a concise evidence-based case for hydration support before diuretic titration, the consultant deferred medication changes and thanked the nurse for 'good clinical reasoning,' and the nurse contributed more actively to the next three cases" (Observation, board round).

This observed reinforcement showed how recognition moments altered subsequent participation patterns during the same meeting.

"Recognition moments accumulate and become scaffolding for future voice, especially for newer staff" (Analytic memo).

This memo highlighted the cumulative nature of identity building. The cumulative effect was a virtuous cycle in which credibility generated more opportunities to exercise clinical judgement.

Building an identity around advocacy

Participants framed evidence use as integral to ethical advocacy for patients whose needs might otherwise be deprioritised.

"...patients in frailty units can be overlooked...having solid evidence allows us to advocate with authority. You are not just appealing to emotions...you are bringing facts that back up why a particular approach is better for that person" (Interview, P11, Ward Manager).

This advocacy was collaborative, presenting data that others could endorse rather than oppositional claims that invited defensiveness.

"The frailty matron used functional trajectory notes to argue for a short inpatient rehabilitation period rather than same-day discharge; the team accepted the plan and set a review point" (Observation, family conference).

This example demonstrated how documented change over time legitimised a request for additional input while keeping a clear exit point, maintaining team confidence.

"Advocacy is data rich and patient led, aligning ethical commitments with shared organisational languages" (Analytic memo).

This memo clarified the mechanism by which advocacy achieved traction, as moral claims were braided with measurable indicators.

Maintaining clinical expertise

Participants connected ongoing engagement with evidence to integrity and trustworthiness in care.

"...you cannot rely only on what you learned years ago; frailty care evolves, and so must we. Keeping up with evidence is part of respecting the patients who trust you" (Interview, P06, Staff Nurse).

This commitment manifested through cycles of practice, reflection, and micro-teaching that embedded learning within routine work rather than separating it into distant training events.

"A senior nurse paused during handover to explain a new delirium screening nuance and linked it to last week's incident review, turning an adverse event into shared learning" (Observation, teaching moment).

This moment transformed organisational learning from a retrospective critique into prospective improvement, closing the loop between incident analysis and bedside action.

"Identity is sustained through practice, reflection, and micro-teaching that keep evidence alive in the ward's culture" (Analytic memo).

This emphasised culture as the medium through which individual competence became collective reliability. The cumulative effect was an environment where professional development was woven into daily care.

Social position and credibility

Participants linked who they were within the organisation to how their evidence informed proposals landed during fast paced decision making, describing strategies that secured voice while remaining aligned with shared clinical standards.

"As someone who trained abroad, I learned to bring the audit figures or a printed guideline line because my suggestions get more traction when the evidence is visible on the table" (Interview, Senior Staff Nurse).

This practice converted personal judgement into a collectively defensible position by attaching claims to portable proof that colleagues could verify quickly, and internationally educated nurses described anticipating credibility tests and responding with visible warrants that matched ward routines. Comparative analysis indicated that sponsorship by a higher status colleague amplified uptake of equivalent content during periods of flow pressure.

"Ward manager restated a junior nurse's point about anticholinergic burden using the medication reconciliation sheet; the pharmacist immediately suggested an alternative plan" (Observation, MDT huddle).

This sequence showed that legitimation travelled through both message and messenger, with endorsement operating as a relational accelerator rather than a substitution of evidence. Participants described cultivating institutional fluency as part of everyday professionalism, which included adopting local acronyms, citing hospital dashboards, and matching the cadence of board rounds.

"I noticed that when I use the same words the consultants use, like functional readiness or reattendance risk, the room listens differently to the same point" (Interview, Staff Nurse).

This adjustment rephrased evidence in locally meaningful terms and reduced translation work for recipients, which increased the likelihood of immediate adoption.

"Legitimation is interactional, with identity, sponsorship, and institutional language shaping whether a claim functions as clinical reasoning or as opinion" (Analytic memo).

Field notes captured repair moves that protected future participation.

"After a brief dismissal of a junior nurse's suggestion, the ward manager returned to the point, attributed the idea to the nurse, and asked the pharmacist to comment; the pharmacist agreed and the adjustment was made" (Observation, board round).

Participants also learned to pair person centred reasoning with quantifiable indicators to bridge professional languages.

"I now add a one line outcome the patient cares about and a number the team cares about, like steps to the front door and falls risk score, so the plan speaks to both" (Interview, Senior Staff Nurse).

Memo comparisons documented situational variability rather than a fixed hierarchy.

"Credibility fluctuates with time pressure, team composition, and recent events; when flow pressures are high, proposals that already carry the right institutional tags travel further" (Analytic memo).

Overall, findings show that race, nationality, class, and migration experiences did not change evidentiary rules, and instead shaped the interactional work required for shared evidence to be taken up through effects on recognition, sponsorship, and institutional fluency.

Grounded theory of constructing situated evidence-based practice

Fig. 2 presents the substantive theory. The core concern is producing defensible care decisions in acute frailty units while working within hierarchy, speed, and resource constraint. Nurses mobilised EBP through four interrelated practices that operate together: negotiating professional boundaries, integrating patient and family preferences, mediating organisational pressures, and sustaining professional identity. Evidence sources included validated tools, audit and dashboard data, experiential knowledge, and patient narratives. Credible proposals were crafted through concise source linked contributions, timing and tone that invited uptake, translation of patient goals into organisationally legible indicators, and transparent documentation of rationales. These moves generated warranted options that aligned with what mattered to patients and with institutional expectations. Greater preparation was often required for internationally educated and junior nurses whose contributions faced closer scrutiny, yet sustained use of the above strategies built trust, sponsorship, and institutional fluency. Feedback loops connected the four practices: persuasive boundary work attracted recognition that amplified future voice, clarified patient goals strengthened arguments to mediate flow targets, and successful mediation protected space to deliver patient centred plans. Consequences were visible in smoother multidisciplinary deliberations, fewer late reversals, and decisions experienced as accountable and ethically coherent. The

Table 4
Analytic matrix linking contextual triggers, interactional strategies, and outcomes across core practices.

Core category/practice	Conditions/contextual triggers	Actions /interactional strategies	Consequences /outcomes
Negotiating Professional Boundaries	Need to gain legitimacy in MDT spaces; hierarchies shaping whose knowledge is privileged; variable institutional fluency; expectation of concise clinical justification	Framing nursing insights with guideline prompts and audit data; citing validated tools (for example, CFS, 4AT); selective guideline use; preparing short data-based narratives; reading the room; timing and tone adaptations; securing sponsorship when needed	Increased influence in MDT decisions; nursing assessments rendered legible; legitimacy and credibility enhanced; safe plan adjustments accepted; strengthened future opportunities for voice
Integrating Patient and Family Preferences	Multimorbidity; fluctuating risk and priorities; ethical commitment to person-centred care; family concerns; variable tolerance of risk	Eliciting patient priorities; reframing risk as tolerability; aligning proposals with functional goals (for example, stairs practice, early home support); negotiating alternatives to standard pathways; collective agreement-building with families	Care aligned with what matters to patients; safety preserved through negotiated risk; smoother discharge trajectories; improved patient and family engagement; reduced rehospitalisation risk where implemented
Mediating Organisational Pressures	Flow targets; bed availability; staffing variation; competing priorities; rapid turnover; limited assessment time	Transparent prioritisation; negotiated compromises; documenting rationale; translating clinical risk into organisationally meaningful terms; securing early therapy input; micro-teaching and rapid dissemination of updates	Maintained safety while sustaining flow; organisational trust preserved; flexibility secured during peak pressures; reduced moral distress; evidence use sustained under constraint
Sustaining Professional Identity	Need for recognition and credibility; institutional expectations; variation in status (seniority, international training); emotional labour; commitment to professional standards	Micro-teaching and reflexive practice; positioning advocacy as evidence-linked; pairing patient outcomes with quantifiable metrics; adopting institutional language; cultivating sponsorship; visible engagement with evidence	Strengthened professional confidence; amplified voice; cumulative recognition shaping future influence; enhanced identity as credible evidence brokers; equitable participation strategies for internationally trained and junior nurses

theory explains how nurses translate shared evidence into situated action through relational and organisational work, thereby maintaining legitimacy and protecting care quality in acute frailty settings. These dual analytic streams jointly produced the model presented in Fig. 2. Table 4 complements Fig. 2 by detailing how observed conditions, behaviours, and outcomes aligned to shape each theoretical component.

Discussion

The findings extend existing accounts of EBP by showing how nurses in acute frailty care translate heterogeneous sources of evidence into credible, actionable proposals within fast paced multidisciplinary forums, highlighting the interactional and relational work that renders evidence usable under constraint. Comparative positioning with established frameworks clarifies contribution and scope. Relative to the Integrated Promoting Action on Research Implementation in Health Services (iPARIHS) framework, which conceptualises implementation as the product of evidence, recipients, context, and facilitation,[15] the present analysis specifies micro facilitation as performed by bedside nurses who actively work on context through sponsorship seeking, use of institutional language, and transparent documentation of rationales that enable colleagues to accept proposals under constraint. Alignment with iPARIHS is strongest around the centrality of facilitation and contextual fit, whereas extension lies in showing how facilitation unfolds as brief, distributed moves embedded in ward routines rather than as discrete projects led by designated facilitators.[23–26] The grounded theory therefore complements rather than replaces iPARIHS, offering micro-interactional specification of facilitation processes within acute frailty environments. Situational mapping strengthened theoretical coherence by making material and organisational artefacts analytically visible. In comparison, the Iowa Model reveals further distinctions. The Iowa pathway's staged logic from topic selection to evaluation offers valuable structure for planned change, yet observations here depict looping, abductive moves in which negative cases and shifting risk trigger rapid recalibration rather than linear progression, a dynamic characteristic of complex adaptive systems.[27–29] Convergence with the Iowa Model appears in emphasis on team engagement and evaluation, while divergence concerns tempo and granularity because acute frailty decisions frequently demand near real time adaptation that resists stepwise sequencing.

Services that care for multimorbidity under time pressure, including emergency admissions units, acute medical wards, and short stay geriatric services, share contextual features such as throughput targets, limited protected time, heterogeneous teams, and reliance on a small set of legitimising tools, which supports application of the model beyond the study site when comparable conditions are present. Variation should be anticipated around availability and status of tools, maturity of interprofessional routines, and organisational tolerance for documented deviations from ideal pathways, each of which can amplify or dampen the identified practices.[30–32] Strategies used by junior and internationally educated nurses, including making warrants visible, enlisting sponsorship, and cultivating institutional fluency, map to wider literatures on psychological safety and voice in cross cultural teams, suggesting modifiable levers for equitable participation rather than fixed deficits.[33–36] Aggregated demographic reporting and attention to role patterns preserve anonymity while inviting examination of social position as a mediator of uptake without implying that race, class, or migration status determines how evidence is used. Rather, shared evidentiary standards persist, while interpretation and legitimacy are interactionally shaped by how institutional cultures receive and respond to contributions.

While grounded theory privileges conceptual explanation rather than statistical inference, the patterns identified here provide an analytic generalisation rather than claims of universality.[18] The model is transferable to settings where nurses work within fast tempo, multidisciplinary environments that rely on shared tools, visible accountability systems, and rapid decision cycles. These conditions are present in acute medical assessment units, emergency care interfaces, and short-stay geriatric services, suggesting relevance across comparable high-pressure care pathways. Transferability is

strengthened through thick description of organisational routines, workforce composition, and evidentiary artefacts, which enables readers to make informed judgements about alignment with their own contexts.[18] When tempo is slower, when protected reflective time is available, or when hierarchical distance between professions is reduced, the balance between planned facilitation and micro-facilitation may shift, providing a boundary condition for application of the theory. Even within these contexts, however, the mechanisms described offer useful insights into how nurses establish credibility, translate patient goals into organisationally meaningful terms, and sustain voice in collective decision making.

Comparisons with geriatric decision-making research reinforce the value of early articulation of patient goals and translation of those goals into flow relevant justifications, thereby aligning ethical and organisational logics during discharge planning and risk negotiation.[37–40] Observation of rapid dissemination via briefs, huddles, and micro teaching resonates with studies of clinical dashboards and point of care feedback that convert small fragments of information into timely change, provided indicators are trusted and proximal to action.[41–43] Leadership and governance implications follow from these mechanisms. Facilitative leadership that legitimises brief adaptations, records rationales, and protects micro teaching opportunities can extend the reach of frontline facilitation and reduce reliance on exceptional individual effort.[44–46] Future work should examine how formal facilitator roles and nurse manager strategies strengthen the micro practices identified here, test the model across multiple sites and systems, and incorporate patient and carer perspectives on negotiated risk to refine propositions about conditions, mechanisms, and consequences of situated evidence use.

Limitations

This study makes a novel contribution by offering a grounded theory of how nurses construct and mobilise evidence in the fast-paced context of acute frailty care. Its strength lies in the combination of in-depth interviews, focused observation, and situational mapping, which together enabled detailed analysis of conditions, mechanisms, and consequences. However, it is a single site design, which may constrain variation in organisational arrangements. Although the inclusion of observation strengthened the analysis, longer ethnographic immersion may have revealed additional dynamics.

Interviews necessarily reflected participants' self-understanding and retrospective sense-making, which can introduce selective recall and favourable self-presentation. To address this, interview accounts were systematically triangulated with thirty-six hours of focused observation across board rounds, handovers, and discharge planning meetings. Observations corroborated key interactional processes described by participants, for example strategic guideline citation, use of dashboard indicators, sequencing of proposals, and sponsorship of junior or internationally educated nurses. Observation also enabled identification of tacit practices that participants did not always articulate, particularly rapid recalibration under flow pressure and situational use of institutional language. Nonetheless, field access was episodic rather than continuous, and some dynamics, such as informal influence outside structured forums or overnight decision making, may not have been fully captured. Extended ethnographic immersion across multiple wards and rota patterns would deepen understanding of unspoken norms and subtle negotiation practices that unfold across longer temporal arcs.

Implications to practice and policy

Strengthening EBP in high tempo services requires equipping nurses to link patient goals with portable forms of proof, such as validated tools or audit indicators, so that their proposals are more likely to be adopted in multidisciplinary forums. Micro facilitation at ward level should be recognised as a core safety practice, supported through protected huddles, coaching, and tailored development for internationally educated and early career nurses who may need additional support to build institutional fluency and voice. Guideline implementation efforts could draw on situational mapping to identify the human and non-human factors that shape uptake, ensuring that local conditions and team dynamics are addressed rather than relying on linear rollout plans. At a policy level, complementing time-based flow metrics with indicators of functional readiness and negotiated risk would reduce incentives for unsafe discharge and provide legitimacy for patient-centred adaptations when these are transparently documented. The model is transferable to other acute and emergency settings managing multimorbidity and throughput pressures, provided local teams adapt the identified practices to their own tools, cultures, and accountability structures.

Conclusions

This grounded theory shows how nurses make evidence usable in acute frailty care by embedding facilitation within everyday ward routines. It adds to existing implementation frameworks by specifying how credibility, sponsorship, and institutional language shape the uptake of proposals in fast-paced multidisciplinary settings. Future multi-site studies that include patient and carer perspectives are needed to test the mechanisms identified and evaluate strategies that strengthen ward-level facilitation in contexts of multimorbidity and throughput pressure.

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Data availability

The data that support the findings of this study have been provided in the manuscript.

Data confirmation

Confirm that any data utilised in the submitted manuscript have been lawfully acquired in accordance with The Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization to the Convention on Biological Diversity. State that the relevant fieldwork permission was obtained and list the permit numbers

Ethical approval

The study was conducted in accordance with the principles outlined in the Declaration of Helsinki. Ethical approval was obtained from the University Research Ethics Committee (Reference ID: #001,284). Additional approval was secured from the Research and Development Units of the participating hospital sites, ensuring compliance with institutional governance protocols.

Consent to participate

Informed consent to participate was obtained from all participants prior to their enrolment in this study. Participant information sheets and consent forms were provided in advance via email.

Declaration of competing interest

We declare no conflicts of interest.

CRediT authorship contribution statement

Jude Ominyi: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Aaron Nwedu:** Writing – review & editing, Writing – original draft, Visualization, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Uchenna Chima:** Writing – review & editing, Writing – original draft, Visualization, Validation, Data curation, Conceptualization. **Adewale Alabi:** Writing – review & editing, Writing – original draft, Visualization, Validation, Data curation, Conceptualization.

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Supplementary materials

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