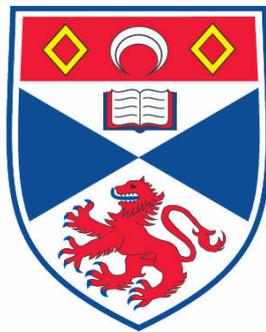


**MANAGING TO IMPLEMENT EVIDENCE-BASED PRACTICE? AN  
EXPLORATION AND EXPLANATION OF THE ROLES OF NURSE  
MANAGERS IN EVIDENCE-BASED PRACTICE  
IMPLEMENTATION**

**Joyce E. Wilkinson**

**A Thesis Submitted for the Degree of PhD  
at the  
University of St. Andrews**



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**MANAGING TO IMPLEMENT EVIDENCE-BASED  
PRACTICE?**

**An exploration and explanation of the roles of nurse  
managers in evidence-based practice implementation.**

Thesis submitted for the degree of PhD

Joyce E. Wilkinson

5th March 2008

I, Joyce Elizabeth Wilkinson, hereby certify that this thesis, which is approximately 100,000 words in length, has been written by me, that it is the record of work carried out by me, and that it has not been submitted in any previous application for a higher degree.

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## *ABSTRACT*

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Nurses face ongoing difficulties in using evidence and making a reality of evidence-based practice. Studies of the factors that facilitate or impede evidence-based practice suggest that nurse managers should have a key role, but the nature of this role has not yet been fully articulated. This study aimed to explore and explain the roles of nurse managers in relation to evidence-based practice implementation. Four case studies in Scottish NHS Acute Trusts provide rich data on evidence-based practice implementation, drawing on interviews (n=51), observation and documentary analysis.

A wide literature on evidence use in nursing suggests that implementation is hindered by confusion and debate about what counts as evidence, and by an incomplete understanding by staff of the complexity of implementation processes. This study confirms such conclusions. Moreover, the study reveals that the roles of nurse managers in facilitating evidence use are currently limited, largely passive and under-articulated. As such, the findings expose significant discrepancies between nurse managers' roles in practice and those espoused in much of the literature. Partial explanation for this can be found in the organisational contexts in which nurses and their managers work (e.g. competing demands; confused communication; diffuse and overloaded roles and limits to authority and autonomy). In particular, the role of the contemporary nurse manager is one that places considerable emphasis on aspects of general management to the detriment of clinical practice issues.

More positively, the study uncovered genuine facilitation in two study sites where hybrid roles of nurse manager and clinical nurse specialist were in place. In both sites, these roles had been successful in supporting and progressing implementation in discrete areas of practice and show some potential for advancing evidence-based practice more widely. These findings have significant implications for research, policy and practice in relation to evidence-based practice in nursing.

*To Ian, Matthew and Lois, who gave, and gave up so much, during the completion of this work and to whom I will always be grateful for inspiring and providing a sense of purpose*

*And to my parents, who could not provide the knowledge needed for the task, but who gave me the wisdom and courage to follow my heart and taught me the value of hard work, which saw me through.*

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---

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## ***ABBREVIATIONS AND GLOSSARY OF TERMS***

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### ***Abbreviations***

Definitions of the first four terms are provided in the body of the thesis and CNS, in the glossary.

<b>EBP</b>	Evidence-based practice
<b>EBPI</b>	Evidence-based practice implementation
<b>RU</b>	Research utilisation
<b>NM</b>	Nurse manager
<b>CNS</b>	Clinical nurse specialist

### ***Glossary***

<b><i>CNS</i></b>	No widely accepted definition of a clinical nurse specialist exists, but in essence, a CNS is a registered nurse who has acquired additional knowledge, skills and experience in a clinical specialty. They may also hold additional academic or professional qualifications, where available and relevant to their specialist area of practice. They practice at an advanced level and may have sole responsibility for an episode of care or a defined patient group.
<b><i>CSBS</i></b>	Clinical Standards Board for Scotland. This body had a role in developing, setting and monitoring quality standards throughout Scottish health care organisations. It ceased to exist in 2003. It monitored generic standards, such as the implementation of clinical governance and specific clinical standards, such as those relating to cancer care or renal services. This was undertaken by review of documentation produced by each Health Care Trust, verified by observation and interviews with staff during monitoring visits to the Trusts. This information then formed the basis of reports and recommendations on each Trust's performance against the standards.
<b>Marsden manuals</b>	Clinical procedure manuals developed and produced by staff from the Royal Marsden Hospital. They contain a broad range of clinical procedures for nursing and the sixth edition (2006) is acknowledged by the authors to be the first that is explicitly evidence-based, with references to national guidelines underpinning many of the procedures. Previously, and where this still does not exist, expert opinion is the basis for the guidance given.
<b>NHSQIS</b>	National Health Service Quality Improvement Scotland was created in 2003 as a special health board. It comprised several bodies that had existed independently prior to this, such as NMPDU, CSBS and the Clinical Resource Audit Group (CRAG). NHSQIS took over the monitoring role of the CSBS and many of the aspects of strategic

health policy implementation and monitoring of quality in Scottish health care.

**NMC** Nursing and Midwifery Council, formerly, the United Kingdom Central Council for Nursing and Midwifery for Nurses, Midwives and Health Visitors (UKCC). It is the professional regulatory body for all nurses and midwives. In addition to holding the professional register for nurses and midwives, it sets out a code of conduct to which all registrants must adhere. The responsibility for monitoring this lies with employers, but the NMC has the power to remove, suspend or recommend skills updates for registrants who do not meet or who contravene, the code. The code has a specific clause (6.5) relating to the use of evidence-based practice, which states: *'You have a responsibility to deliver care based on current evidence, best practice and where applicable, validated research when it is available'*. (NMC, 2004)

**NMPDU** Nursing and Midwifery Practice Development Unit, formed in 1999, as a means of standardising and developing nursing and midwifery practice throughout Scotland. The unit developed a link nurse network, a specialist nurse network and a practice development forum, open to all nurses and midwives across Scotland. A significant part of the unit's remit was to involve nurses in developing evidence-based nursing best practice statements on subjects chosen by Scottish nurses. By 2002, five statements had been completed, were widely disseminated and were available for every nurse via the internet. NMPDU ceased to exist after January 2003, when it became incorporated into the newly formed, NHSQIS as the Practice Development Unit. The focus of the unit has changed and it is now more strategically focused, although updating of best practice statements and some new development of these, continues.

**Practice Development** Practice development is a continuous process of improvement towards increased effectiveness in person-centred care, through the enabling of nurses and health care teams to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous and continuous process of emancipatory change (McCormack, et al., 1999).

**SIGN** Scottish Intercollegiate Guidelines Network. SIGN, now part of NHSQIS, began in 1993 as means of creating medical evidence-based guidelines. It has become a successful and robust means of developing multi-disciplinary guidelines using practitioners from across Scotland, who are each experts in their own specialty. Adhering to a strict methodology, groups develop guidelines that give precedence to the randomised controlled trial types of evidence and then to others types of research evidence. During the development process, widespread consultation is sought from all interested individuals. Once complete, guidelines are distributed to every Scottish Health Board and to numerous individual

practitioners. They are available at no cost, to all NHS staff and to the public, via the internet.

**Shared  
governance**

An organisational innovation that gives health care professionals control over their own practice and it can extend their influence into areas previously controlled by managers (Hess, 2007). There is no one accepted model. Each organisation develops its own approach to best reflect their desired goal in adopting shared governance. It is seen as a means of empowering nurses and as a professional development strategy.

## CHAPTER ONE

### INTRODUCTION:

#### *Evidence-based practice, implementation and nurse managers*

---

##### INTRODUCTION

Evidence-based practice (EBP) has become an essential element of contemporary health care, but is not readily or easily achieved. There are complexities relating to almost every aspect of EBP such as the notion of evidence itself, the ways in which evidence is incorporated into practice and the roles of staff involved in facilitating and sustaining evidence-based practice implementation (EBPI). Many barriers to EBPI have been identified and there have been some attempts to address these in nursing and wider health care practice. However, many aspects of the processes through or by which evidence is implemented are still poorly understood and in particular the impact of context and individual staff roles and the interaction of these with evidence on the process remain something of an enigma.

In nursing there has been some development in understanding implementation – a process which can be viewed as ‘*evidence incorporation into clinical practice*’ (Cheater & Closs, 1997: 5) but gaps still remain. The emphasis has moved away from the role of the individual nurse in the process to recognising the importance of wider organisational factors and as one aspect of these, the roles of nurse managers (NMs). The combination of the health care context, historical influences on the NM and their current role in relation to EBPI are the focus of this research which aims to explore, understand and explain the roles of NMs in implementing evidence into nursing practice.

The thesis begins by outlining the main concepts of EBP, EBPI and by providing some background to the NM role and highlights the importance of this in the EBPI process. It progresses through an examination of the literature relating to EBP, EBPI and research utilisation (RU) and the barriers to these processes and literature which focuses on the roles of various individuals in EBPI. Through the deployment of a theoretical framework that considers the context, content and process of change in organisations, the research endeavour takes shape and is executed in four Scottish

Health Care Trusts using intensive case studies. The results are presented according to the three factors of the theoretical framework, those of context, content and process, and the discussion of these provides evidence that the role of the NM in EBPI is one of importance, albeit one that is not yet at its full potential. A specific NM role emerges that highlights the scope for successful EBPI and the thesis ends with recommendations for research, policy and practice.

## **KEY CONCEPTS**

This chapter introduces the concepts at the heart of the thesis, those of evidence-based practice (EBP), evidence-based practice implementation (EBPI) and nurse managers (NMs). It provides a brief background to the development of EBP as a means of highlighting its central role in contemporary health care. Detailed literature review is pursued in chapter two, but first, this introductory chapter outlines the complexities and challenges of EBPI and draws attention to changes to the structures and the roles of NMs over the last two decades that impact on the process. It presents an overview of nursing management as a means of setting the scene for the subsequent literature review and empirical research. Finally, it gives a brief outline of the author's interest and experience in EBPI and nursing management by way of defining her standpoint at the outset of the study.

### *Evidence-based practice*

*'Evidence of inappropriate variations in health care provision across a wide range of conditions, together with the delay in incorporating new knowledge into clinical practice and limited resources with which to do it, have accelerated the trend towards evidence-based nursing'. (Closs & Cheater, 1999:11)*

This is a fairly comprehensive explanation of the current emphasis in nursing and wider health care on the need for practice to become more evidence-based. During the 1990s, health policy reflected an increasing focus on clinical effectiveness which would be achieved through the use of EBP (NHSE, 1996). Clinical effectiveness was concerned with achieving a number of objectives, including reducing inconsistencies in care provision, improving understanding of care and treatments provided, changing

practice according to evidence of effectiveness, using audit to monitor and improve care quality, providing better value for money, inspiring greater confidence in the National Health Service and its staff and increasing the accountability of staff (Le May, 1999a).

In 1999, clinical governance was introduced, representing one of the most significant policy developments in health care in recent years. Linked to clinical effectiveness, it placed a statutory duty on health organisations to develop all the systems, standards and processes necessary to improve the quality of health care delivery (Wilkinson, *et al.*, 2004). While Currie & Loftus-Hills (2002) demonstrated that nurses have not always grasped the statutory nature of clinical governance, seeing it instead as an optional activity, it has always been clear that this should not be the case and that *every* practitioner has responsibilities to work towards improving the quality of care through, for example, the use of EBP (RCN, 2000).

Clinical governance focussed on all aspects of change in health care, acknowledging the need for a change in the culture of health care organisations, changes to systems and processes (McSherry & Pearce, 2002), the need for improvement in individual competencies and learning and the development of organisational learning (Davies & Nutley, 2000; Nutley & Davies, 2001; Wilkinson, *et al.*, 2004). However, the main focus was the use of evidence to improve care delivery. There was recognition that many of these policies would require significant changes to the environment of health care delivery and only a limited amount was known about the strategies to support these changes (Davies, 2001). The ‘top-down’ focus on delivery of health care and performance management that accompanied it, were seen as undermining the potential of clinical governance (Degeling, *et al.*, 2004).

However, claims that viewing the NHS as a learning organisation would facilitate these changes (Donaldson, 2000) belied the necessity for specific conditions to enable organisational learning to flourish (Kim, 2005; Rushmer, *et al.*, 2006).

*‘It is not choice but habit that rules the unreflecting herd’.* (Wordsworth, 1849: 323)

The crux of the concept, highlighted by Wordsworth's sentiment, centred on the belief that it would no longer be acceptable to continue to practise according to routine and ritual (Walsh & Ford, 1989; Holland, 1993; Ford & Walsh, 1994; Biley & Wright, 1997) or because '...sister says...' (Tod, *et al.*, 2004: 211) as these had been the basis of much nursing (and medical) care in the past. The government's focus became one of 'what works' (Davies & Nutley, 1999) although there is more to EBP than this alone and the nature of EBP is explored in full in chapter two.

In health care, medical research led the way to proving what worked with randomised controlled trials (in the main) of treatment interventions. However this approach was not without its critics, many from nursing, for example, Bonnell (1999), Colyer and Kamath (1999) and French (2002). The notion that care should be based on 'evidence' of effectiveness of good quality care was not contested, in general, by nurses. It was not new and the application of the findings of nursing research was generally seen as the basis for quality care provision (McKenna & Slevin, 1995; Van Achterberg, *et al.*, 2006). However, the concept of EBP was contested and nurses were concerned about its origins, its implications for nursing, nurses and patients (Mitchell, 1999; Ingersoll, 2000; Holmes, *et al.*, 2006). Not everyone believed that promoting EBP was the ideal way forward, but few were confident enough to reject it outright as the following quotations demonstrate:

*'The essential value of EBP is the emphasis it places on rational action through a structured appraisal of empirical evidence, rather than adherence to blind conjecture, dogmatic ritual or private intuition. Its value for the delivery of healthcare interventions is unquestionable'.* (Trinder & Reynolds, 2000: 122)

*'EBP is overly simplistic and reductionist, which fails to do justice to the complexity of practice situations. However, few, if any, would reject it completely'.* (Trinder & Reynolds, 2000: 216)

Many of the concerns for nurses stemmed from their belief that EBP was a medical imposition as the term that originally appeared in the literature was evidence-based medicine. It was dominated by a dependence on randomised controlled trial research, and by implication devalued other potential 'evidence', such as qualitative research.

As a result, many nurses were suspicious of what it had to offer to nursing, where other types of ‘evidence’ might be more valuable. The specific difficulty lay with the incongruence between most nursing interventions and care and their suitability for appraisal by randomised controlled trials. There was a growing awareness that accepting the principles of ‘evidence-based’ care had importance for nursing, but adopting the terminology of evidence-based medicine did not (Ingersoll, 2000).

Many definitions of EBP exist as shown in Box 1.1 (adapted from French, 2002) with some common features, but a wide range of beliefs. This list is intended to illustrate the range of views and definitions, rather than being an exhaustive account.

**Box1.1: Definitions of evidence-based practice**

*‘A shift in the culture of health care provision away from basing decisions on opinion, past practice and precedent toward making more use of science, research and evidence to guide clinical decision making.’ (Appleby, et al., 1995:3)*

*‘...the conscientious, explicit and judicious use of current best evidence about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research’. (Sackett, et al., 1997: 71).*

*‘Proving care for clients for which there is evidence of clinical effectiveness is the cornerstone of EBP. Evidence may come from research, audit, feedback from clients and expertise’. (RCN, 1996)*

*‘Evidence-based health care involves using a combination of clinical expertise with the best available research evidence, together with patient preferences, to inform decision making’. (Flemming & Cullum, 1997: 28)*

*‘The systematic interconnecting of scientifically generated evidence with the tacit knowledge of the expert practitioner to achieve a change in a particular practice for the benefit of a well defined patient/client group’. (French, 1999:74)*

Some of the quotations appear quite similar, however these reflect the different viewpoints that have influenced nurses' views on EBP, some derived from nursing sources, others mirroring more evidence-based medicine roots, such as Fleming and Cullum (1997), whose approach to EBP is more similar to that of evidence-based medicine, than that of, for example, the RCN (1996).

While many of the issues relating to definitions of EBP are germane to this research, they are fundamentally part of an epistemological and ontological debate that was not at the core of this study. For the purposes of this research, the author's stance was a pragmatic and all encompassing one, taking a broad view of evidence as a concept and one that included research, national guidelines and best practice statements, locally developed evidence products, local data, such as audit or NHSQIS standards and outcome data, knowledge of or from practice, patient preference and opinion. The author's aim was to be inclusive rather than exclude any types of evidence. Views of the purpose of EBP are related and at the outset of the study it is important to acknowledge that the author is of the belief that EBP is fundamentally concerned with standardising and improving care delivery and health outcomes for patients. EBP is seen as relating to patient care delivery in the first instance, rather than to organisational initiatives or strategies, although the author recognises that evidence may have a role in determining the management of scarce resources.

It has been suggested that EBP is probably the most used but least understood concept in contemporary health care (Craig & Pearson, 2002). Publications aimed at practitioners sought to address queries, such as the *Evidence-based Practice* monograph (Le May, 1999). Despite this, it remained a contentious concept punctuated by lack of consensus, extremism and controversy (Estabrooks, 1998; Freshwater, 2002) and misunderstandings which were reflected in the number of papers appearing in professional journals with titles such as '*Evidence-based medicine, what it is and what it isn't*' (Sackett, *et al.*, 1996); '*Evidence-based Nursing, some misconceptions*' (DiCenso, *et al.*, 1998), '*Misconceptions among nurses about evidence-based practice*' (Jennings & Loan, 2001), '*Evidence-based nursing: what it is and what it isn't*'. (Ingersoll, 2000) and Mitchell (1999) '*Evidence-based practice: critique and alternative view*'. The main differences between views lay with the extent

to which evidence was considered to be only research or when evidence was considered to take account of professional's experience and judgement.

So EBP is a complicated, contested and ambiguous concept. Its progress in nursing has been hindered by its associations with evidence-based medicine, being viewed by some nurses as a medical imposition and an attempt to de-professionalise nursing and further medicalise health care (McCormack, 2006). Despite this, there is some evidence to suggest that one of the first nurses to use EBP was Florence Nightingale, as she gathered statistics on mortality and infection rates from her observation and experience of nursing and made changes to her practise which brought about improvements in patient outcomes (Castledine, 1997; McDonald, 2001). This combination of data (research), personal experience, change to practice and patient benefit certainly illustrates many of the central notions of EBP, reflected in the quotations in Box 1.1.

Further debates on the nature of evidence aside, evidence was being produced, then summarised and translated for use in health care, initially in the form of clinical guidelines and more recently in Scotland, as best practice statements for nursing. While early clinical guidelines were more medically orientated, this was by no means the only evidence available for nurses as the Royal College of Nursing has also produced guidelines specific to nursing care. However the use of these in practise was not straightforward. Kitson (1997a,b) recognised that EBP would be hindered by nurses' lack of autonomy, despite efforts of the (then) professional regulating body (UKCC) to make nurses more accountable for their practice. She acknowledged that the use of evidence in practice needed nursing structures in organisations that would support autonomy, develop relationships between nursing and medicine and foster new roles in nursing to promote EBP. Although highlighting the lack of nursing research which could be used as an evidence-base for nursing practice, she believed that this would be less of an impediment to EBP than her other concerns.

There was a growing awareness that despite greater availability of evidence of effective practices, the conditions that would support its use, such as increased autonomy and greater accountability (Hancock & Easen, 2004) and the development of new nursing roles, these were in their infancy and not yet widespread (Taylor-

Piliae, 1998). It seemed that there were both structural and cultural impediments to the use of EBP (Bonnell, 1999). Despite Ham's (1999) belief that practitioners were well motivated to deliver improved care, his assertion that there was a need for training, development and support before EBP would become a reality, was becoming more widely acknowledged.

## **Implementation**

Concurrently, there was greater emphasis on the processes by which evidence came to be used in practice. Large scale research projects during the 1990s such as PACE (Promoting Action on Clinical Effectiveness), (Dunning *et al.*, 1997; Dopson *et al.*, 1999), STEP (South Thames Evidence-based Practice project), (Ross & McLaren, 2000), GRiPP (Getting Research into Practice and Policy) (Dopson & Gabbay, 1995) drew attention to the fact that the existence of evidence alone (mainly in the form of guidelines) did not guarantee its use. Interest grew in trying to understand the elements which contributed to the process of evidence use including the role of individuals, the structure and culture of organisations and the social and human aspects of evidence use (Wood, *et al.*, 1998; Rycroft-Malone, 2004). Empirical research into the process of evidence use developed. The importance of the EBPI *process* was recognised.

EBPI is concerned with the process by which practice is changed in line with evidence. While there are numerous definitions, the following derived from health care, reflect the range of views, from a succinct, simplistic and linear description to a fulsome definition that acknowledges complexity and significant factors:

*'Implementation...[is] the process of introducing or changing practice into a specific local setting. It focuses on the specific effort to fit a program, treatment, device or procedure within a specific care context'. (Chambers, 2004:6)*

*'Implementation occurs when changes based on the results of evidence are made in practice. These activities rely not only on the availability of relevant knowledge, but more crucially on the critical evaluation of that knowledge. Implementation is fraught with difficulties. It requires not only a means to translate knowledge from a variety of sources into the language and action of practice, but also the opportunity to elicit sustained change. Successful*

*implementation depends on many factors. Some relate to the characteristics of individual knowledge, ability and motivation and others to the wider politico-economic and organisational issues*'. (Mulhall & Le May, 1999).

It is the second of these definitions that form the basis of the view of implementation taken in this thesis. The concept is explored in more detail in chapter two.

Just as the concept of evidence is confounded by numerous definitions and theories as to its constituents, so too is the notion of implementation complicated by a number of definitions of the process. References to this process in the literature refer to utilisation, transfer (of knowledge or ideas), transmission of the evidence-based initiatives and innovations. Throughout the thesis the term implementation is used to describe the *evidence into practice process*, but other terms, such as research utilisation (RU) are used where appropriate, when describing the process of the implementation and utilisation of research alone, rather than evidence in its widest sense. While the two processes are not thought to be significantly different and research can be seen as a constituent or sub-set of EBP (Jennings & Loan, 2001) both processes reflect the same characteristics.

Conceptual exploration of the process of EBPI added to the knowledge of the complexity of this process and continues still (Kitson, *et al.*, 1996; 1998; 2008). Earlier studies in nursing had focused on the use of (or lack of) research in nursing. These studies had often considered the application of research in practice through the lens of the diffusion of innovations or as an aspect of change management (MacGuire, 1990; Bircumshaw, 1990). While many of these studies concluded that the responsibility for research use lay with individual practitioners, and that greater educational input would 'solve' the problems of lack of research-based practice, increasingly, these have been seen as simplistic and unrealistic notions. Nutley, *et al.* (2007) note that research use is a process characterised by iteration, non-linearity and unpredictability and it is reasonable to conclude that the process of implementing EBP would reflect these same characteristics. The view of EBPI as a linear, rational process is recognised as being founded on the assumptions that if nurses possess all the necessary skills and evidence, then implementation will occur (Harvey, 1993; 2005; Hewison, 2003a).

Studies of EBPI in nursing and in other areas of public service delivery begin to echo similar themes such as: EBP implementation (EBPI) does not just 'happen' (Cheater & Closs, 1997); it is a slow, haphazard process (Bonetti, *et al.*, 2005); it necessitates change, for which planning is required (Bircumshaw, 1990; Yin King Lee, 2003); it is a complex and dynamic process (Bucknell, 2004) and '*... it is a very significant practical and intellectual challenge*'. (Nutley, *et al.*, 2007:3). Debates relating to EBPI processes do not accurately portray a full appreciation of the complexity and numerous significant factors involved (Kitson, *et al.*, 2008). Despite a relatively long history of investigation into and activities to promote research use in nursing (Mulhall & Le May, 1999), only moderate progress had been made that could elucidate the problems with EBPI.

What did become clear was that there were a significant number of barriers or impediments to EBPI (for example, Funk, *et al.*, 1995; Dunn, *et al.*, 1998; Sitzia, 2001; Bryar, *et al.*, 2003). While these barriers were not exclusive to nursing (Dopson & Fitzgerald, 2005), they had been the subject of a considerable number of studies into RU and EBPI. These are explored more fully in chapter two.

Factors relating to the organisational context, culture and social and human aspects of EBPI, such as facilitation were also seen as necessary foci of future research (McCormack, *et al.*, 2002a; Harvey, *et al.*, 2002; Rycroft-Malone, *et al.*, 2004a; Harvey, 2005; Scott-Findlay & Estabrooks, 2006). Gaining an understanding of the obstacles to EBP is thought to be the basis of finding strategies to overcome these (Grol & Grimshaw, 2003).

Organisational strategies adopted to develop nursing practise and enable nurses to become more involved in practise are also linked to EBP. These are practice development and shared governance. These are not a major focus of this study, but still have a role in EBPI and therefore a brief description of both follows.

### ***Practice development***

As with all of the concepts described so far in relation to EBPI, practice development is another that lacks a universal understanding and has been recognised as a nebulous concept that is not used consistently (Clarke, *et al.*, 1999; Garbett & McCormack, 2002; McCormack, *et al.*, 2004). In Scottish health care it has been defined by NHSQIS (2007) as:

*‘Practice development is the term used to describe a collection of processes which enable individuals, teams and organisations by sharing examples of good practice across the organisation [NHS Scotland] as a whole to the benefit of patients and staff’.*

However, McCormack, *et al.* (1999:259) from their considerable practical and empirical experience of practice development assert there is no ‘*one right approach to “doing practice development”*’. Instead they suggest that it encompasses a range of activities related to professional practise such as: promoting and facilitating change, communicating, responding to external influences, education, facilitating the research into practice process and undertaking audit and other quality improvement related activities (McCormack, *et al.*, 2005). They define it as:

*‘Practice development is a continuous process of improvement towards increased effectiveness in person-centred care, through the enabling of nurses and health care teams to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous and continuous process of emancipatory change’.* (McCormack, *et al.*, 1999: 258)

While EBP is not specifically mentioned, many of the activities outlined would include EBPI. There is a recognition in the all encompassing concept of practice development that these are significant and that importance of clinical effectiveness and EBP in health care have led to the creation of many practice development roles and initiatives, often without strategic direction and a lack of support for practitioners (McCormack, *et al.*, 1999). The haphazard way in which many roles have developed and practice development units (most often a collection of practice development nurses based together in an organisation) have lacked both strategic direction and a

systematic approach to practice development, have left practice development nurses without the necessary support to achieve organisational or managerial expectations that lack clarity and focus. Despite this, practice development nurses require many of the skills also necessary for EBPI such as change management skills, evaluation techniques and methods and the knowledge and confidence to use them appropriately in particular contexts as well as the personal characteristics which are important in leading and negotiating change (McCormack, *et al.*, 1999). To date, specific practice development qualifications or training do not exist and this may have led to the belief that it is a role that any nurse could fill.

These difficulties aside, practice development nurses and units have, in many organisations, been charged with the responsibility of leading and supporting EBPI and is for this reason that this brief overview has been provided.

### ***Shared governance***

One other approach to leading and developing EBPI has been adopted in some Trusts – that of shared governance. Originally developed in private sector organisations as a means of devolving responsibility and increasing staff involvement in decision making, it was adopted originally in health care organisations in the USA as a way of improving quality of care. It has been described or defined as:

*‘...an organizational innovation that gives health care professionals control over their practice and can extend their influence into administrative areas previously controlled by managers’.* (Hess, 2007:1)

There is no single model of shared governance, but organisations are encouraged to create one which best reflects their situation and requirements (Scott & Caress, 1995; Williamson, 2005b). Shared governance has been introduced in some organisations, both as a means of modifying the culture (from one where nurses had very little autonomy or involvement in strategic decision making, to one in which they were fully involved and completely autonomous) and as a method of implementing EBP (Elton, *et al.*, 2001). The focus in UK health care has been largely on developing leadership skills for nurses (Cooper, 2003), which was in line with government policy and it was hoped that this would be achieved through the three underpinning principles of shared

governance namely: the responsibilities for the management of nursing must rest with nurses; authority for nurses to act must be recognised within the organisation and that nurses must be accountable for the delivery of patient care and their professional conduct (Gavin & Wakefield,1999). If shared governance were fully implemented and working according to these principles, it would obviate the need for nurse managers as management responsibilities would be devolved to nurses and they would become self governing.

While much of the literature pertaining to shared governance relates to the leadership development potential of the approach, it has also been adopted as the principal means of improving practice and as a strategy for EBPI (Edgar, *et al.*, 2003).

In organisations where shared governance has been established, it has taken the form of a number of councils, for example, a research council, a practice development council, a quality improvement council, but as noted above, no two organisations have exactly the same approach. These councils are ‘staffed’ by nurses who volunteer or are nominated to participate on a regular basis in meetings and activities related to the particular council. For example, those in a practice development council might be required to gather and appraise evidence for the development of local nursing guidelines and then lead EBPI. The councils together come under the umbrella term of a shared governance forum.

Much of the literature relating to the leadership development aspects of shared governance is very positive in its appraisal of this (Goeghan & Farrington, 1995a,b; Williamson, 2005; Scott & Caress, 2005). Review of its success in nursing has shown that it has not been widely used to support EBP and it has had limited success. In addition, it has not been implemented fully in any of the organisations, with NMs remaining in post and nurses continuing to have limited autonomy, even within their own practice (Edmonstone, 1998; Gavin & Wakefield, 1999; Burnhope & Edmonstone, 2003). It has not delivered the promises, nor achieved its potential for nursing or EBP and its suitability and success as a tool for EBPI remains unproven (Gavin & Wakefield,1999).

Despite innovations such as practice development and shared governance, many of the impediments to EBP were known to be organisational in nature, such as structures,

communication networks and management resistance (Ross & McLaren, 2000; Redfern, *et al.*, 2003; Dopson & Fitzgerald, 2005). Specifically in nursing, issues relating to autonomy, accountability and nursing management were thought to contribute to the difficulties that nurses had in using evidence in practice (Kitson, 1997 a,b; Colyer & Kamath, 1999; Estabrooks, *et al.*, 2002; Hurst, 2003; Tod, *et al.*, 2004). Studies of the barriers to RU/EBP have also highlighted issues with NMs in particular, and there is a growing recognition that issues relating to practice are not solely a practice responsibility; managers also need to be involved (Perry, 2002).

There is no doubt then, that developing strategies for EBPI and interventions to support it represent a '*...formidable challenge*'. (Ross & McLaren, 2000: 2). Why is it that some studies have identified nurse managers as being impediments to RU and the EBPI process? These are discussed fully in chapter two after a brief history of the role of the NM is provided.

## **Nurse Managers**

### ***A brief, recent history of development in the role of nurse manager in Scotland***

The contemporary NM role is one that has undergone significant changes, which reflected overall changes to the organisation and management of health care since the 1970s in the UK. Reforms to health care have had a radical impact on NMs, nurses and nursing (Hewison, 1994). Restructuring in 1974 gave NMs (still known as nursing officers at that time) team manager status, equal to that of medical managers. However this was withdrawn just 10 years later with the introduction of general management to the NHS. Both their status and roles were undermined by these changes and there followed a dismantling of nursing hierarchies which left a legacy of inconsistencies between titles, roles and responsibilities and considerable ambiguity about these (Hewison, 1994). Senior nurses became advisors to general managers and there was increasing emphasis placed on the importance of gaining management qualifications (Cooper, 1996). This was seen as detrimental to their clinical interests and created difficulties in maintaining knowledge and skills related to practice as well as having an impact on their influence over all. This in turn decreased their legitimate authority over practice and affected the way in which they were viewed by nurses.

Further reforms in 1990 reduced the number of nurse management levels and the ward sister was viewed as the most senior nurse, with some previous NMs being replaced

by non-nurse managers (or managers with no nursing background). Throughout the 1990s organisational changes saw the disappearance of the term 'nurse manager' and 'clinical nurse manager' (replaced with terms such as 'assistant directorate manager' or 'operational services manager') and many former NMs were forced to apply for their 'own' posts, but with different requirements and responsibilities, focussing more on general, rather than nursing, management. In many health care Trusts, NM posts ceased to exist (Cooper, 1996). The dissolution of the 'internal market' in health care in 1999, saw further reforms and the re-introduction of some NM posts, but with a significantly greater remit for administrative and operational aspects of management, than for clinical practice. There is no doubt that these changes have had an impact on the current role of the NM (Hewison, 1999; Hewison & Stanton, 2002; 2003) These changes affected the influence of nursing within organisations (Hewison, 1994) with nurses no longer having the greatest influence on nursing posts, the development of nursing and the management of nursing budgets. There is evidence that this continues today, with contemporary NMs failing to recognise the impact they have on organisational culture, seeing themselves in a role without influence for nurses and one which impacts on job satisfaction and promotion prospects for nurses (Kane-Urrabazo, 2006).

### ***Implementing EBP, a role for nurse managers?***

Evidence can only be implemented by a process of managed change (Le May, 1999). While it need not be NMs who undertake this, they have role as part of the wider organisation to support EBPI, as one aspect of clinical governance and quality improvement, discussed above. It has been suggested that they have a crucial role in influencing the policy of organisations to ensure that staff adhere to evidence-based guidelines (Cheater & Closs, 1995). While recognising that NMs are now less involved in practice than in previous years, implementing change in practice is not solely a clinical issue (Dunning, *et al.*, 1999; Perry, 2002). It has previously been suggested that the main role of middle managers within an organisation is to implement change (Currie, 2000). However, studies concerning the barriers to RU/EBP consistently highlight the role of the NM and wider organisational studies have shown that the role of management in EBPI is significant (Dopson, *et al.*, 2005). Issues of autonomy to make changes to practice continue to haunt nursing and the influence of wider health care managers and doctors have both been recognised as

relevant ( Mulhall & Le May, 1999; Fitzgerald & Dopson, 2005). Even Directors of Nursing have been identified as not having the power within organisations to make significant decisions affecting nurses (Carney, 2004). The scope and particular roles and responsibilities, as well as influence, of nurse managers largely reflect individual organisational requirements and there have been concerns that this scope has become so large that they are unable to be effective in their roles (Duffield & Franks, 2001).

Walshe and Rundall (2001) have suggested that there had been a change in emphasis within health care organisations, away from a focus on the responsibility of the individual professional to make changes to practice, to one that accepted a greater corporate responsibility and approach to the process. However, they also acknowledged that this required changes to all levels of health care organisations with an impact at all levels, in order for this change in focus to be realised.

While there is a widespread belief that individual nurses are responsible for making changes to their own practice (and this is underpinned by the Nursing and Midwifery Council: clause 6.4), nurses are asking for support from NMs to enable them to do so.

*'While placing the expectations of responsibility and accountability on individuals within the nursing profession, through the demands of EBP, it appears that the conditions under which these roles may be fulfilled are often neglected'. (Taylor-Piliae, 1998: 190).*

Taylor-Piliae has identified what appears to be a crucial aspect of EBP. Management strategies and support are necessary to enable nurses to undertake EBPI, as are the existence of organisational conditions that are favourable to them. There is a dearth of research into nursing management (Hewison, 2006) and indeed into the role of managers within the public sector generally (Currie, 2000). In essence then, this sets the scene of the thesis. It relates to the interaction between evidence, EBPI and NMs. It seeks to uncover the roles of NMs in EBPI.

### **Definitions of terms**

Since previous sections have demonstrated the minefield of definitions involved in understanding this area, it seems prudent to state the definitions that have been used by

the author as the basis for the thesis. However, no single definition of evidence, implementation or nurse manager exists that adequately portrays or captures the complex notions of each. Rather than complicate matters further by trying to create additional definitions, the following are used in their stead to give a sense of the ideas and constructs that were important in underpinning the research. The aim was always to remain fluid and inclusive when interpreting the concepts, rather than have fixed, exclusive notions about their composition and this is reflected in the outlines provided below.

***Evidence-based practice:*** the application and *use* of evidence, to inform and shape better practice. ‘Evidence’ includes findings from research (any robust empirical enquiry), EBP products such as guidelines or best practice statements developed from an appraisal of available evidence, organisational data such as audit information, clinical experience that has been subject to reflection or consideration, patient preferences and values and in the absence of all else, expert opinion. The exact way in which patient preferences, values and expert opinion can or should be incorporated into EBP is still the subject of considerable debate in the nursing literature. The EBPI should have the aim of improving care or patient outcomes.

***EBP implementation:*** An active process, which does not occur in a step-wise fashion. It is ongoing, rather than a ‘one off’ process and facilitates the use of evidence in practice. It has been described as a continuum (Nutley, *et al.*, 2007) and this is a helpful notion as it implies that there is scope for seamless movement between different phases, such as awareness (of evidence), understanding and use. However, it is not a straightforward notion and the use of evidence in practice is more likely to be iterative than linear (Wimpenny, *et al.*, 2008). EBPI strategies can take many forms such as education or the provision of staff with specific expertise to facilitate change to take place. It is influenced by many factors and is not a simple process, but is, in essence one of change and the active management of that change.

***Nurse Manager:*** Anyone employed within a health care organisation who has a role in and responsibility for managing nurses, whatever that may involve. They may have a nursing background, but this is not always the case. They occupy a position within

the nursing hierarchy of the organisation above that of ward sister (also sometimes known as ward managers) or charge nurse level. There is a recognition that structures, hierarchies and roles and titles vary between organisations.

### **NMs AND EBPI – THE AUTHOR’S INTEREST**

The conduct of the research described in the thesis was framed and focused by the author’s own experience of nursing and management. Prior to commencing the research, her most recent post had been as a practice development nurse/nurse manager in primary care, employed in a large general practice to facilitate the implementation of all aspects clinical governance, including EBPI. The primary care team were working towards the Royal College of General Practitioners highest award for quality practice, ‘the QPA’ (Ring, 2003). Charged with building multi-disciplinary relationships, which had previously been poor, the post also involved reforming the practice nursing service, to better reflect the current needs of the practice population. This involved managing nurses, who had never been managed before. However, the main aspect of the role was to support the primary care team to use evidence in practice, by developing evidence-based products, encouraging, supporting and undertaking audits of practice and developing and facilitating EBPI and changes to care across the practice. This took place over a two-year period.

The practice was successful in achieving the award in 2001, and there was objective evidence (such as audit and patient satisfaction data) to demonstrate that the changes had been beneficial. However, involvement in the process revealed the substantial commitment required to achieve this. It also emphasised the complexity of EBPI which included incorporating the views and expectations of multiple actors and managing resistance to change. There was a significant desire to adhere to familiar practices and fear and mistrust of the new. The experience also demonstrated the difficulties that arise from uncertain and contested notions of ‘evidence’ and how haphazard, partial and patchy EBPI often was. It waxed and waned, contingent on numerous factors that were not always obvious or manageable. Despite specific, tailored education and skills updating, shared events, incentives, rewards, reminders and frequent feedback and encouragement, there were significant impediments and managing implementation was a mammoth task.

This experience has undoubtedly informed and underpinned the direction and conduct of this research. An awareness of the barriers to research use and EBPI, focused on attempting to better understand these and how they can be managed rather than continuing to highlight them. It was important to acknowledge that this experience became a lens through which the literature on EBPI was viewed and which, in time, led on to the development of the research.

## **SUMMARY OF THESIS CHAPTERS AND CONTENT**

Having set out the main rationale and background for the research, the following brief section outlines the content of the remainder of the thesis.

**Chapter two:** examines the literature pertaining to the nature of evidence and research as a basis for nursing practice. It considers EBPI, also drawing on information from outwith health care to elucidate the process. Barriers to EBPI are presented and briefly discussed, with a specific focus given to those relating to NMs. The chapter concludes by considering the literature related to NMs, their role and potential involvement in EBPI.

**Chapter three:** outlines the aims of the research and the research question and justifies the choice of case study methodology and the methods used in the conduct of the study. It attends to the issues of rigour and presents Pettigrew's contextual approach (1985a; 1988) as the theoretical framework, which underpins the research, detailing its utility and importance in understanding EBPI and the role of NMs.

**Chapter four:** the first of three parts of the presentation of the research findings. It covers the context aspects of the theoretical framework, also chosen as a means of presenting the results. It provides the detailed analysis findings relating to the context of each case and is presented in a case by case format.

**Chapter five:** content: the second of the three factors of the theoretical framework. The results focus on the wider aspects of evidence content, not only EBP products, but

also the ways in which these were used to inform practice change and the changes or improvements that were anticipated from their application in practice.

**Chapter six:** this focuses on detailed analysis of the process aspects of EBPI and the roles of the NMs in this. It includes details of the strategies adopted by NMs to facilitate EBPI but also includes wider aspects of the EBPI process, involving practice development nurses and CNSs.

**Chapter seven:** presents a detailed discussion of the key findings and relates these to the literature discussed in chapter two and considers the findings in relation to the study propositions presented in chapter two.

**Chapter eight:** concludes the thesis by stating the unique contribution of the study to research, policy and practice. It presents a reflection on the choice and use of the methodology and methods used and discusses their appropriate use in the study. It concludes with a reflexive account from the author of the conduct and findings of the study.

## **CHAPTER TWO**

### **LITERATURE:**

#### ***A review of literature relating to EBPI and nurse managers***

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#### **INTRODUCTION**

The introductory chapter has provided something of the background to EBP and this chapter starts by reviewing the literature relating to some of the wider aspects of EBP. Organised in three sections, it provides a broad overview and discussion of the current debates relating to the nature of evidence and goes on to review aspects of EBPI. These two sections provide both a background to and a foundation for the final section that considers the roles of key individuals in EBPI processes, concluding with a review of the literature relating specifically to the role of the NM. The first two sections are necessary to map the terrain of EBP and demonstrate the complexity of implementation and both are germane to understanding the nature of the role of the NM in the process.

#### *Search strategy and selection of the literature*

The review was undertaken using a systematic approach to searching online databases, in the first instance, such as CINAHL, Medline, Science Direct and which included searches of the NHS e-library for Scotland and searching the Research Unit for Research Utilisation's (RURU) database at the University of St Andrews. Hand searches of specific journals such as *Evidence Based Nursing* which has an implementation forum were undertaken to uncover papers which may have related to EBPI, but did not include any of the search terms in their title. Likewise, hand searches of the *Journal of Nursing Management* and *Nursing Management* journals were undertaken from 1997 onwards to check for papers that may have related to EBPI and NMs, but which failed to use any of the search terms in their title. Reference lists and bibliographies in books and papers and directories of theses, were used as an additional source of literature.

The literature review does not contain every book or paper obtained, but only those which after thorough critique and selection were considered to be relevant and contributed to the research enquiry (Hart, 1998).

The literature relating to EBPI is vast and is informed by and arises from various bodies of literature from a number of different fields. These include: management, knowledge management, change management, the diffusion of innovations, organisation studies and development, with contributions from psychology, social marketing and behaviour change (Harvey, 1993; Richardson, 1999). While the application of these to evidence-based nursing literature is considered, these underpinning fields are not considered in their own right. While it is acknowledged that each of these may have insights to offer, many of these are focussed on private sector business and industry and individual behaviour change and the context is not similar enough to health care to consider them as part of the review (Hart, 1998; Murray, 2002).

## **EVIDENCE**

### *The nature of evidence*

Almost every author of a paper relating to EBP has an opinion as to the nature of evidence and the contentious nature of the concept was outlined in chapter one. From the introduction of EBP the concept has been complex and contested (Thurston & King, 2004; Leach, 2006) and this has led to nurses having either no clear view of what evidence and EBP are, or holding very strong views about their nature (McInnes, *et al.*, 2001; Driever, 2002; Holmes, *et al.*, 2006). Despite the clarity and inclusiveness of the concept provided by Le May (1999a), confusion remains, with some nurses having a poor grasp of the subject (McKenna, *et al.*, 1999; Jennings & Loan, 2001). While it has been suggested that this is a result of the theory-practice gap that exists in nursing (Rolfe, 1998), it may also be a reflection of the complexity of the concept and its emerging nature. However there appears to be some consensus that ideas on the nature of evidence fall into two schools of thought. Evidence is considered by many, for example, Taylor-Piliae (1998), Bonnell (1999), Upton (1999a), Ingersoll (2000) and Sleep, *et al.*, (2002) and Stetler (2001) to be synonymous with research. This conclusion stems from the belief that there are similarities between the two processes, both are systematic, both take a problem-solving approach (Upton, 1999a; Ingersoll, 2000) and both have the scope to contribute to the professionalisation of nursing (Bonnell, 1999). Others, such as Hunt, (1997), who also views evidence as research, supports this with reference to her earlier work on research utilisation in nursing and views the two processes as similar.

The links between clinical effectiveness and EBP have led others, such as McClarey and Duff (1997), to view research as the only type of evidence worthy of consideration as it was viewed as having the ability to demonstrate clinical effectiveness. Bradshaw (2000) takes this a step further by stating that randomised controlled trials are the only type of research that should be considered as evidence. This view has largely been promoted by the Centre for Evidence Based Nursing and Cullum (1997; 1998) makes it clear that it is not possible to consider evidence as anything other than research as this is the only means of providing proof of patient benefit.

While the randomised controlled trial has dominated evidence-based medicine (Sackett, *et al.*, 1997; 2000), within nursing, other types of research are viewed as just as valid and useful (Upton, 1999b; Bonnell, 1999). Pearson (2002, 2003) argues that any research enquiry which is conducted in a robust manner should count as evidence. By this he is acknowledging that other research methodologies have a contribution to make to EBP. For nursing, the main concern has always been that by accepting a paradigm that emerged from and was upheld by medicine as the 'gold standard', it denied aspects of nursing that were not amenable to measurement in the same sense. The need to continue to recognise the art and science of nursing were paramount and EBP, at first, did not appear to value both equally.

Some authors consider that the main issue in the debate should be less concerned with exactly what 'types' of evidence are considered to be evidence, but that the quality of each type should be of over-riding importance (Griffiths, 2002). He cautions nurses against just '*quoting articles to support practice when the status of the knowledge contained in them may be questionable*'. (Griffiths, 2002: 38). So rather than view the randomised controlled trial as an imposition to nursing, seeing it as a means of providing evidence that is of a higher quality and that has considerable scope for answering the kinds of questions nursing might be asking about practice, is a more productive way of progressing EBPI.

In more recent years, the debate on the nature of evidence has developed to take account of the epistemological complexity of the term evidence. Scott-Findlay and Pollock (2004) argue that nursing is informed by a number of sources of knowledge,

but that evidence and knowledge are not the same. While they claim that they are not trying to minimise the variety and sources of knowledge that underpin nursing, they are clear that personal experience, personal knowledge and clinical expertise can only ever be influences in any clinical decision making process, not the foundation. Therefore they argue that research is the only 'true' evidence. To reflect this, they propose a change in terminology to highlight this significant difference. They suggest that research should be called research (or evidence) and knowledge, such as clinical experience, should be called knowledge, to overcome the confusion caused by the number of terms often used ambiguously and interchangeably. In their response to these suggestions Rycroft-Malone and Stetler (2004) regard the central issue as one that is less concerned with the semantics (although they do acknowledge that these are interesting), but is instead one of finding ways to support practitioners as they seek to meld the various types of research, evidence, knowledge and patient values and preferences to provide an overall 'package' of evidence-based care.

#### *What comprises evidence-based practice?*

While some authors are of the belief that EBP developed from research based practice (which had long been the goal of nurses), they also recognise that EBP is more than research alone and that research and evidence are not the same (Stetler, 1985; Carnwell, 2000). Many authors recognise the role that research has in EBP and highlight that EBP must take a systematic approach to appraising research as evidence, rather than including it on its pedigree alone (Estabrooks, 1998; Mulhall, 1998; Upton, 1999a; Ciliska, *et al*, 2001; Craig & Pearson, 2002; Yin King Lee, 2003).

Practice knowledge, such as clinical expertise (Kitson, 1997; DiCenso, *et al*, 1998; Le May, 1999; Craig & Pearson, 2002) which can take account of patient values or preferences and reflection on practice are all viewed as types of evidence that have a contribution to make to EBP (Goode & Piedalue, 1999; Rolfe, 1999; DiCenso, *et al.*, 2004). In addition to this, other data, such as international, national or local standards, audit data, quality improvement information and risk data, cost effectiveness analyses, policies and benchmarking can all be used as evidence on which to base practice decisions (Le May, 1999; Kendrick, 2001; Stetler, 2001; Rycroft-Malone, *et al.*, 2004; Rycroft-Malone & Stetler, 2004; Harvey, 2005). The essence of this more inclusive

approach to evidence still requires the caveat noted by Stetler (2001), that evidence, whatever it encompasses, must be able to act as ‘proof’ for making clinical decisions.

Empirical work has shown that it is the clinical experience type of evidence that nurses find most useful (Estabrooks, 1998; Thompson, *et al.*, 2001a,b). This, combined with the opinion of experts, has been shown to be more important to nurses than research alone. However, these sources of evidence are not without difficulty (Thompson, 2003) and the most complex aspect of including them as evidence is the way in which they are synthesised and integrated to support clinical decision making (Kitson, 1997a,b; Castledine, 1997, Closs & Cheater, 1999; French, 1999, 2002; Goding & Edwards, 2002; Zietz & McCutcheon, 2003; Rycroft-Malone, *et al.*, 2004; Rycroft-Malone & Stetler, 2004). Despite the difficulties with this, Castledine (1997) and McDonald (2001) suggest that Nightingale began EBP by doing just this.

#### *The purpose of evidence*

EBP emerged in nursing after clinical effectiveness became a significant focus in health care in 1996. Experience had shown that not all interventions, treatment and care, worked as intended or as predicted by theory and there was a move towards providing evidence to demonstrate that they would work to provide patient benefit (Holm, 2004). Although evidence-based medicine had preceded it by some years, this appears to have been the main driver for considering the basis for practice in nursing. Once clinical governance had become a statutory requirement for health care organisations, as a means of improving and proving quality care (Donaldson & Muir Gray, 1998; McSherry & Pearce, 2002), EBP assumed even greater importance as it was seen as one way of demonstrating quality care and patient benefit. While EBP is only one facet of clinical governance, it links with and is underpinned by other aspects. The concurrent interest of policy makers in improving learning, both individual and organisational learning, link these with clinical governance (Davies & Nutley, 2000; Nutley & Davies, 2001; Wilkinson, *et al.*, 2003). These initiatives were all aspects of improving and modernising the health service (McSherry, 2004). While the implementation of clinical governance is a statutory duty, the ways in which individual Trusts and health care organisations have approached this have varied (Lough, *et al.*, 2002) and so the emphasis that has been given to each aspect, including EBP, has varied also.

McDonald (2001) has suggested that the evidence-based changes that Nightingale made to her delivery of care improved the outcome for patients and this has been the driver for many EBP 'projects' in nursing, for example, application of evidence to reduce fasting times prior to anaesthetics (Jester & Williams, 1999). While most authors would agree that this is the over arching goal of EBP, others see the finer details and suggest that there are other ways of using evidence in health care. What is clear is that while there may be an assumption that EBP *could* lead to improvements in individual care and the wider public health, the notion was not readily adopted by nursing (Upton, 1999b). The development of knowledge and technology relating to health care and the ageing population has led to the necessity of considering the best use of scarce resources (Muir Gray, 2001; Baggott, 2004). This view of EBP is probably best summed up by Pearson and Craig (2002:3), who suggest that EBP is necessary to ensure that patients get '*...appropriate care in an efficient manner.*' However, others have suggested that the lack of evidence on which to base nursing practice has meant that evidence should only be used in a quasi-legal way, as a means of defending practice decisions (Rolfe, 1999). DeBorough (2001) has also suggested that evidence could be used to support practice in this way and therefore must be defensible. Pearson (2005), acknowledges that in day to day life, evidence is regarded as a means of providing supporting facts, in health care the focus is on the use of evidence to underpin practice that will be most likely to produce a positive or improved outcome for patients.

While it is undoubtedly important to have a defensible basis for practice and one that has been thoughtfully considered, taking account of all aspects of the evidence, to reduce EBP to a means of preventing litigation does detract from the many positive aspects of EBP and sees it more as a means of protecting practitioners rather than providing benefits to patients.

### **Problems with evidence-based practice**

In addition to the difficulties with EBP outlined above, several other problems exist. The contested nature of evidence becomes an even greater problem when the debate moves away from the discussions about the randomised controlled trial to engage in the debate that recognises that different types of evidence are favoured to different

degrees by different professional groups and is seen as having a different purpose by each (Ferlie & Dopson, 2005; Felie, *et al.*, 2005). One of the initial concerns about EBP was the extent to which it limited professional autonomy (Upton, 1999b; Bonnell; 1999; Bradshaw, 2000; Dopson & Fitzgerald, 2005). This has not only been perceived as a problem for nurses or specifically in relation to the implementation of EBP, but other clinicians have expressed reservations about the impact of policies imposed by management, that impact on practice and practitioners (Powell, 2006). These concerns seemed to arise largely from the belief that nursing was being forced to adopt the evidence-based medicine paradigm and that this did not acknowledge the contribution of experiential knowledge (Miles, *et al.*, 2003, 2004). However, it was not solely related to this. One of the problems with EBP is that for many years nursing academics had focussed on developing the research base for nursing, as a means of providing an empirical foundation for care. While seeing this translated into changes in practice was not without difficulty (Hunt, 1981; Hunt, 1987), nursing research was viewed as one means of creating a 'science' of nursing that was independent from that of medicine. This was related to notions of developing the nursing 'profession' (Keogh, 1997), although much of the research that was undertaken at that time focussed more on nurses than patients, in that it was theoretical in nature, rather than clinically orientated (Rolfe, 1999). Nurses were concerned that the arrival of evidence-based medicine had the potential to obviate much of this work and to further medical domination of health care provision (Rolfe, 1999). Although this has been previously noted, it stands out in the EBP literature as a strong and recurring theme.

While there have been debates about the nature of nursing science (Forbes, *et al.*, 1999), overall, there are fundamental problems for nurses concerning the use of EBP that has been based on the randomised controlled trial. Nurses were concerned that they were being 'forced' to accept a way of managing patients that did not reflect nursing skills and patient values and that it might actually reduce, rather than augment nurses' autonomy and authority (Bonnell, 1999). Closs and Cheater (1999) reiterate that EBP is not a means of devaluing clinical skills; it is the use of skills with evidence that makes the use of EBP beneficial to patients and Hancock and Easen (2004) believe that EBP actually increases autonomy and accountability for nurses. However, the way in which this integration of knowledge, skills and evidence takes place and the emphasis given to any one over the other, is more complex still (Colyer

& Kamath, 1999; Thompson, 2003; Rycroft-Malone & Stetler, 2004; Rycroft-Malone, *et al.*, 2004b). These difficulties result from EBP having become entangled in and encumbered by the struggles of and tensions between, autonomous professional groups (Ferlie & Dopson, 2005). Nurses do not have the power base of medicine and doctors have also had to strive against changes in health service management to retain their professional autonomy over practice (Ferlie and Dopson, 2005). This may well have exacerbated the situation that they find themselves with regards to nurses trying to increase *their* autonomy over clinical practice as the result of EBPI.

Despite the purported advantages for increased autonomy promised by EBP, nursing remains in a subordinate position in health care (Mulhall & Le May, 1999). The historical legacy and current working practices and the interactions of different professional groups can have a profound impact on notions of autonomy for groups of nurses (such as a ward) or individuals. These interactions have the potential to impede every aspect of the EBPI process from the identification and adoption of legitimate evidence to possessing enough autonomy to put it into practice, practice that may well be under the scrutiny of managers and other health care professionals (Mulhall & Le May, 1999).

While some of the earlier concerns of nurses might have diminished or disappeared, recent research into nurses conceptions of evidence-based practice and associated terms demonstrates that it is still a poorly understood concept and that using it in practice reflects this to some degree (Banning, 2005).

Notwithstanding the earlier section on what counts as evidence, one of the other problems with evidence, other than research, such as local policies, procedures and guidelines, is the extent to which these are actually evidence based. Both Estabrooks (1998) and Thompson, *et al.*, (2001a,b) in their empirical studies of the types of evidence preferred by nurses found that significant percentages of the written information available to nurses in these formats, were not, in fact, evidence-based. Many of the textbooks used were many years out of date and journal articles referred to by nurses were not research based, but were opinion papers. Local policies, procedures and guidelines had no references and so their evidence-base could not be traced or proven. Perry (2002) in an evidence-based guide for nurses, emphasises the

importance of ensuring that nurses have the necessary skills to critically appraise and grade evidence, before commencing any type of evidence-based product development. The quality of any products that are produced depends on these skills and if they are implemented into practice, then it is imperative that this aspect of their creation is seen as important (Von Degenberg, 2001). While there have been concerns about the need for nurses to improve their skills and knowledge to enable them to implement and use evidence in practice (Van Mullem, *et al.*, 2001), there is clearly also a need to give attention to skills in relation to evidence-based product development .

The final difficulty with EBP is that it is only able to benefit patients if it is actually used in practice. For this to be a reality, evidence has to be both disseminated and applied and the implementation in particular is a complex process, involving many organisational and individual actions for it to be successful (Mulhall & Le May, 1999). The (lack of) availability of evidence in the clinical area has also been found to be a hindrance to the use of EBP (Thompson, *et al.*, 2001a). A detailed review of the literature relating to EBPI is presented after consideration has been given to the connection between EBP and RU.

Despite the recognition that evidence is more than research alone, there are many authors, for example, Stetler (2004) and Estabrooks (1998) who believe that EBP developed from earlier efforts to base practice on research. In particular, Stetler, in the USA, has made a significant contribution to this over a number of years. A review of the literature relating to research utilisation follows.

## **RESEARCH UTILISATION**

Research utilisation (RU) and the use of evidence in practice are often seen as the same; however, RU predates notions of EBP by some decades. In the UK, the Briggs Report (Department of Health, 1972) is often seen as the beginning of an interest in research utilisation in nursing (Smith, 1979; Hunt, 1981; Closs & Cheater, 1994; Mulhall, 1995; Tordoff, 1998). However, the extent to which this interest has successfully been translated into changes in practice is less clear. In the USA, there had been substantial efforts in the form of large well funded RU projects which were

focussed as much on increasing the research skills of nurses and assisting them to undertake research, as they were with RU (Omery & Williams, 1999). In the UK there was less clarity about the goal of RU, with discussions ranging around whether nursing research actually made any difference (Hunt, 1981) and whether research was even relevant to nursing (Mulhall, 1995). What most authors did agree on was that available nursing research was not being used (Hunt, 1981; MacGuire, 1990; Bircumshaw, 1990; Closs & Cheater, 1994; Pearcey, 1995). The reasons for this were outlined by Hunt (1981:192) in her seminal paper:

1. *'Nurses do not know about research findings*
2. *Nurses do not understand research findings*
3. *Nurses do not believe research findings*
4. *Nurses do not know how to apply them*
5. *Nurses are not allowed to use research findings'.*

Hunt did not conclude that there was a lack of research on which to base nursing practice, although this has been raised as a problem since (Mulhall, 1995). However, even this has not been without contention. Some authors have seen the problems not only as a lack of research, but also that the research base for nursing was poorly developed, not organised and not of sufficient quality to be applicable to practice (Mulhall, 1995). In contrast MacGuire (1995) believed that there was a plethora of research available to nurses and the difficulties arose from overload and lack of ability to assimilate the amount of information available.

In addition to improving the care for patients, there was a concern that research had not been part of the educational preparation of nurses and that this was a hindrance to RU (Smith, 1979). Nurses lacked the skills to undertake research and to understand it. It gradually became fully integrated into the pre-registration curriculum (by 1988 in Scotland). At the same time, nursing was trying to raise its profile as a profession and the possession of a unique knowledge base on which to base nursing care and to see it as separate from medicine, became entangled in the RU goal.

## **Types of RU**

As thinking about the concept of RU has developed, there is a growing understanding that there are different types of RU. Closs and Cheater (1994) discussed the different ways in which research might influence practice, suggesting that it might be more than causing changes to practice, but that it might also influence the way that nurses think about or reflect on practice. Stetler (1994) in the further development of an RU model acknowledges that there are different types of RU, naming them; instrumental, conceptual and persuasive, also known as symbolic, RU (Estabrooks, 1999). These terms reflect the belief that research can influence individuals in different ways. In health care the focus has always been on instrumental use, that is, the direct use or impact on policy or practice. A specific piece of research could be identified as the basis for practice or policy. Conceptual use acknowledges the more diverse ways that research might influence an individual's way of thinking about a practice problem or affecting their understanding of it. It is a means of affecting attitudes, rather than direct behaviour as in instrumental use but can also be considered as producing wider influences on knowledge and understanding, beliefs, practice behaviours and outcomes (Walter, *et al.*, 2005). It is a more complex, less specific use of research, more difficult to trace or demonstrate (Nutley, *et al.*, 2007). Symbolic or persuasive use describes the influence that research can bring through a third party, for example, practitioners using a piece of research to lobby for changes to service provision, within their own organisation (Stetler, 1994) or by using research to make a 'good case' for increased human or financial resources (Lacey, 1994).

Drawing on experience of studying cross sector research use Nutley, *et al.*, (2004a) also note that RU can be viewed as a continuum, in which research raises practitioners awareness, through the development of knowledge and understanding, to influencing actual change in practice or policy (Nutley, *et al.*, 2007). In an earlier paper, they suggest that in a review of the RU literature, three types of RU can be identified, depending on who the main focus of the RU is: those focussed on professionals, those types of RU that are organisation-wide and those that involve entire systemic re-orientations (Nutley, *et al.*, 2002b).

In a study of the process of RU, Landry, *et al.* (2001a,b), once again identify the three main types of RU, instrumental, conceptual and symbolic, but they acknowledge that

the processes for getting research used in practice are complex and rarely depend on an individual knowing about a piece of research alone. Indeed, much of the work on RU over the recent years has begun to move away from the focus on the individual, to take account of the complexity of the process and the role of the employing organisation in this, for example, Estabrooks, *et al.*, (2002); Estabrooks, (2003); Estabrooks & O’Leary, (2006).

There has been a growing awareness that efforts to improve the use of evidence and research in practice need to focus on the wider aspects of implementation, moving away from expecting nurses to know about and then use evidence in practice as the sole means of increasing evidence use. Studies such as that undertaken by the Foundation of Nursing Studies (2000; 2001), in recognising this, make recommendations which are designed to impact at all levels within the local and national NHS and at individual level. This move to consider wider organisational factors is demonstrated in the type of research that is now being undertaken to improve understanding of RU at this level, such as the study by Meijers, *et al.* (2006) and that outlined by Stetler, *et al.* (2007) which aim to improve understanding of the impact of contextual factors on RU.

Having considered the nature of evidence in its widest sense and introduced the concept of RU, the following section goes on to review the literature relating to EBPI and that is more directly related to the empirical concerns of this study. The section begins to focus the review on the complexities of the process and highlights the role of individual nurses in EBPI processes. It then goes on to consider the literature relating to the organisational aspects of EBPI and NMs within them. The section concludes by considering the difficulties in the process and presents the well-researched barriers to the process.

## **IMPLEMENTING EVIDENCE**

### *Clinical guideline development and implementation*

The previous section considered the nature of evidence and the role of research as a type of evidence. National clinical guidelines are a major and significant source and

resource of evidence and while they are not the main focus of this research they are readily available to all health care practitioners.

Clinical guidelines can be viewed as a type of evidence (research based) presented in a format that is easy for practitioners to use (SIGN, 2002). However, they can also be seen as a method of the application of evidence and it is for this reason that they are included here as a bridge between evidence and implementation. The literature on guideline development and use is considerable and as they are not the main focus of this thesis, they will only be considered here in brief. However, they do have a role in EBP and to date a considerable amount of time and financial resources have been committed to their development. Much of the work relating to the development of guidelines and their use in practice has focussed on the medical profession. Indeed, many nurses view guidelines as a medical imposition to dictate nursing care (Davenport, 2000). Guidelines differ from standards, policies, protocols and procedures, although the terms are sometimes used interchangeably, which suggested that practitioners do not fully understand the differences between them (Jankowski, 2001). Guidelines provide a specific set of instructions to guide the care of patients with specific conditions (Woolf, *et al.*, 2000a) and their main aim is to improve the quality of patient care (Woolf, *et al.*, 2000b; Larson, 2003). Guidelines are designed to assist practitioners in making decisions about patient care, and are considered to be guidance, but if they are not followed, without a rationale for this decision, there may be professional consequences (Hewitt-Taylor, 2003a,b). Some consider this to be a threat to autonomy and accountability and the Medical Defence Union has stated that national guidelines, at least, are rigorously developed and are based on the best and most up- to-date research and knowledge and practitioners should only deviate from these with good (and documented) cause (Colbrook, 2002). It is the research basis of guidelines that lends weight to the need to use them in practice (Duff, *et al.*, 1996).

While guidelines can lead to the standardisation of care, this is not always viewed as a benefit to patients, but rather as a means of denying their individuality and removing professional nurses' autonomy (Hewitt-Taylor, 2003a,b). This has been contested by those who support the guideline movement, as untrue, since the use of evidence in practice (including guidelines) requires that consideration be given to patients' values and preferences and that patients are viewed as individuals. Hewitt-Taylor (2003a,b)

is more concerned with a 'blanket approach' to care that is guideline-based, without consideration. This has the potential to return nursing to the days of ritualistic or routine care that is provided in an unthinking manner and from which nursing has fought hard to distance itself (Walsh & Ford, 1989; Holland, 1993; Ford & Walsh, 1994).

Most national guidelines (those produced by the National Institute for Health and Clinical Excellence in England and Wales, SIGN in Scotland and the Royal College of Nursing throughout the UK) are developed by large multi-disciplinary groups, according to a lengthy and rigorous process. The validity and acceptability to practitioners of the guideline will, in part, depend on the composition of this group (Duff, *et al.*, 1996; Cheater & Closs, 1997). Since guidelines are designed to be specific, the process begins with a specific clinical question and although it varies according to the body involved, the guideline is developed around a research or evidence hierarchy with recommendations built around the strength of the evidence (SIGN, 2002).

Although the most research has been undertaken into the development and use of national guidelines, review of the literature demonstrates that there are many local guideline development programmes in place, for example, Mank and Van der Lelie (2003). Von Degenberg (2001) highlights the risks of practitioners undertaking the development process locally, not least, the cost, the time taken and the need for specialist critical appraisal skills to ensure the quality of the finished product. Without good quality, appropriate material as the basis for guidelines, they risk either not being used, or if they are adopted into practice there may be issues relating to the quality of care. The studies undertaken by Thompson, *et al.* (2001a,b) have shown that many of the sources of evidence available to nurses in the clinical area, were not in fact, evidence, or research based. The other danger of local development is that of duplication (Von Degenberg, 2001). Poor inter-organisational communication may mean that there is considerable duplication of effort when it comes to guideline development. The resources required in terms of time and finance, would suggest that duplication is costly and inefficient. A review of the literature relating to guideline implementation has shown that it remains a considerable challenge to all practitioners and that a review of the strategies for implementation suggests that since most studies

have focussed on medical staff, it is not possible to make recommendations that would readily translate into nursing practice (Richens, *et al.*, 2004). However, it was possible to conclude that while a strategy for implementation is important (Duff, *et al.*, 1996), it must take account of several key principles which address aspects of the complex process and no single definitive strategy could be recommended from a systematic review of the literature relating to guideline implementation in nursing (Richens, *et al.*, 2004).

Once the guideline is complete it is disseminated widely prior to the implementation process. However, it is the local adaptation and implementation of guidelines that continues to be the most considerable challenge of the process (Davenport, 2000; Richens, *et al.*, 2004) as the development of good guidelines alone does not guarantee their use in practice (Feder, *et al.*, 2000). National guidelines need local adaptation prior to application in the local context and this is the responsibility of each organisation (Foord-Kelcey, 2001; SIGN, 2002). Achieving 'local ownership' of national guidelines is an important, but not straightforward issue in securing their application to practice in the local setting (Ring, *et al.*, 2005, 2006). In a review of literature relating to dissemination and implementation of guidelines, Cheater and Closs (1997) found that enabling practitioners to discuss national guidelines could influence their use in practice. Hedley, *et al.*, (2003) believe that people will support an initiative, if they are involved in the development process. However, even the approach taken by the NMPDU in Scotland of involving local nurses in a national development process, did not guarantee wide-spread dissemination or use in practice (Ring, *et al.*, 2005; Ring, *et al.*, 2006). The complexity of the process of implementation is often under-estimated as the focus has traditionally been on the development of the guideline rather than on EBPI.

## **EBPI**

If implementation concerns change (Mulhall & Le May, 1999) then '*change is the raison d'être of EBN [evidence-based nursing].*' (Flemming & Cullum, 1997). Understanding EBPI requires an acknowledgement that the focus is on processes of change.

In nursing the concept of EBPI grew from the notion of RU. In the early days of interest in RU, there was a belief that if nurses understood that they should be using research or evidence in practice, then they would do so. This was reflected in a statement from the international council of nurses, which suggested that once nurses knew about research, they would use it in their practice (ICN, 1996a,b). However, this was not the case and many of the initiatives put in place, such as research facilitators, were not based on a full understanding of what the problems were and what suitable remedies would be (Hunt, 1996). Hunt saw these attempts as simplistic and flawed because they failed to take account of the complexity of the process involved and the situations in which implementation would occur (Hunt, 1996). For many, the focus was on dissemination of research findings, which involved presenting research findings and circulating them within organisations, without any additional attempts to encourage the actual use of the research (Walter, *et al.*, 2003). While effective dissemination has been recognised as a prerequisite of EBPI (Dickson, 1996; Smith & Masterton, 1996), this often resulted in overload of information, but little else in the way of practical implementation (Knott & Wildavsky, 1980; Nutley & Davies, 2000a). The circulation of research, without any active measures to facilitate EBPI has been shown to be ineffective (Bero, *et al.*, 1998). There has been a growing understanding that EBPI is not the simple linear process that it is often thought to be, but a complex endeavour that may be iterative and unpredictable in outcome (Dopson, *et al.*, 2002; Stetler, *et al.*, 2006; Nutley, *et al.*, 2007). There are clearly differences between the processes, purposes and outcomes of dissemination, which is concerned with communicating evidence or research and implementation, which brings about a change in practice as a result of the *use* of research and evidence (Mulhall & Le May, 1999; Nutley, *et al.*, 2007). However, the process has been acknowledged as one that has particular challenges as a result of the investment required at all levels of an organisation and the need for multiple strategies to tackle the complex process (Pearson, 2004).

In the same way that Stetler (1994) identified three different types of RU, conceptual, instrumental and symbolic or persuasive use, (also described as active and latent research use by Bartholemew and Collier (2002)), this has been more widely recognised, but much of the effort in healthcare has been on increasing instrumental use. Although not specifically stated, this is likely to be seen as the way in which the

greatest patient benefit will result. There are increasing policy demands for the demonstration of quality and benefit from health care systems (Marshall, 2001; Mannion, *et al.*, 2001) and instrumental use of research will be more amenable to measurement and evaluation than the other types.

Originally seen as the responsibility of the individual practitioner (Hunt, 1981), there has been a growing awareness that making changes to practice is often beyond the ability of unsupported individuals who may lack the knowledge and skills to do so. There are a number of other factors that have a substantial impact on the circumstances, which facilitate or impede EBPI. These impact at individual, team and organisational level (Redfern & Christian, 2003; Rycroft-Malone, *et al.*, 2004a,b; Ring, *et al.*, 2005). The importance of other variables in RU/EBP was gradually recognised and the need to take account of organisational structure, personal factors and EBPI processes came to the fore (Luckenbrill Brett, 1989). Increasingly, there has been a move away from seeing the individual practitioner as key in the process; instead the organisations in which they work are viewed as having a greater influence on the ability to be successful in implementing EBP (Halliday & Bero, 2000). The context in which EBPI is taking place is seen as one of the most significant factors, but contexts vary widely and strategies for implementing EBP in one context will not necessarily be effective in another (Nutley, *et al.*, 2000; McCormack, *et al.*, 2002; Greenhalgh, *et al.*, 2004; Dopson, *et al.*, 2005; Walter, *et al.*, 2005; Dopson, 2006). If context is seen as the setting in which EBPI will take place, within this there are other key factors, which influence the success of EBPI. These include organisational culture; the type of evidence; social factors; and the management of change process selected to facilitate the application of evidence to practice (Bucknell, 2004).

Work led by the Royal College of Nursing into the EBPI process has developed an explanatory framework (Kitson, *et al.*, 1996; 1998; Rycroft-Malone, *et al.*, 2002; Kitson, *et al.*, 2008). Focussing on three elements that are seen as the most significant in the process, evidence, context and facilitation, each of these has been further researched to determine their impact (McCormack, *et al.*, 2002a,b; Harvey, *et al.*, 2002; Rycroft-Malone, *et al.*, 2004a). While many of these factors have long been recognised as problems to be overcome, this has not necessarily led to effective management of them (Thomson, 1998). With the early focus being on the individual

practitioner, many of the implementation strategies, were seen as 'bottom-up', that is, change would begin at practice level and would spread upwards (and outwards) through an organisation. However, many of the more recent EBP initiatives, such as national guidelines and best practice statements, enter the organisation at senior nurse level and are disseminated downwards (top-down) to practice level. A combination of both methods is seen as important (Nutley, *et al.*, 2007).

The role of context is seen as key to effective EBPI and the necessity of undertaking a diagnostic analysis (Kitson, *et al.*, 1996; Kitson, *et al.*, 1998; Rycroft-Malone, *et al.*, 2002; McCormack, *et al.*, 2002a; Rycroft-Malone *et al.*, 2004a; Dopson & Fitzgerald, 2005) is recognised as an important first step to understanding both the context and the role of individuals within it, as well as identifying the readiness for change (Richardson, 1999, 2000; Harvey, *et al.*, 2002). Specific processes (and occasionally key staff with specific skills) need to be put in place to enable EBPI to take place and these need to actively involve practitioners (Perala, 2000; Newhouse, *et al.*, 2005; 2007).

One aspect of context that occurs with increasing frequency and relates to the success of EBPI, is that of management support, administrative commitment and autonomy to make changes to practice. For example, Wallin, *et al.*, (2006) found in a survey of contextual factors influencing the uptake of quality initiatives, that support and commitment from management and enough autonomy for nurses to make changes to practice were crucial factors. Likewise, an overview of qualitative approaches to studying RU, highlighted the importance of management support and autonomy for nurses to make research and evidence-based changes to care (Tripp-Reimer & Doebbeling, 2004). A UK-wide review of EBP progress undertaken between 1994 and 2000 also showed that management and leadership were crucial to effective EBPI, not only by the promotion of positive research cultures, but also by active involvement in supporting practitioners, through the development of specific roles and by fostering autonomy for nurses. Their role in building and maintaining positive relationships with other professions, within the wider organisational context was also seen as significant (Foundation of Nursing Studies, 2001). Studies of change in health care have continued to demonstrate the significance of context in mediating change (Pettigrew, *et al.*, 1992a,b; Ferlie, *et al.*, 1998; Iles & Sutherland, 2001).

One related factor features in the literature relating to change and evidence use in practice - that of culture. While it is acknowledged that culture is a complex and contested notion (Scott, *et al.*, 2003a, b; Mannion, *et al.*, 2005; Scott-Findlay & Estabrooks, 2006), it is nonetheless one that has some significance in understanding EBPI and nurse managers. Studies of culture have shown that it has an impact on many aspects of health care, including performance and research use (Scott, *et al.*, 2003a,b; Sheaff, *et al.*, (2003); Hyde & Davies, 2004; Mannion, *et al.*, 2005; Scott-Findlay & Estabrooks, 2006). Pettigrew, *et al.* (1992) in their study of strategic change in the health service found that there was not one, but many cultures within the organisation and this has also been noted by other authors as significant. Traynor (1994), Mulhall and Le May (1999) and Thompson and Learmonth (2002) assert that not only does each professional group have its own culture, but so too does each clinical area, ward or unit, each directorate or clinical grouping and each hospital within a Trust. The relationship between context and culture is not clear, but both impact on each other (Pettigrew, *et al.*, 1988b; Tod, *et al.*, 2004; Pepler, *et al.*, 2006). Culture has been identified as a barrier to EBP and RU and managers are thought not only to have a considerable role in influencing culture, but also to have the potential to ameliorate problems arising from organisational culture (Nolan, *et al.*, 1998; Sitzia, 2001; Estabrooks, *et al.*, 2002). Nurse managers have a role in shaping or informing organisational and nursing cultures and recognise that to an extent, this happens through the priority or importance that NMs attribute to aspects of practice and their wider roles (Kane-Urrabazo, 2006; McSherry, 2006; Biron, *et al.*, 2007).

It is clear that EBPI is a complex and multifaceted process. However, certain factors have emerged that are significant in facilitating the evidence use, not least the role of context and more specifically, in relation to nursing, the part played by managers in this. Before going on to look at this in greater detail in the final section, a review of EBPI models and then strategies will be provided as a means of indicating the different ways in which evidence has been or is being implemented and to illustrate the potential ways in which nurses or NMs seeking to embark on the EBPI process, have at their disposal.

## **Implementation models**

As outlined above, evidence and research use in practice are highly complex processes, involving many factors at all levels of health care organisations. Despite this, many attempts to conceptualise and instrumentalise the process have been undertaken. This section presents the main models that have been used to guide or underpin EBPI. Many of these were originally designed for RU, as they preceded the introduction of EBP, but nonetheless, they have the same goal and therefore they have been included. Some of the older models have been updated to reflect changes in thinking and understanding regarding implementation and the advent of EBP. This section is intended to give an overview of EBPI models and is not exhaustive. Although brief details are given in Box 2.1, fuller explanations of the models follow in the text.

### **Box 2.1: Examples of models used to explain and facilitate EBPI**

#### ***Organisational models***

Conduct & Utilisation of Research in Nursing (CURN) (Horsley, *et al.*, 1978)

Iowa model (Titler, *et al.*, 1994)

Titler & Everett model (2001) based on the diffusion of innovations

Stetler & Marram model (1976), updated in 1985, with further refinements by Stetler in 1994 and 2001.

Tyler collaborative model (Olade, 2003)

Organisational model (Kitson, *et al.*, 1996) revised and expanded in 1998 and named Promoting Action on Research in Health Services (PARIHS). Further refinements in 2002 (Rycroft-Malone, *et al.*; Kitson, *et al.*, 2008)

Organisational excellence model (Walter, *et al.*, 2004)

#### ***Organisational and/ or individual models***

Modified diffusion of innovations model (Dobbins, *et al.*, 2002)

Burrows and McLeish, research-based practice model (1995)

Jack & Oldham model (1997)

Framework to assist EBP (McInnes, *et al.*, 2001)

Research-based practitioner model (Walter, *et al.*, 2004)

Embedded research model (Walter, *et al.*, 2004)

#### ***Explanatory models***

Pipeline model (Glasziou, 2004; 2005; Glasziou & Haynes (2005)

It is clear that the number of models conceptualising the evidence into practice process is increasing and in addition there has been a greater focus on the mechanics of EBPI than in some of the earlier models, which has led to further refinements of these over time. While models have something to add to understanding the process, many, particularly those that focussed specifically on research use, were simplistic and did not capture the complexity of the process. Many were linear in form, which failed to acknowledge that there is more likely to be a non-linear, or iterative progression through the stages from knowledge or awareness of evidence, to EBPI (Nutley, *et al.*, 2007). Many of the earlier models failed to take account of the barriers to EBPI and presented an overly optimistic account of the process. These were built on the assumptions that if nurses had the skills and knowledge, they would

automatically make changes to practice. These do not take account of the complexity of the process and the numerous other factors involved.

Some models have developed from hospital and university collaborations (for example, the Iowa model), but these fail to determine the ways in which this guides, informs or supports EBPI. Hunt (1987) created research 'triads' which consisted of a ward sister, a nursing university lecturer and a librarian, to work on accessing research and finding ways of using it in practice. Focussing on changing specific practices, which were not technical in nature (such as mouth care), it took two years to develop protocols and they were faced with considerable opposition and obstacles along the way. It is not clear the extent to which these were ever fully implemented, or if they supported sustained changes to practice. Having academic involvement does not necessarily guarantee success.

Other models, for example, the early Stetler and Marram model (1976, 1985) and the model developed by Jack and Oldham (1997) have the individual practitioner as the main focus of the model. Others have acknowledged different levels of involvement in the EBPI process within organisations and identify roles for individuals, teams and the wider organisation, for example the Iowa models (Titler, *et al*, 1994, 2001) and the emerging PARiHS models (Rycroft-Malone, *et al*, 2002; Kitson, *et al.*, 2008). Walter, *et al.* (2004) recognise that in different types of organisations, different models describe or guide EBPI, having identified three such models. In the research-based practitioner model, the individual takes responsibility for accessing, appraising and implementing research into their own practice. They have the knowledge, skills and autonomy to enable them to do so. This is very much the model that was proposed in the earlier days of RU in nursing. In other organisations, research is 'embedded' into aspects of day to day work, through the use of research acting as the basis for policies and procedures and staff themselves may be unaware that they are using research in practice as they carry these out. Walter, *et al.* (2004) found this method of evidence application in organisations where there were greater numbers of unskilled, or less highly qualified staff. In other organisations, the whole ethos is built around using research and evidence to maintain and improve standards and it is integrated into all aspects of organisational life. It is used by individual practitioners, it forms the foundation of policies, standards and procedures and underpins quality

initiatives to maintain overall organisational excellence. This has been the basis for other models, such as the Iowa model, which developed to supersede quality assurance models already in use (Titler, *et al.*, 1994) and is based on organisation level approaches to using research.

Several of the models are based on management of change models, or adaptations or syntheses of these, for example, Dobbins, *et al.*, (2002) use Rogers diffusion of innovations (1995) as a basis for the development of their model. This approach has been taken by many others in understanding the EBPI process (Nutley & Davies, 2000; Nutley, *et al.*, 2002; Ferlie & Dopson, 2005), but it has been criticised for taking a rational view to change management that does not acknowledge the complexity of the process and this over-simplification is evident in some of these models. In an attempt to address this complexity, the development of the Tyler model (Olade, 2004) has merged two change management models (those of Lewin and Havelock) to try to represent the barriers to change and the phases involved in implementation. However, it fails to provide detail as to how this will actually take place. Many nurses are aware of the barriers to change. They require more specific guidance to help them overcome these, tailored to fit the specific context in which they work.

The PARIHS framework developed over the last 10 years reflects the complexity of implementation and has researched aspects of the equation  $SI=f(E, F C)$ , which is said to represent successful implementation being a function of the combination of evidence, facilitation and context (Kitson, *et al.*, 1998) looking in detail at each aspect and its contribution to successful EBPI. It has the advantage that it can be used to imply the ideal conditions for successful EBPI, but also has utility as a 'diagnostic tool'. As such, it determines the ideal conditions, in each of the three domains and those using it can decide where their organisation fits on a continuum between, high (successful implementation more likely) and low (successful implementation less likely). This would enable any problems to be addressed or countered prior to EBPI initiatives being introduced.

The model developed by Rosswurm & Larrabee (1999), although a simple, staged, linear model, is noteworthy in that it highlights a specific role for nurse managers, recognising the crucial role that they play in overall EBPI.

The pipeline model (Glasziou, 2004, 2005; Glasziou & Haynes, 2005) identifies seven stages in the evidence to practice process and suggests that the EBPI process begins with awareness of evidence and ends with improved health outcomes. Evidence 'leaks' as if from a pipeline thus accounting for the diminishing impact or adherence to it. It is a linear model that does not explicitly acknowledge the impact of other factors on the 'movement' of evidence through the pipeline.

Despite the number of models available, it becomes clear from the wider literature that these are not the main drivers behind EBPI. The readiness of practitioners, or the willingness of the wider organisation to use models to guide evidence application are still a significant factor in their adoption (White, 1995). However, these few models demonstrate the complexity of the process and highlight a developing understanding of the factors that are contingent for successful implementation.

Despite variable use of models and variable understanding of the RU or implementation processes, many practitioners are attempting to apply evidence to practice and have adopted a number of different strategies in order to do so. These are discussed below.

#### *Implementation strategies and projects*

Once again this section aims to provide an overview of the kinds of strategies that have been adopted by nurses and are available to nurses as a means of facilitating EBPI. It is not exhaustive, but provides a breadth of information about the number and main types of strategies used. Box 2.2 shows examples of empirical work that has been undertaken in practice to facilitate evidence use. Some details are provided in the legend that follows the Box.

**Box 2.2: Examples of empirical work relating to EBPI.**

- Hunt (1987). Action research, using research triads to implement changes to practice.
- Pearcey & Draper (1996). Action research using the diffusion of innovations model.
- Lindsay (1998). Randomised controlled trial into the introduction of a new nursing service.
- Ferlie, *et al.*, (1998) Case study of evidence-based changes to HIV/AIDS services in England.
- Newman, *et al.*, (2000) Action research to develop an entire evidence-based ward.
- Ross & McLaren (2000); Ross & Christian (2003); Ross, *et al.*, (2003). Multifaceted strategies to introduce evidence-based practice across the South Thames region.
- Kinsman & James (2001). Retrospective audit of nursing records to determine the extent of EBP protocol use in Australia.
- Thompson, *et al.*, (2001). Mixed methods study to determine nurses' most used sources of evidence-based information.
- Dopson, *et al.*, (2001). Implementation of EBP in 16 different projects across England and Wales using a number of strategies.
- Jolley (2002). Survey of nurses' attitudes to and use of research to monitor the success of implementation.
- Kilbride, *et al.*,(2003). Implementation of protocols and then surveys to monitor infection rates after changes to practice in the USA.
- Mank & Van der Lelie (2003). Three part study across Europe, involving the development of an inventory of evidence-based guidelines, implementation of the guidelines and monitoring infection rates after changes to practice.
- Feifer, *et al.*, (2004) 13 projects in Canada aimed at individual, team and organisational level to implement EBP. Development of a conceptual framework from findings.
- Tolson, *et al.*, (2005). Research into the development of online communities of practice to support the EBPI using link nurses across Scotland.
- Ring, *et al.*, (2006). Survey of the effectiveness of a link nurse network for the dissemination and implementation of NMPDU best practice statements across Scotland.

While these examples only represent a few of the empirical studies undertaken into EBPI, they do demonstrate the breadth of work and variety of clinical areas studied. The size of the research also varies, with some studies such as STEP (Ross & McLaren, 2000; Ross, *et al.*, 2001) PACE (Dunning *et al.*, 1997; Dopson, *et al.*, 2001) and the European study undertaken by Mank & Van der Lelie (2003) were large and well funded, while others were small local studies. What becomes evident from these is the extent to which success in making evidence-based practice changes varied. Some studies stand out for these reasons. Newman, *et al.*, (2000) found that while they were able to support EBP while the research was ongoing, it was not sustained after the researchers were no longer involved. This coincided with a change to the ward manager and they conclude that sustaining EBP depends very much on the support and commitment of managers. Likewise, Hunt (1987) in her early study of implementation of research based practice found that the process was time consuming (taking two years to develop and introduce change) and it was clearly beyond the ability of individual nurses to make and sustain these changes.

In addition to the empirical work undertaken into EBP, a number of other strategies and projects demonstrate the willingness of nurses to try to make changes to practice. Box 2.3 provides some examples of models used in practice and details of notable projects are provided in the text following. Again, these are included in this review of the literature to highlight the wealth of information available to nurses and managers, relating to EBPI.

**Box 2.3: Examples of the use of models in implementing EBP.**

Tranmer, *et al.*, (1995). Use of the Stetler and Marram model (1974) to undertake and implement research.

Cutcliffe & Bassett (1997) used two approaches, based on normative-re-educative and rational-empirical models to implement change in two clinical settings.

Oates, (1997). Synthesis of the Iowa model (Titler, *et al.*, 2001) and Havelock's theory of planned change to implement EBP in paediatric care.

Taylor-Piliae, (1998). Use of Rogers' Diffusion of Innovations theory to guide evidence implementation in intensive care nursing.

Uitterhoeve & Ambaum (1999). The Stetler 1994 model was used as a means of directing the implementation of cancer care in the Netherlands.

Thurston & King (2004) describe the use of Russworm & Larrabee's (1999) six step model for implementing change in 10 nursing teams in a number of clinical settings in Canada.

Ellis, *et al.*, (2005) used the PARIHS (Kitson, *et al.*, 1998) model to implement EBP in rural Australian hospitals.

The number of examples provided gives testament to the efforts of nurses to implement EBP in different settings and in different ways. Many of these authors have concluded that despite choosing a model to guide EBPI, there is no 'one best way' to tackle this and that many factors will influence its success. Notably, Uitterhoeve and & Ambaum (1999) describe a large and well-funded initiative, which failed to reach the implementation stages of EBP because management support and commitment to the project were withdrawn. Once again this emphasises the significant role of nurse managers in enabling EBP to take place.

In addition to the projects outlined above, which were based on recognised models for research and EBPI, a number of other strategies and projects have been undertaken. These have mainly been based on educational initiatives relating to EBP and tailored 'packages' to enable nurses to use evidence in practice, for example, Thomson, *et al.*, (2000), Gennaro, *et al.*, (2001), Abbott & Hotchkiss (2001) and Sleep, *et al.*, (2002). Many of these have been based on the premise that increasing nurses' knowledge of EBP and research will increase their use of EBP in the clinical setting. This has not necessarily been shown to be effective and relies on the individual practitioner taking

the lead and making changes to his or her own care, without acknowledging the organisational context in which they work. Royle and Blythe (1998; 2000) highlight the role of the wider organisation and in particular the significant role of nursing administration in developing a culture that supports EBP, rather than relying on individuals to make changes themselves. This is borne out by the experience of Abbott and Hotchkiss (2001), trying to implement changes to continence management. Despite the provision of adequate education, and evidence-based protocols, enthusiasm and 'buy in' from nurses, EBPI did not take place. They conclude that education alone could not be successful in facilitating EBPI in the absence of specific administrative or management support and a change to the culture in the working environment, to one which valued EBP.

Having presented a number of different approaches to getting evidence implemented into practice, this final section considers the effectiveness of these. Several steps have been identified as important precursors to EBPI. Dissemination alone is not enough to ensure EBPI, but it is a means of ensuring that information reaches different levels within organisations (Firth-Cozens, 1997).

Dissemination, in itself, can be complex. A balance is needed between providing enough information to facilitate and enable EBPI and providing so much information or evidence that practitioners are overwhelmed (Knott & Wildavsky, 1980). Many of the strategies presented in the above sections have been described as educational, supported by opinion leaders, product champions or as marketing or audit strategies (Firth-Cozens, 1997; Effective Health Care Bulletin, 1999). Others are underpinned by theoretical models of changes such as Rogers diffusion of innovations (1995). Systematic reviews of these strategies have been undertaken and have shown that changing practitioner behaviour to facilitate the EBPI is complex and goes beyond the influence of the individual. There are considerable organisational influences involved, at all levels, and support from management is necessary to initiate and sustain EBP. A systematic review of implementation strategies has shown that no single strategy is more effective than any other in any given situation, but that adopting a number of interventions is more likely to be effective (Effective Health Care Bulletin, 1999). Once again, the key role played by managers in EBPI is highlighted, both as a means of providing knowledge of the wider organisation and in supporting practitioners to

implement practice changes. The commitment of managers is seen as necessary to sustain change and link it to organisational objectives (Firth-Cozens, 1997; Effective Health Care Bulletin, 1999). It becomes clear that application of evidence to practice is not only an individual responsibility, but that the organisation itself can support or impede EBPI.

Alongside a growing knowledge of implementation strategies, gaps have been identified and many of these have emerged from research into the barriers to RU/EBPI. There have been a significant number of studies concerned with these and their conduct and contribution are now considered.

#### *Barriers to EBP and evidence use*

It was recognised from the earliest attempts at RU that it was a process fraught with difficulties and that many barriers existed to the routine and regular use of research in practice. Originally nurses reported that lack of time was a considerable barrier to RU, and this continues up to the present (Bryar, *et al.*, 2003). As EBP has come to the fore, these barriers have been the subject of a considerable number of studies and measurement in an attempt to better understand them, as a means of tackling them and increasing RU and EBP. Studies have shown that these barriers are widespread and that they exist across professional groups, clinical settings, in different countries and across time. Research into barriers in medical and surgical nursing (Parahoo & McCaughan, 2001), paediatrics (McCleary & Ted Brown, 2003b), learning disability nursing (Parahoo, *et al.*, 2000), oncology nursing (Rutledge, *et al.*, 1998), orthopaedic nursing (Adams, 2001) peri-operative care (Windle, 2006), psychiatry (Bartholemew & Collier, 2002) and studies undertaken in primary care (McKenna, *et al.*, 2004) and community nursing (Walsh, 1997a; Olade, 2004b) are just some examples of the work that has been undertaken across different clinical settings to try to identify barriers to EBP. In addition to these studies, research has been undertaken across a number of different countries, for example, in the USA (Funk, *et al.*, 1991b; Carroll, *et al.*, 1997; Fink, *et al.*, 2005), Canada (McCleary & Ted Brown, 2003; Micevski, *et al.*, 2004), in the UK and Northern Ireland (Walsh, 1997b; Dunn, *et al.*, 1998; Newman, *et al.*, 1998; Closs & Bryar, 2001; Parahoo 2000; Marsh, *et al.*, 2001; Bryar, *et al.*, 2003), in Ireland, (Glacken & Chaney, 2004), in Australia (Restas & Nolan, 1999; Restas,

2000; Hutchinson & Johnston, 2004; Nagy, *et al.*, 2001) and in Sweden (Nilsson Kajermo, *et al.*, 1998; 2000) and Finland (Oranta, *et al.*, 2002). More recently, a study using the barriers scale has given some insights into the problems faced by newly qualified nurses in using evidence in their practice (Andersson, *et al.*, 2007). Some of the findings indicated that the nurses were focussed on adjusting to and assimilating to the ward environment (which has been supported by findings from qualitative research, for example, Benner, 1984), the main barriers cited reflect those of the majority of other barriers studies. The most significant barriers to EBPI were organisational and not individual. This finding had been reflected in the other, numerous barriers studies. Despite this, researchers continue to study these using the BARRIERS scale. A closer examination of this follows.

### **Studying barriers to EBP**

Initially, when Hunt (1981) began to consider the reasons why research was not used as the basis for practice, the focus was very much on the individual nurse. Suggestions that nurses should undertake critical evaluation of research and consider the implications for practice and be ready to change failed to take account of the complexity and number of barriers that nurses faced in trying to undertake EBPI (Carter, 1996). Once this became more widely recognised, research into the nature and extent of these barriers flourished, beginning with the development of the BARRIERS scale in 1987 (Funk, *et al.*, 1991a,b) in the USA. This survey tool sought to measure four domains of research use activity; the characteristics of the individual nurse, the setting or context in which the nurse worked, the research itself and the way in which the research was communicated, that is, the presentation of the results by the researcher. This was intended to provide an overall view of the barriers (and facilitators) to RU. In total it examined 29 aspects of RU presented as individual items that nurses rated according to how much of a barrier they perceived each item to be, from the greatest to the least. This tool has been used extensively since, in a number of settings and countries as outlined above and has been subject to a number of adaptations to ensure a better 'fit' with the country in which it was being used, for example Marsh, *et al.*, (2001). However, there were concerns that changes to the scale may have highlighted limitations of the survey tool, but despite this, it has continued to be used extensively (Dunn, *et al.*, 1998; Closs & Bryar, 2001). The aim of the BARRIERS tool was the identification and measurement of barriers to RU and more

recently EBP which would lead to the implementation of strategies to overcome these in the clinical setting (Marsh, *et al.*, 2001).

While this survey approach has been used repeatedly, there are a number of limitations of this. In addition to the concerns recognised by some of the researchers who used the tool and found it necessary to make adaptations to the language, the tool was developed 20 years ago and there have been a number of changes to the practice setting in this time, calling into question the relevance of this aspect of the questionnaire. Questions have been raised about the construct and content validity of the tool, if adapted for use in different countries (Gerrish, *et al.*, 2007). Research now plays a greater part in nurse education and this may also make some of the questions relating to this irrelevant. On a similar theme, the instrument was developed for use in the USA where nurses received much greater educational input relating to research at a time when this was not the case in, for example, the UK. Asking nurses with little knowledge of research to answer questions relating to the presentation of research would have affected the validity of the tool.

While response rates from these surveys varied, it remains, as with most surveys, that nurses who are more interested in research may have completed them and therefore the samples are not representative of wider nursing populations (Parahoo, 2006). They also remain self-reports, with no objective measures to support nurses' views. Nevertheless, these surveys have provided a considerable amount of information relating to the barriers to EBP and there is no doubt that these have formed the basis for action to address these.

In addition to the BARRIERS scale, other survey methods have been adopted to try to understand the barriers to EBP, for example, Wallin, *et al.*, (2003), McKenna, *et al.*, (2004), Micevski, *et al.*, (2004) and Nagy, *et al.*, (2001). Descriptive studies, for example Olade (2003) and Sharp, *et al.*, (2004) and a phenomenological study undertaken by Adams (2001) have provided more detailed information about the types of barriers that nurses felt were a problem to them in using EBP. A grounded theory study undertaken by Bartholomew and Collier (2002) in a mental health setting sought to uncover greater detail about the context and its impact on barriers to EBP. Two other methodologies stand out as taking a very different approach to

understanding barriers to EBP: the rapid organisational appraisal design used by Newman, *et al.*, (1998) and the mixed methods study involving interviews and Q methodological modelling undertaken by McCaughan, *et al.*, (2002). However the majority of these studies have merely replicated findings of others in different settings or within different professional groups. The surveys of barriers have provided a great deal of the same information many times over. This duplication is helpful in one sense in that it provides some impression of the extent of the problems faced by nurses trying to implement EBP, but these surveys have limitations in the regard that they are unable to provide any detail about any one of these *perceived* barriers. Surveys do not provide a means of verifying whether these are actual barriers or merely perceptions of them and do not suggest or provide any substantial means of overcoming these barriers in practice. The main barriers identified are outlined below.

### **Main barriers to EBPI**

As outlined above, there is a considerable amount of information about the nature and extent of barriers to EBP. Most of this information arose from the use of the BARRIERS tool and from other surveys that used this tool as a basis for the development of an amended survey instrument. Adaptations and amendments to the original tool make it impossible to make comparisons between them, in terms of rating the barriers. However, it is possible to get a sense of the barriers noted by nurses as being the most significant and those which occur most frequently in these studies. Overall, these studies have consistently identified the problems as being related to lack of time and experience to access research and appraise it, research being presented in such a way as to make it difficult to understand (McSherry & Simmons, 2002; Gerrish, *et al.*, 2007) and lack of a culture in which research is valued or in which nurses had a positive attitude towards research (Windle, 2006). These findings were also reflected in the many barriers surveys outlined in the previous section. However, by far the most frequently cited barriers and those which were considered by researchers to be the most significant (Bartholomew & Collier, 2002) related to what were often referred to as organisational aspects of EBP. These relate to aspects of management of nurses and are those which are at the heart of this thesis. These key roles are considered in the following section.

## **KEY ROLES IN EBPI**

### **The individual nurse**

It is clear from the discussion in the two previous sections that much of the focus in the early days of research into RU and EBP had the individual as its centre. This grew from the belief that nurses could and should implement research into their own practice. Hunt's paper (1981) outlined previously was the first to suggest that there may be other influences that had an impact on the ability of the nurse to use research in practice, when she noted that nurses were not allowed to use research (Hunt, 1981). Despite this, she did conclude by stating that each nurse was responsible for using research in practice. This belief has underpinned many of the studies undertaken since. Surveys have focussed on the individual determinants (such as educational level, reading research, and attitude towards research) of RU and numerous studies of this kind have been undertaken across the globe. These have focussed on the attitudes of individuals to research, the attributes deemed necessary and the education needed to use research in practice. All of these studies have had similar structures and methodologies. While response rates varied, it remains the case that the most likely respondents would be nurses who had a knowledge of or interest in research and so there is still a large population of nurses about whom nothing is known regarding their RU. The extent to which these surveys are generalisable is therefore questionable. In addition, some ontological and epistemological questions remain as to the suitability of surveys to assess attitudes, although it is acknowledged that attitudes do affect behaviour, they are recognised as being poor predictors of this (Perry, 2002).

While these surveys have provided interesting information relating to RU and they have provided information regarding educational attainment and research reading activity, they have often been inconclusive in providing robust detail about the most significant individual determinants or those most likely to determine RU/EBP. As a means of addressing this, Estabrooks, *et al.*, (2003) undertook a meta-analysis of studies of individual determinants of RU/EBP. They concluded that the only statistically significant factor was a positive attitude to research. However positive attitude as a factor was not defined, and could have varied considerably between studies. Despite this, their study has shown that many of the other factors thought to be significant, are less important than first thought. Hatcher & Tranmer (1997) found a current leadership role to be statistically significant in increasing RU in their study,

but this highlights the difficulties in comparing studies and trying to draw conclusions across them, when a number of different approaches have been used, without definitions of terms and without analysis of the impact of variations in context (Milner, *et al.*, 2005).

However, other approaches have also been used to try to better understand the role of the individual nurse in RU. Rodgers (1994, 2000) used participant observation and interviews with nurses to measure their use of research in their practice. Building on this approach in her first study she then undertook a survey of Scottish nurses' RU. She concluded that RU went beyond the ability of the individual nurse and recognised that it was a complex process that involved issues of autonomy, accountability and organisational factors.

Action research projects (Hunt, 1987; Armitage, 1990) undertaken to support individual nurses to use research in practice highlighted the difficulties of affecting change even in individual practice and the time involved in the process.

In addition to the practical approaches to studying the role of the individual in RU/EBP, theoretical studies of the concept have been undertaken and bibliometric analyses of the RU field have provided detailed information about the development of the concept and understanding of the role of individuals within it (Estabrooks 1999a,b; Estabrooks, *et al.*, 2004).

In the early days of research into RU, the role of the individual was seen as crucial. There was a focus on their attitude to research, their knowledge of research and the educational preparation that would enable them to use research. However, further research has shown that the impact of any one individual is limited, however committed they are to using research in practice. Despite a professional responsibility to use EBP (Nursing & Midwifery Council, 2004), it has become clear that this is not easy to do and that many of the factors highlighted in the 'barriers' studies involve aspects of autonomy and management support. A recent study of nurses' use of research demonstrated that even nurses who were confident of their knowledge of research found management and organisational barriers to be a hindrance to using research in their practice (Wallin, *et al.*, 2006).

RU and EBP efforts have often focussed on the needs of nurses in relation to having the required knowledge and skills to use research. Wallin, *et al's.*, (2006) study demonstrates that some nurses now have these skills as the integration of these into nurse education took place some years ago. Newly qualified nurses are well positioned to use these skills once in practice, however, an influential study of nurses role development, has shown that novice nurses while still focussing on learning and improving their care delivery skills, are also concerned with becoming part of the nursing team (Benner, 1984). If this is the case, research skills and EBP related knowledge may not be the priority for them at that time. These skills may diminish through lack of use, so they may become more proficient nurses, but less able to use EBP.

At the other end of the nursing spectrum are Benner's (1984) 'expert' nurses. Review of the literature seemed to suggest that clinical nurse specialists (CNSs) were more autonomous practitioners than others and a trusted source of knowledge for nurses (Thompson, *et al.*, 2001a). While this study also found that practice development nurses and practice development *per se* were also important to nurses (Ward & McCormack, 2000), there is a paucity of literature relating to the detail of this at this time. The CNS role is more established and therefore might be seen as having more to offer nurses undertaking EBPI. The following section reviews the literature relating to the CNS and EBP to try to determine if this is the case and consider how this might relate to the role of the nurse manager in overall EBPI.

### **EBPI and the clinical nurse specialist**

Clinical nurse specialists are viewed as having a role in EBPI (Rutledge, *et al.*, 1998). Research into the ways in which organisational contexts impact on the decisions that CNSs make about practice and their use of evidence have shown that they have a significant role in not only applying evidence in their own practice, but also in acting as 'boundary spanners' within and outwith health care organisations (French, 2005). However, it is a role that is complicated by the way in which many posts developed (Castledine, 2002; Lloyd-Jones, 2005). Roles vary across hospitals and Trusts due to the historical development of the role but the specialist or expert nature of the role is reflected in the grades the posts have been given. In Scotland, these vary from a grade equivalent to a junior charge nurse through to one which equals or exceeds those of

NMs (ISD, 2004) In general, these nurses work within one area of specialist practice and a study of CNSs in Scotland has shown that they have a number of key facets to their role such as clinical practice, consultancy, education and management, with a few being involved with audit and/or research (ISD, 2004). Although there is a limited amount of empirical work on the role of the CNS and EBP, they do seem to possess some of the attributes that have been recognised as significant for implementing EBP, such as greater autonomy, confidence and clinical expertise (MacKay, 1998; Milner, *et al.*, 2005). As a result of their more senior positions, they are not subject to the same hierarchical restraints as other nurses and this facilitates communication with management (De Borough, 2001). Often on similar grades to charge nurses (although not always), charge nurses are seen to be overloaded in their roles and still subject to the nursing hierarchy (Allen, 2001; Alderman, 2003). CNSs ability to work in a number of different clinical areas also assists the dissemination of EBP and they are often regarded as ‘boundary spanners’ since they are able to link the research and practice communities and this role is seen as crucial in EBPI (Gerrish & Clayton, 2004; Milner, *et al.*, 2005; Dopson & Fitzgerald, 2005; Nutley, *et al.*, 2007). Their clinical expertise and personal use of research and evidence in their own practice encourages other nurses to use EBP also (Milner, *et al.*, 2005).

CNSs are often seen as possessing higher educational qualifications than other nurses, which would enable them to appraise and implement evidence more easily. However, the title CNS, does not denote an educational level or nursing grade. Nor is it a standard role, as noted above, with considerable variation within and across Trusts in the UK, and across other countries. In the USA, the advanced practice nurse is the nearest equivalent to the UK’s CNS, and they are required to be educated to Master’s level. This is not the case in the UK. There is also considerable role ambiguity as many CNS roles were created in an *ad hoc* manner, with roles and responsibilities developing over time. A systematic review of the role of the CNS in RU in Canada showed that knowledge and skills of the CNS varied considerably and they did not use their knowledge of research and evidence to make changes to practice protocols or procedures. They also lacked confidence in using research in practice (Milner, *et al.*, 2006). A survey comparing nurses and CNSs and NMs perceptions of barrier to RU, demonstrated that the CNSs saw all of the barriers to RU as more significant than the nurses (Rutledge, *et al.*, 1998). This suggests that despite wider perceptions that

CNSs have the knowledge, skills and opportunity to implement EBP, this is not necessarily the case. While there may be scope for development of this aspect of their role, a consistent picture does not appear to emerge from the limited research in this area. The study undertaken by Rutledge, *et al.*, (1998) found that CNSs felt that lack of support from management and lack of authority to change practice were significant inhibitors of EBP. It is not clear from the study if this relates to the CNSs own practice, or if it refers to practice change that they were supporting for other nurses. While the situation may have altered since this study was published, it once again highlights the influence of the NM on EBPI. So despite the perceptions of other nurses that CNSs are more autonomous and the belief that this will facilitate EBPI, this does not appear to be the case (Profetto-McGrath, *et al.*, 2007).

Having considered, in the previous sections, the nature of evidence and RU and EBPI as a background, several factors continue to emerge as significant hindrances to EBP. These are, issues of autonomy for nurses, their inability to make changes to practice and the belief that they are prevented from making changes to practice. In addition, they also feel that they lack commitment and support from nurse managers in relation to EBP. Review of the literature has shown that individuals are limited in the extent to which they can change practice and that complex organisational and cultural factors play a significant part in the process, either impeding or facilitating it. The following section moves on to consider the literature relating to organisations and EBPI and that pertaining to NMs as agents of their health care organisations.

### **Organisations and EBPI.**

Organisational context has been described as the setting in which practice occurs (Stetler, 2003), but it is thought to be more than a mere back drop to practice, instead it is an interacting factor in practice (Le May *et al.*, 1998; Scott-Findlay & Estabrooks, 2006; Dopson, *et al.*, 2006). Over time there has been a growing understanding of this aspect of EBP and it has become more of a focus than in previous work which considered the individual as having the main responsibility for EBP. Acknowledgement that any change within organisations is complex is widely recognised and in the NHS, information and support to facilitate changes including EBPI has been provided (Iles & Sutherland, 2001; Iles & Cranfield, 2004). Indeed, this view is not exclusive to understanding and facilitating changes within the NHS

alone, studies of organisational change in other sectors have shown that it needs to be viewed as a process that requires effective management and co-ordination (Caldwell, 2003).

The ability of NHS managers to manage change was seen as important when widespread re-organisation took place in the 1980s but this ability may not have been translated into an ability to tackle EBPI (Pettigrew, *et al.*, 1992). In addition, there have been concerns that within health services, managers have always sought the *status quo* and have (not necessarily consciously or explicitly) blocked innovation and implementation of new initiatives with robust objections (Truman, 2001). The role of the organisation is now viewed as integral to the long-term success of EBP (Stetler, 2003). Some of the organisational factors are related to infrastructure and resources, but there are also issues of professional power and boundaries (Mitchell, 1998). Each of these is significant in terms of EBPI. The need for EBP to be aligned to wider organisational objectives is important if it is going to be resourced and sustained in the longer term. It has been suggested that one of the difficulties for managers is that EBP often conflicts with other organisational objectives despite its aim of clinical effectiveness (Rosenheck, 2001). Despite the recognition that there is a need for organisations to tell a consistent story in relation to EBP, this is not easily achieved, but if successful it could enable EBP to be given a higher profile and priority (Stetler, 2003). The importance of a uniform approach to discussing EBP has been identified to ensure that there are not inconsistencies between what practitioners hear about EBP and what they see in terms of management support and commitment to it (Walshe & Ham, 1997a,b; Rosenheck, 2001, Stetler, 2003).

At practice level, one method of ensuring that EBP is consistent across an organisation is through the use of evidence-based policies and procedures, so that they become integral to everyday practice (Stetler, 2003). However, the existence of policies and procedures alone is not sufficient to ensure their use and their existence does not guarantee that they are evidence-based. Empirical work on both aspects of the use of policies and procedures as a means of promoting EBP has shown that these are significant limitations (Thomson, *et al.*, 2001a,b; Squires, *et al.*, 2007).

Other empirical work has shown that there is a need for multiple strategies across organisations to implement EBP, rather than relying on any individual strategy (Gerrish & Clayton, 2004). This study also highlights the importance of management support and commitment to EBP. One of the ways in which managers can demonstrate support for practitioners is through the delegation of authority to make changes to practice and through clear explanation of roles and responsibilities in relation to EBPI (Stetler, 2003; Milner, *et al.*, 2006). There is a need for management expectations to be made clear and underpinned by organisational structures and processes, such as annual review of achievements in relation to EBP and planning individual contributions to the wider organisational goals (Stetler, 2003).

Despite the recognition that there is a need for multiple strategies, it needs to be acknowledged that organisational complexity and variability prevent the recommendation of any one strategy as guaranteeing successful implementation (Dopson & Fitzgerald, 2005). What is clear, from the meta-analysis of the PACE studies (Ferlie & Dopson, 2005), is that EBPI is highly dependent on organisational context and needs to go beyond the introduction of new policies and procedures. It needs to be seen as an ongoing process rather than a one-off event. The need to concentrate more fully on enabling factors in organisations is now being recognised and is the focus of ongoing empirical work (Stetler, *et al.*, 2007). Organisational research, that which considers the wider context of EBPI, can offer important insights into the implementation process, as it takes account of all those involved, as well as organisational systems (Fraser, 2004).

Nurse managers as agents of the organisation and as the individuals occupying a crucial middle position in those organisations may be ideally situated to facilitate EBPI. The following section considers the literature relating to NMs and EBPI in some detail.

### **Nurse Managers and EBPI**

This is the body of literature relating to EBPI that is at the heart of this thesis. The research question and propositions explored in the study are detailed in the following chapter, but in essence they relate to uncovering the role of the NM in implementing EBP. Literature pertaining to NMs and EBPI is presented in this section. There is a

paucity of empirical work into the role of the NM and EBPI processes; however, other literature provides some insights into the wider role of the manager in the current NHS context. The changes to the structure of nurse management were outlined in chapter one. It has been suggested that NHS management is in a constant state of flux and that the role of the NM became unclear during these reforms (Ulusoy, *et al.*, 1996; Hewison, 2006). These changes to the context and the role of the manager led to managers being given additional roles without adequate preparation and support, and their work now encompasses a ‘...*vastly complex sphere of activity.*’ (Ulusoy, *et al.*, 1996, Jasper, 2006: 331). Difficulties arose for both managers of nurses who had a clinical practice background and those without, in relation to implementing and monitoring quality initiatives (Scott, 2002). Those without a nursing background found it difficult to know if quality care was being provided and those with clinical backgrounds felt under pressure from their managers to show that they could perform management functions. As a result, the quality of care was not fully monitored by non clinical managers and managers with a clinical background were focussed not on care delivery, but on balancing the budget (Scott, 2002).

Despite the lack of clarity about their role, it seems that it is necessary for managers to have a large repertoire of skills to enable them to tackle the breadth of their work (Doherty, 2003). A study of the preparation for the clinical nurse manager role demonstrated that many NMs recognised that they were inadequately prepared for key aspects of their roles, such as providing mentorship, a clinical leadership role or collaborating with medical staff (Gauld, *et al.*, 2001). In addition, the managers in this study felt that the areas that they were least prepared for related to implementing, supporting and monitoring clinical developments and clinical governance.

While EBP is a relatively new concept, that of RU has featured for many years and the earlier discussion of RU and barriers to EBP indicated the extent to which NMs are seen as potentially inhibiting factors. Their lack of support and commitment to EBP, the lack of authority and autonomy of practitioners to undertake EBPI have all been found to be significant barriers to the progress of EBP. While EBP is specifically related to developing practice, it is not the exclusive responsibility of practitioners (Dunning, 2001; Perry, 2002) and managers have been shown to have a critical role in the management of change, which encompasses EBPI (Currie, 2000; Hill, 2003;

Iacono, 2006; Ferguson & Day, 2007). Indeed, Pettigrew, *et al.* (1992a,b) found the management/clinical practice interface to be crucial in supporting change in the NHS. Many of the barriers studies and similar research have shown that elements of leadership, management and developing 'EBP friendly' working environments, are the responsibility of nurse managers (Taylor-Piliae, 1998; MeInyk, *et al.*, 2005; Caraminica & Roy, 2006). The concept of support at the clinical/management interface has been further complicated by changes to job titles and delegation of duties to (former) ward sisters and charge nurses, when their title changed to that of ward manager. For some, initiating, managing and supporting change was seen as an inherent part of the ward manager role (Baulcomb, 2003). In Baulcomb's study, staff responded well to a direct and controlled approach to the introduction of change, with participation of the ward manager as a means of demonstrating support and acting in a change agent role. This participative and supportive style of managing change was seen as key to the success of initial and sustained changes (Baulcomb, 2003).

However, several studies have found that managers see clinical practice as the responsibility of practitioners while their focus is on finance and meeting organisational goals (Wong, 1995; Price, *et al.*, 2007). McCutcheon's (2002) work has shown that the greater the sphere of responsibility of NMs, the greater the distance from practice and the less able they are to influence it. It may be that NMs do not see themselves as having a role in EBPI and it is the expectations of nurses that highlight the discrepancy, rather than any deficit in the NM role. If managers see nurses as professionals in their own right and accountable for their practice (a view which is supported by the Nursing & Midwifery Council, (2004), then this would explain their lack of involvement in EBP (Scott, 2002). However, the empowerment of nurses to make changes to practice is seen as an important role for managers and there is a need to make this explicit (Tourish & Mulholland, 1997). Stetler, *et al.*, (1998), Stetler (2003) Care & Udod (2003) and Udod and Care (2004) all see the manager as crucial to the success of RU/EBP but they emphasise the need for managers to underpin their rhetoric regarding EBP with action that can be seen as support and commitment by their staff. In a survey of Canadian nurses and managers both agreed that managers needed to give EBP a high priority for it to become a reality in practice (Royle, *et al.*, 2000). Other surveys, for example, Funk, *et al.*,

(1995) have similar findings, with RU not being valued by managers, but management support being cited as the most significant facilitator to EBP.

As well as demonstrating commitment to staff, there is scope for managers to build EBP goals into aspects of management for example, through annual appraisals, personal development targets, through the use of explicit EBP responsibilities in employment contracts or through encouraging participation in nursing research (Van Mullem, *et al.*, 2001; Titler, *et al.*, 2002). Managers may see EBP as the responsibility of practitioners, but practitioners may not be clear about their own responsibilities in this regard. Nurses need management expectations to be explicit (Parfitt, 2002).

While practitioners see the lack of management support and their lack of authority as personal failings of NMs, there may be more complex contextual or organisational reasons for this situation (Biron, *et al.*, 2007). A study of middle management in the NHS demonstrated that clinical effectiveness, of which EBP is one aspect, was not generally seen as a management concern (Dopson & Fitzgerald, 2006). It is not clear from this study whether it includes NMs, as much of the discussion relates to the success of the hybrid role of clinician/manager, (i.e individuals who have combined medicine with management, but NMs would comprise the middle management tier of the NHS hierarchy. West, *et al.*, (1999) in a study comparing the roles of medical and nursing directors highlighted the difference between the shared medicine and management role of doctors and the exclusively management role of nurses. This resulted in isolation of NMs, particularly the Director of Nursing. This was due to the lack of a peer group for NMs and this isolation from individuals and from wider organisational structures, which left NMs to arrange their own management training, was also recognised by Foster (2000). The role of the wider organisation and organisational hierarchies do contribute to the extent to which NMs are able to engage in strategic development. Carney (2006) found that the Director of Nursing was excluded from strategic planning in one organisation and if this reflects the wider situation, then it is not surprising that NMs are unclear about providing authority and supporting autonomy for nurses to make changes to practice. Alderman (2003) also suggests that other senior nurses (managers) have a lack of authority in their organisations. This finding was supported by Patrick & Laschinger's (2006) empirical work on Canadian NMs, which found that many managers felt that they were

disempowered by the level of organisational support that they received. Despite this, NMs are expected to provide supportive environments for nurses, although they, themselves, lack support (Laschinger & Shamian, 1994; Laschinger, *et al.*, 2001).

A grounded theory study of the role of management and leadership in nursing found that managers have role ambiguity and are disempowered and dissatisfied in their work (Stanley, 2006). Other studies of middle management in the NHS, for example, Currie (2000), have also shown that NMs did not have freedom to act, despite perceptions of decentralisation of authority. It may be impossible for managers to provide support, authority and autonomy for nurses that they do not feel themselves. If this is the case, this will hinder the progress of EBP.

Parahoo and McCaughan (2001) in a study of the barriers to EBPI, found that management support and commitment and lack of authority and autonomy were rated as the most significant barriers to EBP, by medical and surgical nurses in Northern Ireland. From this finding they recommended that rather than continue to study barriers by survey methods, it was important to look in more detail at how these findings were manifest in organisations by undertaking qualitative studies. To date, only three studies have emerged that studied NMs and RU (Kenrick & Luker, 1996; Caine & Kenrick, 1997; Le May, *et al.*, 1998). These will now be discussed in detail. These were conducted in the mid 1990s when the health care context was driven by the division of purchasers and providers of care. As a result, the focus of managers may have been different, much more aligned to achieving financial targets, as suggested by Cooper (1996) for example. In addition, the studies were carried out when there had been significant changes to the structure of management and not all managers of nurses had a nursing background. Crucially, these studies were undertaken when EBP was a new concept (although RU was not) and EBP had not been introduced as a statutory aspect of clinical governance. In addition, the dissolution of the 'internal market' in the NHS, may have changed the focus of NMs. They may now have to place less emphasis on achieving financial targets and other management goals and be able to focus more closely on practice issues once again. However, resource management (both human and financial) issues in the NHS remain and it may be that the situation for NMs is unchanged. In practice, notions of clinical

effectiveness, clinical governance and EBP are more familiar today and this could influence the results of such studies.

Kenrick and Luker (1996) carried out a study to explore the influence of managerial factors on the use of research by district nurses. The focus of the research was on organisational culture and practices regarding nursing management. The research methodology is not clear, but data were gathered through interviews with NMs. While the NHS context has changed since the study, some factors remain, such as the relative autonomy of community nurses compared to those working in secondary care. Results show that most managers viewed themselves as professional managers, but a minority described themselves primarily as nurses. The others felt that they still retained clinical insight and had a good understanding of the issues that were important to their staff. In the Trusts represented by the managers, there was an emphasis on providing management training and qualifications for them. However, for some, training (or learning) was predominantly experiential, with the focus being on learning by 'doing the job'. The management processes of each Trust suggested that these were significant in determining the extent to which managers could influence practice. Kenrick and Luker conclude that the emphasis on management at that time, was at the expense of clinical values and practice. Differences in responses from managers were thought to reflect organisational processes and priorities, which were more management than practice based.

This study demonstrates that organisational factors impact on practice and that changes to nursing management in the 1990s, by necessity, led nurse managers to focus on management to a greater extent than practice. Although there have been a number of changes to nurse management roles and structures since this study, the situation may remain unchanged today. If so, this would have an impact on the ability of NMs to facilitate EBPI.

Caine & Kenrick's (1997) exploratory study of clinical directorate managers considered their role in facilitating EBP. However the interview schedule shows that questions to participants were related specifically to research utilisation rather than EBP and this may have influenced the responses. The study involved directorate nurse managers from two sites. It is not clear if these were two different Trusts or just two

sites from a single Trust. Of the total study population of 10, only two were from the second site. Each manager had direct contact with and some responsibility for a nursing team. Semi-structured interviews focussing on perceptions and expectations of RU, organisational factors, leadership style and progressive measures were undertaken. Demographic details relating to age, gender and nursing degrees were also gathered. Only directorate nurse managers were interviewed and the self-reports of their involvement in RU are a limitation of this study. One manager had a higher degree and her responses were significantly different from the other managers.

The managers described their strategies for promoting RU as those of devolving responsibility to each individual nurse. RU was largely seen as being beyond their sphere of influence and they admitted that they felt that they lacked the academic skills to tackle RU. While they appeared to be willing to foster RU, they were not actively promoting it, or providing support to enable practitioners to take it forward themselves. Despite seeing themselves as facilitators, they did not seem to be taking active steps to facilitate RU. Strategies such as using personal appraisals as opportunities to discuss RU were seen by the researchers as an abdication of responsibility. The devolution of responsibilities to nurses themselves was seen by the managers as an important way of enabling nurses to fulfil their professional responsibilities (that is those relating to their registration with the Nursing and Midwifery Council, rather than contractual responsibilities).

The researchers conclude that while the managers were positive about RU, they were not facilitating it, through lack of involvement and delegation of responsibility of the task to nurses. It was considered that managers were not using their authority to promote RU and that to some extent these failings were the result of an incomplete transition from nursing to management. Caine and Kenrick (1997) conclude that rather than facilitating RU, managers were actually inhibiting its implementation by both their actions and lack of action.

This study provides valuable information about the self-reported views of the role of NMs and RU. It shows that some of the perceptions of nurses reported in the 'barriers' studies are borne out in practice and that NMs do not see RU as their responsibility.

A similar study undertaken in 1996, focussed on the research cultures of nurses and managers (Le May, *et al.*, 1998). The aim of this phenomenological study was to provide more information about the way nurses and managers viewed research and its value in their work. Using semi-structured interviews the research was undertaken across three sites, in both primary and acute care and involved nurses, midwives, health visitors, district nurses, staff nurses, charge nurses, clinical teaching staff and NMs. The focus of the study was research, rather than EBP. The study design yielded large amounts of data, but for the purposes of analysis, three questions provided the main focus. How was research perceived? What was the current status of research-based practice and what were the perceived opportunities and constraints to increasing research-based practice?

Research was seen by managers as something that marked the Trust out as innovative and had a role in creating a good image, which was important for attracting and retaining staff. Practitioners saw research as something which had the potential to enhance the quality of care they provided and professional credibility. They were sceptical as to whether research could actually do either of these. Opportunities and barriers to research-based practice revealed issues such as a lack of dissemination within the Trust, lack of positive attitude to research and organisational issues, such as lack of time (although Redfern, *et al.*, (2000) found that time as a barrier did vary and it was not always a barrier to EBPI) or too much change taking place. Managers saw the barriers as a lack of a research culture, lack of a research and development strategy and the directorate structure.

Le May, *et al.* (1998) conclude that culture is central to the understanding of the use of research, not just one aspect of it. They suggest that national approaches, such as guidelines and protocols, might be one way of increasing RU in Trusts. They note the important role that organisational image had for managers and that managers found that the almost constant change which had taken place during the preceding years had had a detrimental effect on their ability and that of practitioners, to tackle changes to practice.

The nature of the research methodology places limitations on the generalisability of the research, but many of their ideas have salience and transferability. In addition, it

provides important insights into views of nurses and managers on RU. It was not always clear from the responses of participants whether they were focussing on RU or the conduct of research itself. This suggests a lack of understanding of the nature of RU. It shows that nurses and managers view research differently and this must have an impact on the way in which its use is supported or promoted in practice.

Having considered the literature relating to EBP, EBPI and NMs, several factors continue to emerge as significant hindrances to EBP. Management and NM related issues have been explored and have been a common thread throughout. These have led to the development of propositions that arise from the literature and underpin the development of the research. As a means of concluding this literature review chapter and leading on to the development of the research question, in chapter three, the study propositions are presented below.

#### **Box 2.4: Study propositions**

- NMs are significant in their influence and ability to increase EBPI because they occupy a crucial middle position within health care Trusts. They are ideally placed to channel information from above and below and from this position to have an influence through attitudes and behaviours on the nurses that they manage and for other staff in the Trusts, for example, medical staff. It is acknowledged that despite their middle position, their influence on more senior members of staff may be limited (Ulusoy & Knill Jones, 1996; Tourish & Mulholland, 1997; Wong, 1998; Tilley & Tilley, 1999; Carney, 2002, 2006; Hewison, 2003; Dopson & Fitzgerald, 2006).
- EBP is likely to have a higher profile or to have made greater progress in Trusts where NMs champion it by providing support and commitment to it in both practical and 'emotional' ways. For example, by providing or sanctioning time away from the clinical area to undertake EBPI activities, or through financial support for educational initiatives or through the provision of their own expertise. Emotional support will be demonstrated through positive attitudes and behaviours relating to EBPI (Funk, *et al.*, 1995; Caine & Kenrick, 1997; Stetler, 1998, 2003; Scott, 2002; Titler, *et al.*, 2002; Hill, 2003).

- Managers are a significant influence on the culture of organisations and their attitudes and behaviours will reflect this through their approach to EBPI, such as clear devolution of authority and support of nurses' autonomy to undertake EBPI. The culture of the organisations and the part played by NMs within this might also explain the dominant 'mode' of EBPI, whether top-down or bottom-up (Caine & Kenrick, 1997; Titler, *et al.*, 2002; Mathena, 2002; Carney, 2002; Estabrooks, 2003; Gerrish & Clayton, 2004; Kane-Urrabazo, 2006; Biron, *et al.*, 2007).
- NMs are most likely to have come from an era in nursing when research was not so widely recognised or accepted as a basis for care. As a result, it is probable that most NMs will not possess the knowledge and skills to enable them to properly support EBPI, either because they do not value it or they do not fully understand the complexity of it. This situation has left them in the position of having little to draw upon in the way of experience to facilitate EBPI (Caine & Kenrick, 1997; Le May, *et al.*, 1998; Newman & Papadopolous, 2000; Stetler, 1998, 2003; Udod & Care, 2004; Dopson & Fitzgerald, 2006; Patrick & Laschinger, 2006; Stanley, 2006).
- NMs will rely heavily on individual nurses to take responsibility for EBPI or other staff, such as practice development nurses or CNSs, seeing it as a practice rather than management role (Caine & Kenrick, 1997; Dunning *et al.*, 1998; Royle, *et al.*, 2000; Parahoo & McCaughan, 2001; Perry, 2002; Rycroft-Malone, *et al.*, 2004a; Udod & Care, 2004; Newhouse, 2007).

## **SUMMARY AND CONCLUDING REMARKS**

This chapter has reviewed the literature relating to EBP and EBPI and has considered the potential role of NMs within this process. It becomes clear that at almost every step, the process is complicated by numerous competing definitions, lack of consensus on meaning and contribution of EBP and research for practice. It has shown that nursing has a history of trying to use research as a basis for care, but with limited and variable success and in many studies it has been the absence, rather than the presence of EBPI, which has led to conclusions about successful and unsuccessful roles or strategies to progress this.

Research into implementation processes has provided insights highlighting factors which are significant in predicting (if not ensuring) success. One such factor is that of context, the setting in which practice takes place. Others are individual knowledge and skills, the availability and acceptability of evidence, professional relationships, the strategies adopted and the facilitation available. Studies of barriers have provided a wealth of information, but this is often somewhat repetitious and limited in terms of advancing knowledge of EBPI. What appears to be necessary is a change in focus from identifying barriers, to move forward with research that seeks a greater understanding of exactly *how* barriers impact on EBPI.

The review has shown that while the individual nurse may be widely seen as having a responsibility to undertake EBPI, many factors converge to help or hinder. Lack of support and commitment to EBPI from NMs have been identified by nurses as significant, as have the need for autonomy and authority to make changes to practice. CNSs who are often seen as more autonomous, still have difficulties implementing evidence, as the studies outlined above have shown.

The studies that focussed specifically on NMs have demonstrated that NMs were not actively involved in RU. None of these studies considered the specific barriers relating to the support and commitment of managers to EBP, for example, how this manifests in practice, nor the lack of authority and autonomy felt by nurses to implement EBP. What do these 'look like', how are they recognised by staff and what examples do nurses give to illustrate these problems? How do NMs demonstrate their support and commitment to nurses for EBP and how do nurses know that they have the authority to make changes to practice, if indeed they do? If they do not, how is that communicated and what examples illustrate the problem? The importance of organisational context was explored earlier in the chapter and it must be acknowledged that the organisational context of the NHS has changed considerably, particularly in relation to the emphasis on EBP, since some studies were undertaken.

It is for these reasons, which are supported by Parahoo and McCaughan (2001), that this study was conducted to explore and explain the roles of NMs in the EBPI process.

It builds on the literature reviewed in this chapter and seeks to address the gaps identified. The research question, methodology and methods are presented in chapter three.

## *CHAPTER THREE*

### *RESEARCH METHODOLOGY & METHODS*

#### *Choosing case studies, a framework to study implementation and the application of the research methods*

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This chapter provides an account of the choices made in the design of the study and the actual methods used. It has been collated from contemporaneous notes taken throughout the research process in conjunction with reviews of relevant methodologies and literatures.

#### *Aims of the research and research question*

The review of the literature in the previous chapter has shown that while there is a growing body of knowledge relating to EBPI and research utilisation within nursing, the role of the NM in this process is not yet fully understood. It has drawn attention to the paucity of current research in this area and has shown that related research often fails to take account of the complexity of organisations and other contextual factors in studying the phenomenon. While there are many studies that focus on the barriers to implementation and research utilisation, few go beyond identification of these barriers. There is a recognition (Parahoo, 2001; Hewison, 2003a) that is imperative to go beyond these studies to gain a deeper understanding of the barriers associated with NM and the organisational processes that they oversee or are involved in, in relation to EBP. Hewison (2003a,b) identifies the role of the middle manager in health care as significant and one that is, to date, poorly understood. To address the gaps highlighted in the literature, this research aims to explore and explain the roles and involvement of the NMs in the EBPI process and to identify the strategies that they use to this end. It seeks to answer the following research question, which is underpinned by and developed from the study propositions shown in Box 2.4 (p 88-89):

*What are the roles of the nurse manager in EBP implementation processes and what strategies do they use to achieve these?*

## **RESEARCH METHODOLOGY**

### **Research methodologies considered**

In undertaking a study of this nature it was necessary to adopt an appropriate methodology that would in turn, inform the research design. There were several options to be considered:

1. Evaluation studies. These have previously been employed to study the implementation of specific EBP initiatives, for example the PACE project (Dunning, *et al.*, 1997), the GRiPP project (Dopson, & Gabbay, 1995) and the STEP, project (Ross & McLaren, 2000; McLaren & Ross, 2000). The focus of these studies has been upon implementing specific types or pieces of evidence into practice and testing specific implementation strategies, rather than looking in more depth at the process and roles of staff involved. Taking this approach to studying the role of NM would have had several limitations. It would have necessitated the application of evidence and the use of implementation strategies that may not have been applicable in every context and would have been a 'manufactured' process of change, rather than a study of a 'naturally occurring' process. Controlling variables in complex and diverse organisations would not have been possible. Previous studies of this nature have relied upon both considerable expertise and finance from outwith the organisations studied and that would not have been possible for this study.

Consideration of the reality of EBP in the workplace as only one aspect of current nursing practice would not have been possible if the study had focused solely on application of specific pieces of evidence to practice. Dependence on outside experts to manage the process would not take account of internal drivers for change that may be significant in facilitating EBP. This lack of realism calls into question the transferability or applicability of findings to other settings and limits the potential usefulness of these.

The evidence-based ward study (Newman, *et al.*, 2000) represents a natural experiment in which one ward was selected to make evidence-based changes to areas of practice that staff thought were important. Ward staff made the changes to practice and were observed and encouraged to do so by the research team. Researchers state that minimal additional resources were made available to ensure

that the project was realistic. All grades and groups of staff were represented in a change team with a link nurse to practice development taking a key role in leading change. While this design may have been possible, the study took place over 10 months and the research team were able to observe the ward over that time. While observing one ward undoubtedly provided the project team with a wealth of information about the way in which evidence was implemented over that time, their study design does not take account of the wider organisational context or the impact of other nursing or related staff, for example, nurse managers, on the changes that took place on the ward. For these reasons it was not considered to be an appropriate design for this study.

These studies represent a normative analysis of change (the way that implementation should take place) rather than a positive analysis (the way implementation actually occurred) (Dawson, 1994) and this limits their application in 'real life' EBPI (Warburton & Black, 2002). That is not to say that these studies do not provide interesting or valuable information about some aspects of EBPI, but rather that the study designs are limiting in trying to understand the detail and complexity of the roles and processes involved and would not necessarily illuminate all the 'active ingredients' of EBPI (Sofaer, 2002). An experimental or evaluation study design was therefore not thought to be an appropriate methodology for this study.

2. Survey designs. Again, there have been many studies that have adopted a survey methodology to study EBPI and RU in practice as a proxy measure of implementation success, for example, Lacey, 1994; Upton, 1999b; McSherry, *et al.*, 2006. The majority of these have focused on the barriers to the use of research in practice, although many of these are perceived rather than actual reasons for lack of research use, for example, Funk, *et al.*, 1991; Adams, 2001; Bryar, *et al.*, 2003; Fink, *et al.*, 2005. These studies have yielded a significant amount of statistical information, which can be useful in determining the extent of the problem. However, they are not able to go beyond this to provide the information that is necessary to aid understanding of the nature of the problem or which might be able to inform practical solutions to this. In addition, surveys are only able to provide data on information that the researcher has specifically sought. This may

lead to a narrow interpretation or view of the problems and process of implementation. Implementation is a dynamic process and it is less likely to be captured and reflected by a rigid tool administered at a single point in time. The lack of contextual data, not provided by surveys (or very limited extent), excludes information which the literature suggests is of considerable significance in the study of EBP. In essence, the limitations of survey designs in the study of EBPI relate to their inability to capture the complex and variable nature of the process, the roles of staff involved and the importance of other contextual factors. While the contribution of surveys is limited, they do provide a snapshot view of the problem and they are a useful starting point for identifying some aspects of what the significant barriers and/or facilitators to implementation might be.

These studies have enabled the researcher to gain a broad overview of the barriers to implementation and these have informed choices in the methodology, design and data analysis of this study.

### **Case study methodology**

Having appraised the possible methodologies and given consideration to those with the potential for a study of this nature and with supporting literature (Parahoo & McCaughan, 2001), the decision was taken to adopt case study methodology (Hakim, 1987; Gummerson, 2000; Yin, 1994; 2003; Stake, 1995). It was selected as a methodology that would facilitate a more detailed examination of the complex process of implementation.

*“A case study is an empirical enquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between the phenomenon and the context are not clearly evident” (Yin, 1994:8).*

Case study methodology arises from social sciences research and in particular, ethnography. Ethnographic studies are characterised by observation and data gathering from populations, cultures or situations and rely on a variety of data collection methods to build an ‘in the round’ picture of the phenomenon under study (Bowling, 1997; Warburton & Black, 2002). Case study methodology shares the

epistemology and ontology of ethnography (Hill Bailey, 1997), being founded on the beliefs that being in the world becomes a way of knowing and understanding meaning and experience (Denzin & Lincoln, 1994). Its strength is in the ability of the methodology to be pluralistic in nature and to enable and support studies that are descriptive, exploratory and explanatory to be undertaken (Robson, 1993; Pegram, 1999; Yin, 2003). In addition, it lends itself to in-depth, detailed study of a phenomenon with contributions from several data sources. Robson (1993: 146) views case study methodology as:

*“...a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence”.*

It has been used successfully in other studies of EBPI and change management in the National Health Service, for example Ferlie *et al.*, (1998); Bryar (1999); Dopson, *et al.*, (1999) and is able to capture and reflect the complexity of the organisations under study (Wood, *et al.*, 1998). In considering a study of the role of NM in EBPI, case study methodology was selected to provide in depth data and detail of the ‘fine grain’ of the roles, processes and strategies involved. These have all been seen as elements that interact in organisations to produce change (Palmer & Dunford, 2002). This was particularly important given that a great deal of information about EBP already existed, but the detail in relation to the role of NM from empirical work was largely lacking. It was also an appropriate methodology to undertake contrast and comparison of the phenomenon in different organisations, which could, in turn, facilitate the development of an in-depth understanding of EBPI processes.

Despite the appropriateness of the methodology for this study, it is not without its limitations and it was important to recognise these and take account of them in the study design. In particular, the need to make pragmatic decisions while remaining true to the methodology needs to be acknowledged and the complex interplay between methodological decisions and practical considerations in undertaking studies of this nature (McDonnell, *et al.*, 2000). Although the methodology cannot offer statistical generalisability, it is suited to providing in depth analytical data of complex context and processes (Wood, *et al.*, 1998) and it was for these reasons that it was selected.

Some of the criticisms of case study methodology relate to the potential lack of rigour and problems arising from the large amounts of data which are gathered in the conduct of case study research (Yin, 2003). In addition there is often confusion within health care about the use of the term ‘case study’ as it is more readily associated with the use of individual patient histories and as a method of learning and teaching (Vallis & Tierney, 1999; Yin 2003). However in the design of this study, the difficulties often associated with case study research are described below, with a discussion about the ways in which they were considered and countered.

### **Issues of rigour in case study research**

It was important to ensure that the design and conduct of the study were carried out in such a way as to ensure that the findings were as robust as possible (Roberts, 2006). While aspects of rigour are included under the individual headings throughout the chapter, this section provides a summary of the key points that relate to rigour in qualitative research and in particular, to case study methodology.

Pursuing rigour in qualitative research and the ways in which this can be undertaken or ensured are issues that remain hotly contested (Horsburgh, 2003; Dixon-Woods, *et al.*, 2004; Parahoo, 2006). The main issue is the perceived inappropriateness of using criteria, in particular those of validity, reliability and generalisability, which have been designed for use with quantitative methodologies. There seems to be universal agreement among qualitative researchers, for example, Morse (1999a,b) and Mays and Pope (1999), that the criteria selected to judge the rigour of qualitative studies should be appropriate to the paradigm and not be borrowed from quantitative research, which, if used, can lead to the impression that the research is not robust (Horsburgh, 2003, Cutcliffe & McKenna, 1999).

### ***Validity and reliability***

As an alternative to the criteria used in quantitative research, those of validity and reliability, qualitative researchers have developed a set of criteria which better ‘fit’ the aims of the paradigm. Instead, terms such as reflexivity (Bryar, 1999; Horsburgh, 2003; Parahoo, 2006), flexibility (Horsburgh, 2003), relevance (Mays & Pope, 1999), truthfulness, consistency and transferability (Slevin & Sines, 1999), credibility and validity (Burns & Grove, 2001; Miles and Huberman, 1994) (not as a measure of the

accuracy of an experiment, but as an expression of the truth value of the study) are offered as canons of research rigour.

In the conduct of this study the terms that were selected to demonstrate the rigour of the research were validity, as described by Miles and Huberman (1994: 278) as a means by which the research can be appraised as having what they describe as '*truth value*'. That is to say that there is not one way of viewing the truth (Lincoln & Guba 1995), but that different aspects of the truthfulness of the research emerge when it is subject to analysis concerning the *understanding* that can be gained from the study. In a similar vein, Pegram (1999) suggests that this equates to the believability of the findings. Miles and Huberman (1994) also suggest that in the course of the conduct of the research, the researcher subjects the data and findings to certain questions or checks which will enhance the validity of the research. These are outlined in Box 3.1 below. This approach to validity is also taken by Slevin & Sines (1999) and they consider that validity can be assured with the use of particular methods in data analysis, which have been used at all times during the conduct of this study. These are:

- Clear exposition of the conduct of the study and of the decisions made (audit trail)
- Use of a constant comparative method of data analysis (Strauss & Corbin, 1998)
- Convergent truthfulness evaluation (that is searching the data for consistency and checking for disconfirming data)
- Providing rich and dense data

These methods are also supported by Bryar (1999) and Parahoo (2006).

### ***Generalisability***

Rather than be concerned with validity and reliability, this study has therefore provided information to provide for credibility, auditability and validity as truthfulness and with auditability, reflexivity and clear exposition of the research conduct as canons of reliability (Yin, 2003). In addition to these, the issue of generalisability arises. Again this is a notion arising from the quantitative paradigm and in terms of case study research or other qualitative approaches, is less relevant. The term more often used in qualitative research is that of transferability (Slevin & Sines, 1999; Bryar, 1999; Parahoo, 2006). This refers not to the ability of the data to

be statistically generalisable to other populations or situations, but rather to the notion that it is '*the extent to which the findings of a qualitative study can be of use to other populations or settings similar to those in the study.*' (Parahoo, 2006: 410). Other authors highlight different views on generalisability by recognising that it is not statistical generalisation that is sought in case study research, but theoretical generalisability (Popay, *et al.*, 1998; Bryar, 1999; Yin, 2003, Horsburgh, 2003). Horsburgh expands this idea by explaining that it is *situational* representativeness that is provided by case studies and other qualitative research, from which the theory can be '*exported*' (Horsburgh, 2003: 311) to other comparable situations or settings.

The checks undertaken to enhance validity are outlined below. Several aspects of these are thought to be particularly important: these are informant (or research participant) feedback, triangulation and research reflexivity. These are explicated in the following sections.

### ***Informant feedback***

Several authors (Parahoo, 2006; Horsburgh, 2003; Burns & Grove, 2001) suggest that it is important to seek feedback from research participants on interview transcripts or summary reports as a means of ensuring rigour. However the need to undertake this approach is by no means universally agreed and there are also those who believe that it can also jeopardise the research endeavour (Sandelowski, 1993; McDonnell, *et al.*, 2000) as participants may wish to change their responses once they have had time to reflect on the interview or to discuss it with colleagues who may or may not have been interviewed. It is also important to acknowledge, and it is in line with the research paradigm, that there is not one truth or true perspective and that the views of participants are influenced by their role in organisations in which they work (Mays & Pope, 1999). There were also more practical issues of time and financial restraints to consider and in a study of this nature it was not felt to be possible to allow participants the opportunity to review transcripts. Horsburgh (2003) advocates providing the participants with summaries or case reports of aggregated data but once again this was considered and decided against as there were concerns that it might jeopardise anonymity and confidentiality of participants. Having considered the various issues, a decision was made not to use informant feedback in this study. Despite the decision not to provide transcripts or summaries for participants, this is

not thought to have affected rigour in a detrimental way. All of the other checks outlined in Box 3.1 were met and the use of data from several sources was also believed to have enhanced rigour.

**Box 3.1: Checks to enhance truthfulness of data.**

1. Checking for representativeness: this was undertaken by using several data sources and by looking at data sources that were less easily accessible.
2. Checking for researcher effects: use of reflexivity and use of interviews, not just observation.
3. Triangulation: of sources and types of data.
4. Weighing the evidence: by considering data from individual cases, then undertaking cross case analysis and then checking findings against literature.
5. Making contrasts and comparisons: analysis was undertaken using the constant comparative method.
6. Checking the meaning of outliers: disconfirming data and outliers were checked within each case, then checked against all cases and against literature.
7. Ruling out spurious relations: data were checked within and across cases and with literature to ensure accuracy and consideration was given to other variables to check links.
8. Replicating a finding: the use of several data sources strengthened this as well as the use of multiple cases.
9. Checking out rival explanations: this was undertaken by keeping several hypotheses in mind and being prepared to ask 'what could disprove this hypothesis or what does this hypothesis disprove?'
10. Looking for negative findings: an active search for disconfirming data was undertaken and this was checked as in number 6 above and presented in reports of the study findings.
11. Obtaining feedback from informants: this was not undertaken and the reasons for this are outlined above.

(Miles & Huberman, 1994; Burns & Grove, 2001)

### ***Triangulation***

In addition to the above means of ensuring rigour and to expand upon one of the checks highlighted by Miles & Huberman (1994) and Burns & Grove (2001), triangulation was considered to add to the rigour of the study. There are many views as to what constitutes triangulation (for example, Denzin, 1970; Brink, 1991; Begley, 1996; Shih, 1998; Burns & Grove, 2001), but in essence in this study it was considered to be one way of supporting the research rigour. The use of three different sources of data provided both subjective and objective approaches to the case studies (Bradley, 1995; Williamson, 2005a) and the use of a number of different participants in each case was also seen as a means of triangulation as it provides multiple perspectives of the research phenomenon (Jick, 1979; Lofland & Lofland, 1995; McDonnell, *et al.*, 2000).

### ***Reflexivity***

To provide further measure of robustness, the notion of reflexivity (Horsburgh, 2003; Parahoo, 2006) was used to recognise and acknowledge the role of the researcher, beyond the obvious, in the research endeavour. This acknowledgement that the actions and decisions of the researcher have an impact on the phenomenon under investigation adds to the clear explication of the research process and product (Dowling, 2006). The previous experience of the researcher and a reflexive account are provided as a means of demonstrating both the potential for researcher influence and how this was addressed, while recognising that the previous experience of the researcher also brought strengths to the conduct of the research (Carolan, 2003). This recognition is appropriate to the research paradigm (Denzin & Lincoln, 1994; Hill Bailey, 1997). A summary of the researcher's previous experience is shown in Box 3.2 overleaf.

### ***Reflexive account***

Recognising that the researcher is affected by previous experience and that this has the potential for introducing researcher influence (Roberts, *et al.*, 2006) led to the development of a number of checks and balances that were employed throughout the research to minimise any potential detrimental effects on the study. However, there was also a recognition that previous experience could enhance certain aspects of the study (Denzin & Lincoln, 1994; Hill Bailey, 1997; Parahoo, 2006) and these were

seen as strengths. The checks are outlined in Box 3.3 below and the strengths are shown in Box 3.4 as they are viewed as an integral part of the research and not separate from it (Robson, 1993).

*Box 3.2: Researcher experience*

- 13 years experience as a nurse in acute care, some posts involving ward management and the development and implementation of quality initiatives.
- 5 years as a community nurse developing new and improving existing services.
- 2 years working in primary care leading a multi-disciplinary team working towards the achievement of a quality care award. This involved managing nurses and leading and facilitating EBPI.
- Lecturing in clinical governance and EBP.
- Previous research experience working on a grounded theory study, a mixed methods study and as a local researcher for the Medical Research Council general practice framework on a randomised controlled trial.
- Experience as an inpatient, outpatient and of primary care on numerous occasions which influenced views of care delivery. While each encounter was recognised as an individual episode and was seen as affecting one individual patient, it is not possible to experience health service delivery without reflecting on the wider impact of those experiences. Some were positive, others less so: some, such as acquiring HAI, were harmful. However, in undertaking the research the individual nature of the researcher as a patient, in individual episodes of care, and the unique circumstances of those were always borne in mind, rather than viewing these experiences as indicative of wider health care delivery.

### **Box 3.3: Checks used to minimise researcher influence**

- The study was situated in contemporary acute care where the researcher had no experience of working since the advent of EBP to minimise any undue influence from researcher experience.
- The study design sought the views of a number of different grades of nurses, working in a variety of posts, nurse managers and other staff with roles involving EBP to ensure that the researcher was not favouring any one group.
- The researcher had not been employed in any of the four Scottish health care Trusts involved in the study and was not known by any of the staff interviewed and was therefore not favouring any particular Trust, hospital or individual.
- The researcher discussed data with colleagues and these discussions were used, with reference to the supporting literature, to ensure that influence was minimised during the analysis and writing up.
- The use of extensive fieldwork notes and a reflexive diary during fieldwork and data analysis served as a means of reflecting on the interview process. These led to minor amendments when necessary and were later used as a means of testing out and reflecting on emerging themes during data analysis. Once again, these were used with reference to the appropriate literature to minimise any undue researcher influence.

### **Box 3.4: Strengths of previous researcher experience.**

- The researcher highlighted her professional nursing background when negotiating access to cases and introduced herself to participants as a nurse with an interest in EBP. This facilitated access and legitimised the interviews once access had been granted to cases. It facilitated the interview process as participants did not have to provide explanations of the terms they used.
- The researcher was able to bring knowledge and experience of EBPI to the interviews and analysis, which acknowledged the complexity and non-linearity of the process.
- The counselling experience of the researcher was useful during interviews to elicit information and reflect this back to participants to ensure that the researcher had understood their meaning.
- Previous research experience was helpful in all aspects of undertaking the study.

### ***Research rigour***

Concerns about rigour in the conduct of the research have been addressed by ensuring an audit trail throughout the entire research process. Clear exposition of decisions made and transparency around the data gathering procedures and analysis enhance the rigour of the entire research endeavour. Concerns about researcher influence in the process have been addressed through the use of researcher reflexivity and an open acknowledgement that the researcher is not separate from the research enquiry, which is congruent with the epistemology and ontology of case study methodology (Robson, 1993). While it was not possible to involve other researchers in the project, which might have limited potential researcher influence, peer review of the development of research design and review of this by an external body (Medical Research Ethics Committee), has ensured that great care has been taken to minimise these potential problems. It is also important to recognise that congruent with the methodology and underpinning epistemology and ontology, the author's stance is that there is no one 'truth' so having a single researcher does not limit the achievement of this. The use of multiple methods and sources of data (triangulation) as described above have also enhanced the rigour of the study. In particular the use of documentary data relating to each case, but provided from an independent, objective source, (CSBS), limits the potential influence from either the researcher or the research participants in any of the sites.

Perhaps one of the strongest criticisms of the use of the methodology relates to the intense nature of the research endeavour (Pettigrew, 1988a) and the potentially huge amounts of data that can be gathered and the subsequent management and analysis of this, particularly in multiple case study designs (Vallis & Tierney, 1999). In this study, this problem was overcome through the early identification of a robust theoretical framework, which ensured that prior to entering the field, the type of data and the sources of data were clear. The theoretical framework not only informed the research design and conduct, but also served as a lens to guide and focus data analysis. It was the most important 'tool' for ensuring that the data gathering process was focused and not random and with the research protocol ensured that each of the cases were subject to the same investigation. The theoretical framework is described below.

## **Theoretical framework**

The theoretical framework chosen to underpin and guide the research was Pettigrew's contextual or processual approach (1985a,b; 1988a). This is important because it

*“... covers the main features (aspects, dimensions, factors and variables) of a case study and their presumed relationships.”* (Robson, 1993: 150)

and therefore fits well with the methodology. Arising from management research, the contextual approach purports that change cannot be understood as an entity in itself, devoid of the context in which it occurs and without explicit acknowledgement of the change process and the content of the change (Pettigrew, 1987; 1990). The interplay of these three factors take account of the 'where, what and how' of change and recognises that change occurs against a historical, cultural, economic and political background from inside and outwith organisations (Whipp, *et al.*, 1988). Inner context refers to the structure, culture and political context within the organisation while outer context concerns the economic, business, macro political and societal influences on the organisation (Pettigrew, 1988a). In addition, the framework recognises the importance of historical influences and their potential to impact on context, content and process and this was seen as an important aspect of the framework, given the historical changes to the NM role evidenced in the literature.

In this study, EBPI was considered to be one type of change process, with change being viewed as the manifestation of the actions, reactions and interactions (Pettigrew, 1988a; Buchanan & Boddy, 1992; Collins, 1998) of the staff employed within the organisation as they sought to undertake EBPI. This framework had also been used successfully by other researchers undertaking studies of organisational change within the National Health Service for example, Pettigrew, *et al.*, (1992) and McDonnell, *et al.*, (2000). It is also recognised as a method for guiding and underpinning change within the health services (Iles & Sutherland, 2001) which suggested that it had the potential to be a suitable framework for this study. One of the problems with models that have been developed in private sector business organisations is that they do not 'fit' readily or accurately reflect the realities of contemporary health service organisations. Although the Pettigrew framework (1985a; 1988a) originated in the private sector, it has been successfully used to study

change in the health service (Pettigrew, *et al.*, 1992; Iles & Sutherland, 2001) and as such was deemed to be an appropriate choice.

In addition, the Pettigrew framework (1985a; 1988a) provided a means for studying EBPI as a process of change management, but also took account of the importance of the contextual detail that appeared, from review of the literature, to be significant in understanding the process (Pettigrew, 1985b; 1988a; Collins, 1998). Studying EBP can lead to problems with definitions of evidence and the 'content' aspect of the framework provided scope for the research participants to define evidence themselves, to give the widest possible view of evidence, identify the content of changes as the result of EBPI and the changes that would be expected as a result of these, rather than relying on researcher imposed definitions. It also facilitated the gathering of data about different processes of implementation, for different evidence content within the same context and thus led to a greater understanding of overall EBPI in each case. The strength and attraction of the framework also lay in its potential to provide theoretically sound and practically useful research on organisational change as it involves the interplay between the context, content and process of change and takes account of the history of organisations, which may be significant in contemporary change processes (Pettigrew, 1985a,b; 1988a). In addition, the framework was able to guide not only data collection, but also data analysis (in particular, contrast and comparison of cases) and facilitate understanding of the complexity of EBPI in large and diverse organisations. It enabled historical and contemporary issues in nursing and wider healthcare to be factored in as influential contextual factors in current EBP initiatives as aspects of wider context. The holism of the theoretical framework also complements the holistic approach of case study methodology (Robson, 1993; Gummerson, 2000) and is congruent with the overall research paradigm.

The most significant drawback of the contextual approach as a way of understanding change, is the potential for any study to be largely descriptive in nature (Collins, 1998). This was countered by designing a study that set out to describe in the first instance only as a means of identifying then explaining or illuminating the role of the NM in implementing EBP.

## **RESEARCH METHODS**

### **Research design**

One of the drawbacks of undertaking case studies is the amount of data that is collected and the subsequent management of that data (Vallis & Tierney, 1999). The way that this is overcome is through having a theoretical framework as described above (Robson, 1993) and through the use of a robust research design and pre-decided framework for guiding the management of data (Robson, 1993; Vallis & Tierney, 1999; Yin, 2003).

The research protocol was developed according to the methodology, as outlined by Yin (2003). It consisted of a multiple case design, of four cases with embedded units of analysis in each case. The case boundary was the individual National Health Service Trust and the units of analysis were, for example, EBPI strategies and the role and remit of NMs. The focus of the study was on acute medical and surgical care where it was perceived that there would be the greatest availability of evidence-based products, lest the situation arise that research participants were not able to discuss EBPI due to a paucity of evidence, real or perceived.

### **Research sampling**

In qualitative research the sample is not chosen to be statistically representative, instead the sample, in this study the cases, were chosen as a purposive sample (Robson, 1993; Burns & Grove, 2001; Yin, 2003; Parahoo, 2006). The sample was chosen because it was believed to provide the kind of information being sought in this study. Cases were selected for their potential to yield relevant data to answer the study questions (Popay, *et al.*, 1998; Horsburgh, 1993). In case study research the sample is selected as it will provide theoretical replication, not statistical replication (Yin, 2003) and this was the rationale for the choice of cases in this multiple case design study. Burns & Grove (2001) and Yin (2003), suggest that the use of multiple case study designs provides findings that are more compelling and robust than single case study designs and this was also thought to be important in countering concerns about the robustness of the methodology. Since the number of cases is not the crucial element in qualitative methodologies, this was not considered as a factor when selecting the cases in this study. As Yin (2003) describes, it was the recognition that external conditions have an impact on the results and phenomena which are likely to have a

greater number of these, need to be accounted for by having a greater number of cases in the overall study. This had to be balanced with the practicalities of financial resources and what one researcher could reasonably achieve in the time allowed for the study.

An initial approach was made to the Directors of Nursing of all the Scottish Acute Health Care Trusts (now divisions of health boards) to ask if they would be willing to take part in the study. Replies were received from six. Discussions with experts in the Nursing & Midwifery Practice Development Unit were useful in gathering additional information about the Trusts. Information relating to their size, geographical spread, similarities and differences in the organisations and in particular, their nurse management structure and the presence or absence of Practice Development Units within each Trust was gained. This was undertaken to account for the conditions which would determine the need for a larger number of cases (Yin, 2003). From this information a decision was taken to select a purposive sample of four cases, which provided both similarity and difference in the known characteristics of the cases.

### **Research Ethics**

Once the case design had been completed, but prior to case selection, approval had to be sought from the multi-site Medical Research Ethics Committee for Scotland as the result of the introduction of research governance. Once the protocol was complete, application was made to the appropriate committee in September 2002. After two minor amendments and some clarifications, approval to approach cases and to begin data collection was granted in late February 2003. In the interim, case related documentary data, already in the public domain, was obtained. To minimise delay an informal approach was made to the Directors of Nursing in potential cases. As a result it was possible to begin data collection as soon as ethical approval had been secured.

### ***Case Selection***

After case selection, following the process described in the research sampling section, access to each case was arranged through the Directors of Nursing of each health care Trust. Data gathering took place sequentially in each case as follows:

Case A: March, 2003

Case B: May, 2003

Case C: June-July 2003

Case D: August 2003

To prevent contamination of data from one site to another and as a means of maintaining a clear audit trail (Horsburgh, 2003) data analysis did not begin until data gathering was complete in all sites. However reflection on the data gathering processes in each site, particularly undertaking interviews, led to minor amendments to the interview schedule, due mainly to differences within Trust organisational structures and nurse management structures. In addition, more emphasis was occasionally necessary regarding types of evidence and definitions of evidence, due to lack of universal understanding of the concept by research participants. Full details of the research methods are provided in the following sections.

The previous sections have outlined the rationale for the choice of research methodology and provided detail about the research design and sample selection. The following sections go on to discuss the research methods used in the study, providing both the rationale for their selection and their use in the study, as well as outlining the method of data analysis.

### ***Data collection***

Initial approaches were made to the Directors of Nursing of each Trust, to discuss the study in detail and agree access to Trust staff, after ethical approval was gained. The Director of Nursing was asked to describe the nurse management structure and outline the main processes/structures involved in EBPI. In addition, they were asked to provide contact information for staff who they saw as having a role in EBPI. In some cases this initial list was later augmented by NMs, who suggested other staff who had an EBPI role and these staff were included in the study. In Cases B and C, the Directors of Nursing would not agree to pass on information to their staff, as outlined in the protocol for ethical approval, instead they requested that the approach to staff should come directly from the researcher and therefore this was the approach taken in these cases. However, in Case C, this process was facilitated by a senior research

nurse, nominated by the Director of Nursing. All had previously discussed the study with their NMs prior to agreeing to participate in the research. The Director of Nursing in Case D did not agree to talk to the researcher at this stage of the research (or indeed later on), but instead nominated one of the assistant directors of nursing who was able to facilitate researcher access to staff. Research participant information sheets and written ‘consent to participate’ forms were provided for each potential participant and verbal consent was also gained immediately prior to the commencement of interviews. Other than the Director of Nursing in Case D, no-one approached declined to participate.

### ***Research Interviews***

Interviews were undertaken in each case, 51 in total. The types and sources of data were the same in each case as shown in Box 3.5, with variation only in the staff interviewed as shown in Boxes 3.6 - 3.9.

#### **Box 3.5: Types of data from Case A-D**

##### **Documentary Data**

Clinical Standards Boards’ local reports

Health Care Trusts’ Annual reports

General Trust information from staff and websites

Examples of Trust clinical guidelines, protocols and procedures and practice policies

##### **Interview Data**

Full transcripts of audio-taped interviews

Notes taken during interviews

Fieldwork diary notes relating to interviews

##### **Observational Data**

Fieldwork diary notes of direct observations taken while in each Case

**Box 3.6: Details of staff interviewed in Case A**

Interviews with 17 staff

- Director of Nursing
- 5 Nurse Managers
- 4 Practice development nurses
- 3 Charge Nurses
- 2 Clinical Educators
- 2 NM/CNS joint roles

**Box 3.7: Details of staff interviewed in Case B**

Interviews with 12 staff

- Director of Nursing
- 3 Nurse Managers
- 4 Practice development nurses
- 2 Charge Nurses
- 2 senior members of staff in clinical governance roles

**Box 3.8: Details of staff interviewed in Case C**

Interviews with 14 staff

- Director of Nursing
- 1 Assistant Director of Nursing
- 2 Principal Nurses\*
- 5 Nurse Managers\*
- 2 Practice development nurses
- 2 Clinical Nurse Specialists
- 1 Clinical Educators

\*3 staff held dual roles as they were 'acting up', but still had responsibilities for their own post.

**Box 3.9: Details of staff interviewed in Case D**

Interviews with 8 staff

- 2 Assistant Directors of Nursing
- 1 Nurse Manager/Clinical Nurse Specialist
- 2 Clinical Nurse Specialists
- 1 Charge Nurse
- 1 Nurse with an evidence product role
- 1 practice development midwife, formerly a manager

The interviews were semi-structured in nature, with an interview schedule (Appendix 1) that was based on questions informed by the literature review and theoretical framework relating to EBPI and in particular, the context, content and process of this. This was used as a guide rather than a rigid tool during focused interviews (Robson, 1993), specifying key topics, but with the order of questions not being fixed. This format was selected to allow participants the scope to provide information that they felt was important or relevant to the research enquiry and in particular, information that may have been exclusive to their Trust. Some participants needed more prompting in interviews than others and sometimes greater clarification was needed around some questions. However, in the main, the researcher began with a brief introduction and explanation of the focus of the study and allowed participants to discuss issues relating to EBPI as far as they were able after initial prompts. Occasionally it was necessary to ask for further explanation or clarification to ensure understanding, before asking another 'starter question'. Interviews generally lasted about 45 minutes, and none were longer than one hour.

For accuracy, the interviews were audio-taped and augmented with notes taken by the researcher during the interview (Silverman, 2000; Roberts, 2006). As far as was practically possible, interview tapes were replayed prior to undertaking further interviews in the same site to enable the researcher to focus on any specific aspects of implementation or any unusual or unexpected responses to questions with other participants. Confidentiality and anonymity of participants was maintained by the researcher at all times. Each tape was then transcribed verbatim and in its entirety prior to data analysis. Two participants declined to be taped during the interviews; in these cases the researcher took extensive 'shorthand' notes throughout the interviews and wrote these up in detail immediately following the interviews. Only one participant asked to review the notes of her interview as she had chosen not to have her interview audio-taped. Although a decision had been taken not to give participants the opportunity to review interview transcripts, this participant was concerned about the ability of the researcher to take detailed notes during the interview and her intention was to augment the notes if important information had been missed, rather than to change the information provided. For this reason the request was agreed to. Only one amendment was necessary and this was to a minor point relating to the

number of staff undertaking higher degrees, which she had guessed during the interview and then had obtained the accurate number, which was subsequently amended in the notes taken during the interview. All staff received the same information, a research participant information sheet, at least 24 hours prior to interview and therefore this provided them with an opportunity to consider the interview and their responses prior to interview. As the tapes from the interviews were transcribed verbatim and in full, this has minimised misinterpretation of participants responses, as the context and background (preceding questions or topic) and any response or explanation from the researcher could also be taken into consideration (Roberts, 2006).

### ***Documentary data***

There were two main sources of documentary data. Reports from the (former) CSBS (now NHSQIS) were in the public domain. All of the reports available of visits to Trusts before February 2003 were used as data. Each Trust had been subject to the same number of visits by the Clinical Standards Board, covering the same clinical topics. As the focus of much of these data was the extent to which Trusts were implementing evidence, the reports concerning progress towards achieving clinical governance formed the main focus of data analysis, rather than any individual Trust's performance against specific clinical standards. Each of these reports had been compiled after visits by 'third parties' and were therefore considered to be independent and rigorous data. They provided a considerable amount of contextual data and information relating to EBPI content and process.

The second type of documentary data was obtained from Trusts. This was subdivided into two types, 'formal and informal' documentation. Formal documentation consisted of annual reports, policy documents, written guidelines, procedures or protocols. Some of this information was accessed via Trust intranet sites, with permission. Informal documentation consisted mainly of staff newsletters and similar information. Where it was not possible to obtain hard copies of these, detailed notes were taken on site. All the types of documents described have been considered appropriate types of data for understanding EBP (Appleton & Cowley, 1997).

### ***Observational data***

While interviews and documents were the main sources of data, some important contextual data was gathered through ‘observer-as-participant’ (Robson, 1993) observation. The main purpose of this role was to provide additional contextual data and this data was gathered while access to cases and arrangements for undertaking interviews were being negotiated. Some additional data was gathered in the time the researcher spent in cases, interacting with staff who were not the main focus of the research, but who were aware of the researcher’s role and purpose within the organisation (Robson, 1993). This data was in the form of notes taken on each site in a fieldwork diary, which were generally condensed or abbreviated, but were written out in full contemporaneously. Much of this was descriptive and provided rich contextual data. It also served as a reminder to check for specific information on subsequent visits. While the main focus of this was descriptive, it was also a useful means of recording thoughts, feelings and personal impressions. Robson, (1993:205) considers observation of this nature to be appropriate when the prime motivation is to *‘find out what is going on’* and it was used in this study in this way and was particularly important in terms of exploring the context in which EBPI was rooted. The risk of researcher influence in observation is obviously significant and observational data were checked against other data sources to minimise this risk. Awareness of this risk, in itself, goes some way to addressing the potential problem. The researcher was cognisant of the risk of the ‘Hawthorne effect’ such as participants offering the socially desirable response, rather than the true response to questions and of observer effects (Robson, 1993) and took account of these in making notes and in the data analysis.

### **Data analysis**

Management of data in case studies is recognised as being potentially difficult, particularly as a result of the large amounts of data collected (Robson, 1993; Vallis & Tierney 1999; Pegram, 1999; Burns & Grove, 2001; Yin, 2003; Parahoo, 2006). One of the ways of countering this problem is to have a clear strategy for data analysis organised prior to the commencement of analysis. In this study it took place in four stages:

1. Analysis of each individual data set
2. Analysis of each individual case. Writing up of descriptive case account.
3. Cross case analysis
4. Final, overall analysis of all the data, taking account of the appropriate literature.

Analysis was both an inductive and deductive iterative process, for all types of data (Silverman, 2000; 2001). Each case was analysed individually and then contrast and comparative analysis was undertaken across all cases. Analysis was undertaken without the use of computer software, as the transcribing of interviews was viewed as an initial stage of analysis, and through this the researcher became more and more familiar with the data. In addition, the use of large amounts of documentary data would have necessitated the input of this on to computer to facilitate computer assisted data analysis and this was not thought to be a good use of limited time.

Analysis was guided by the analytic strategy (Yin, 2003) which was developed from the theoretical framework and propositions underpinning the research enquiry. These were shown in Box 2.4.

In essence data analysis was undertaken using three parallel processes in each case and then the processes were repeated for the cross case analysis.

Firstly, data was subject to sifting and colour coding to identify themes from which codes (Miles & Huberman, 1994; Strauss & Corbin, 1998) were created. This was guided in the first instance by the theoretical framework and data were coded under the broad headings of context, content and process. Writing an initial descriptive case analysis was undertaken as it was also seen as an important part of the analysis as themes and codes in themselves were less important than the *meaning* of these (Miles & Huberman, 1994). This did not always become clear until the iterative process of writing and returning to the data was underway.

Next, a more detailed process of sorting data into categories and codes and analysis of these produced an account of the key issues that emerged, under the themes of the theoretical framework. Finally a third interrogation of data occurred in the form of an open ended thematic analysis, which allowed themes to emerge from the data itself,

which had not been pre-determined by either the literature or the theoretical framework. These were then compared to and contrasted with regard to the literature to find areas of congruence and variance.

This process was repeated for each case and a detailed descriptive analysis of each was produced. These then enabled a more detailed cross case analysis to take place. Data from each case was organised under the headings of the theoretical framework and through a process of checking and cross checking enabled a refining of the data to take place. This inductive and intuitive process was one of reading and re-reading the descriptive analyses and original data which facilitated an ongoing process of revision of ideas and hypotheses which could be 'tested' against the data within and across cases. Development and writing of partially analysed accounts facilitated an understanding of the dynamic relationship of the themes over time. This continued until no new themes emerged (Strauss & Corbin, 1998).

In the same way as the transcription of interviews was viewed as an initial part of data analysis, writing up of the thesis was considered an integral part of the analysis process also (Roberts, 2000).

## **METHODOLOGY AND METHODS: CONCLUDING REMARKS**

This chapter has presented a detailed account of the methodology and methods used in the conduct of this study and provided an appraisal of alternatives considered. The selection of case study methodology has been shown to be an appropriate choice for the research endeavour and the methods selected are appropriate to this.

A theoretical framework to underpin and guide the study, which reflects change as an active process (and which is therefore congruent with EBPI processes) and which recognises the importance of the interaction of several factors, including historical changes to the context, content and process elements, is a suitable choice. In addition, the selection of multiple data sources conform to the methodology and have the potential to provide rich data in relation to the context, content and process of EBPI and the roles of NMs in this.

Issues of rigour were identified and have been addressed, including the role of the researcher in the study. An appropriate sampling strategy was identified and utilised. Although the numbers of staff interviewed varied across cases, no 'ideal' number of research participants was ever sought; their roles in EBPI were more relevant than seeking to achieve a specific number of respondents.

Identification of a robust strategy for managing and analysing data was an important element and it had not only utility but was significant in directing the analytical process, ensuring that each case was subject to the same process prior to the cross case analysis. It was a successful tool for managing the amount of data gathered.

Having provided detail which serves to underpin the study and fully explicate the processes used in its conduct, the following chapter provides the first of three results chapters, presenting the findings relating to context from the cross case analysis.

## **CHAPTER FOUR**

### **RESULTS (1): CONTEXT**

#### ***Setting nurse managers and EBPI in context***

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##### **INTRODUCTION**

The results from data analysis are presented in this and the following two chapters, under the headings of Pettigrew's contextual framework (1985a, 1988a). In this chapter the results are largely descriptive as a means of 'setting the scene' for NMs and EBPI.

As the chapters progress, there is increasing sophistication of the analysis, with less descriptive and more analytical accounts of content and process providing exploration and explanation of the three factors in relation to NM roles in EBPI.

Pettigrew's framework (1985a, 1988a) identifies the influence of what is described as 'inner' and 'outer' context on the change process. Outer context is comprised of the social, political, economic and competitive environment (the latter being less relevant in health care), while inner context is concerned with the structure, culture and political internal environment of an organisation (Pettigrew, 1987). Prior to considering the detailed inner context of each of the cases on an individual basis, an overview of the wider influences to which all the cases were subject is provided. It is important to acknowledge that the introduction of devolution in Scotland in 1997 brought with it a number of significant changes to health care and set in motion policies and new ways of working that were having an impact at the time each case was visited. Although each of the cases had been subject to changes in policy throughout the 1990s that had had an impact on the structure and the focus of management (with a greater emphasis on general management and less on professional management), the ways in which this had been approached varied between cases and are noted in the section describing the inner context of each.

## OUTER CONTEXT

### **Significant policy and government guidance**

Beginning in 1997, Box 4.1 presents a number of policy and guidance documents which illustrate the main foci for Trusts between then and the time the Trusts were visited. A more detailed explanation of some of the most significant policies follows.

It is important to note that, although numerous, these are by no means the only policies, guidance and information that health care managers were receiving at that time. In addition, there were regular publications and strategies relating to specific clinical matters, particularly those that were current to the public health, 'issues', such as MRSA and other hospital acquired infections, management of illegal drug users and problem alcohol use and mental health issues. There was also regular information and standards relating to other clinical conditions, such as heart disease and cancer that Health Care Trusts were required to adhere to.

**Box 4.1: Selected Scottish Executive health policies and guidance 1997-2002**

1997: *Designed to Care*

1997: Modernising learning in the NHS in Scotland.

1998: *Towards a new way of working: the plan for managing people in the NHS in Scotland.*

05/99: *Hospital Acquired Infection: a framework for a national system of surveillance for the NHS in Scotland.*

07/99: *Fair Shares for All: Review of resource allocation in NHS Scotland*

09/99: *Review of pay and conditions for general and senior managers in NHS Scotland.*

12/99: *Learning Together: a strategy for education, training and lifelong learning for all staff in NHS Scotland.*

06/00: *Strategy document: Working together to build a healthy, caring Scotland.*

10/00: *Report of an exploration of role development in Nursing & Midwifery in Scotland.*

12/00: *Our National Health: a plan for action, a plan for change strategy.*

03/01: *Caring for Scotland: the strategy for Nursing & Midwifery in Scotland.*

07/01: *Introduction of new performance and accountability review system.*

12/01: *Patient focus, public involvement. Strategy for engaging with patients and the public around health services in Scotland.*

03/02: *Publication of plans to establish a new framework for managing clinical effectiveness through the development of a special health board.*

09/02: *Publication of national care standards.*

**The introduction of clinical governance**

*'Designed to Care'* published in 1997, introduced the concept of clinical governance, making it clear that this would be the framework through which quality in health care would be maintained and improved. It also highlighted the corporate nature of this, in that it would be a corporate and managerial concern, not only the responsibility of individual clinicians, but that each member of staff would have a responsibility for maintaining and improving the quality of health care. One aspect of clinical governance was that of evidence-based practice. Clinical governance became statute in 1999 in Scotland.

*'Our National Health: a plan for action, a plan for change'* presented wide-ranging change programmes relating to governance and accountability, increasing patient and public involvement in health care, introducing service changes and modernisation to services. It introduced plans for changes to management as a means of streamlining bureaucracy and increasing accountability while improving and integrating planning and decision making. It outlined the national standards that would be set, detailing the priority areas and clearly identified the goals that Trusts would be expected to meet. Structures were put in place to monitor and guide health care delivery in a transparent way to ensure that the NHS was accountable for the care provided.

As a result the changes outlined were expected to have a significant impact on every Health Care Trust. These were: the introduction of unified Health Boards to replace the (then) current NHS Boards and Trusts and a review of management systems and decision making processes. Each board was expected to set out a programme of service redesign focusing on improving the patient journey. In addition there would be the modernisation of information management and technology and the further development of clinical information systems and, in line with other policies and strategies, the focus on leadership in the NHS would be taken forward with the launch of leadership development programmes.

### **The national nursing and midwifery strategy**

The second document that had significant implications for each of the Trusts was *'Caring for Scotland'*, the nursing and midwifery strategy. The first point made in the strategy is the recognition of the contribution of nurses to EBP. Role development for nurses was also a specific focus of the strategy, providing a formal opportunity for nurses and their managers to acknowledge the scope for developing nurse roles and recognising the greater contribution that nurses could make to patient care in redesigned and modernised health services. The specific roles noted related to nurse triage in accident and emergency departments, nurse endoscopists and the expansion of nurse prescribing, where nurses would take on roles previously only carried out by medical staff. Several elements were described as being important to the strategy and underpinning the evolution of it. These were:

- Accountability, support and clinical supervision (employers had a responsibility to ensure that clinical supervision arrangements for each nurse were in place)

- Leadership
- Professional development
- Career development and workforce planning
- Research, EBP, development and innovation
- Clinical governance
- Greater support for newly qualified staff
- A review of the resources required by charge nurses to deliver their clinical, management, leadership, educational and research roles effectively and of the barriers which restrain them
- Directors of Nursing had to ensure that all charge nurses had access to a leadership development opportunity within a five year plan, commencing 2001
- Continuing professional development opportunities for all nurses

In line with the strategy and other policies from the Scottish Executive, there was an increasing emphasis on leadership development within nursing and two programmes predominated – the LEO programme (Leading an Empowered Organisation) and the Royal College of Nursing leadership programme. These were adopted by many Trusts as the means by which they could address the development of leadership skills for nurses.

### **New Deal**

The preparation for and the introduction of the ‘New Deal’ for doctors (an overhaul of their working hours to bring them into line with the European working hours directive fully implemented in 2003) also had a significant impact for nurses. The reduction in junior doctors hours meant that many of the more routine tasks of patient care previously carried out by doctors were either delegated to or were adopted by nurses by default, such as venepuncture, management of intravenous infusions and simple medication provision. In some Trusts this meant that nurses simply absorbed these tasks after additional training, in others, new roles were developed specifically to take on these tasks. The ‘New Deal’ was viewed by some nurses with concern and negativity from the time it was first mooted (Mouse, 1994; Barrett, 1995), with concerns about the ramifications of the impact on nursing workload. There was a recognition that changes of this nature were going to demand as much in the way of

change to attitudes and professional cultures as to organisational change (Barrett, 1995). This negativity was evident in the interviews with some nurses viewing the 'New Deal' as having had a detrimental impact on nursing and nurses and on inter-professional relationships.

### **Agenda for Change**

The final initiative that was in a preparatory and pilot phase during the time each case was visited was '*Agenda for Change*'. Described as the biggest change to NHS pay and conditions for over 50 years (NHS Employers Organisation, 2007), it was the introduction of a single pay system for all NHS staff, with the exception of doctors and the most senior managers. It depended on job evaluation and the use of a knowledge and skills framework for staff which in turn, were linked to annual reviews, up-to-date job descriptions and personal development plans which would determine pay and conditions. While this was still only in the preparatory phase at the time of the research, one case was a pilot site for this. Staff in all cases were aware of the forthcoming changes and were both uncertain and anxious about the implications of it for them or their staff, with few viewing it as an opportunity to have their role reviewed and receive appropriate and equal pay for the work they were doing. Rather, it was seen more as a means of saving money (Doherty, 2006; Hurst, 2007) by placing everyone with the same job title on the same grade, regardless of their specific role (Kendall-Raynor & Snow, 2006; Chubb, 2007). Within Trusts, the preparatory phase involved reviewing job descriptions and updating them and linking them to the knowledge and skills framework.

In addition to the above policies, strategies and major change initiatives happening across NHS Scotland, numerous clinical guidelines and nursing best practice statements were being developed and disseminated, for local implementation. While the NMPDU was still relatively new, it was developing specific nursing guidance, and SIGN, which was well established, was developing, updating and disseminating numerous guidelines relevant to varying extents to all health care staff across Scotland.

### **National standards for health care delivery**

Guidelines from SIGN and the NMPDU in conjunction with the CSBS standards formed the basis of the assessments that each Scottish NHS Trust had undergone since 2001. While most related to specific clinical conditions, such as cancer or heart disease, general assessment of achievement and adherence to clinical governance standards were also undertaken. Each assessment was the subject of a single visit, so each Trust was visited a number of times over the course of each year. Since each assessment required the completion and submission of significant amounts of written evidence and then a subsequent visit from an assessment team who interviewed staff and observed process (rather than practice), being subject to several visits a year was onerous and disruptive. This was subsequently acknowledged by the CSBS and this format has since been changed. The performance of the Trust against specific standards was judged and was then the subject of written reports highlighting areas of success and those standards which (at the time of the visit) remained unmet or only partially achieved, with suggestions as to how they could be met. The executive summaries of visits to all the cases showed that they were facing similar situations and challenges to other Scottish Trusts and that while the main focus had been on disseminating (mainly SIGN) guidelines, further effort was required to consolidate this work by concentrating on systems for prioritising and then implementing these and other evidence-based guidance. Overall, the efforts of all Scottish Trusts visited by the CSBS showed that use of guidelines in practice was still a 'work in progress' and that several still had some way to go to achieve the foundations in terms of structures and systems within their organisations that would enable EBPI to be a reality. The complexity of organisations and the restraints of limited finance were recognised by the CSBS as being common to all health care organisations in Scotland, but were not to be seen as a reason for lack of commitment to progressing EBP as a means of improving the standard of health care provision.

### **Professional regulation**

While each of the above has had an impact on all staff working in NHS Scotland, two other changes that only concerned nursing were also significant. In 2002 the former United Kingdom Central Council for nursing and midwifery was replaced by the Nursing and Midwifery Council. While this did not affect the way in which nurses or midwives were registered to practice, the focus of the new council was on protecting

the public to a greater extent than previously. It was described as a regulatory body for nursing and midwifery and within the first few months of its existence had produced four new guidance documents which reflected this: guidelines for employers and the public for making complaints about professional conduct and registration, new guidelines for records and record keeping, new guidelines for the administration of medicines and a new code of professional conduct which made mention of EBP for the first time.

Overall, it can be seen that the number, breadth and scale of changes in the NHS in the few years leading up to this research were considerable. Many had far reaching impact, while others were more discrete. However, each had the potential to influence the inner context of the cases and serve not merely as a backdrop, but an underpinning, interacting and contributing factor. These illustrate the challenges that Trust managers were faced with on a daily basis, in addition to managing the operational and strategic aspects of health service delivery.

Having presented the outer context factors that were pertinent to each case, a detailed exploration of aspects of inner context follows. A brief introduction to each of the four cases is provided to facilitate contrast and comparison and is followed by a detailed cross case analysis that explores the issues related to context and EBPI.

## INNER CONTEXT

Data in each case were gathered from a number of sources and several different types of data were used. In each the data sources were the same, with only the number of staff roles varying between cases. The types of data and sources from each case are provided in chapter three.

### *Case introduction: Case A*

#### Organisational setting and structure

This Trust provided health care to a large remote and rural population. The number of acute medical and surgical beds available in 2003 was approximately 600. The Trust comprised one District General hospital where the Trust headquarters were situated and two community hospitals at a considerable distance from this. These had been

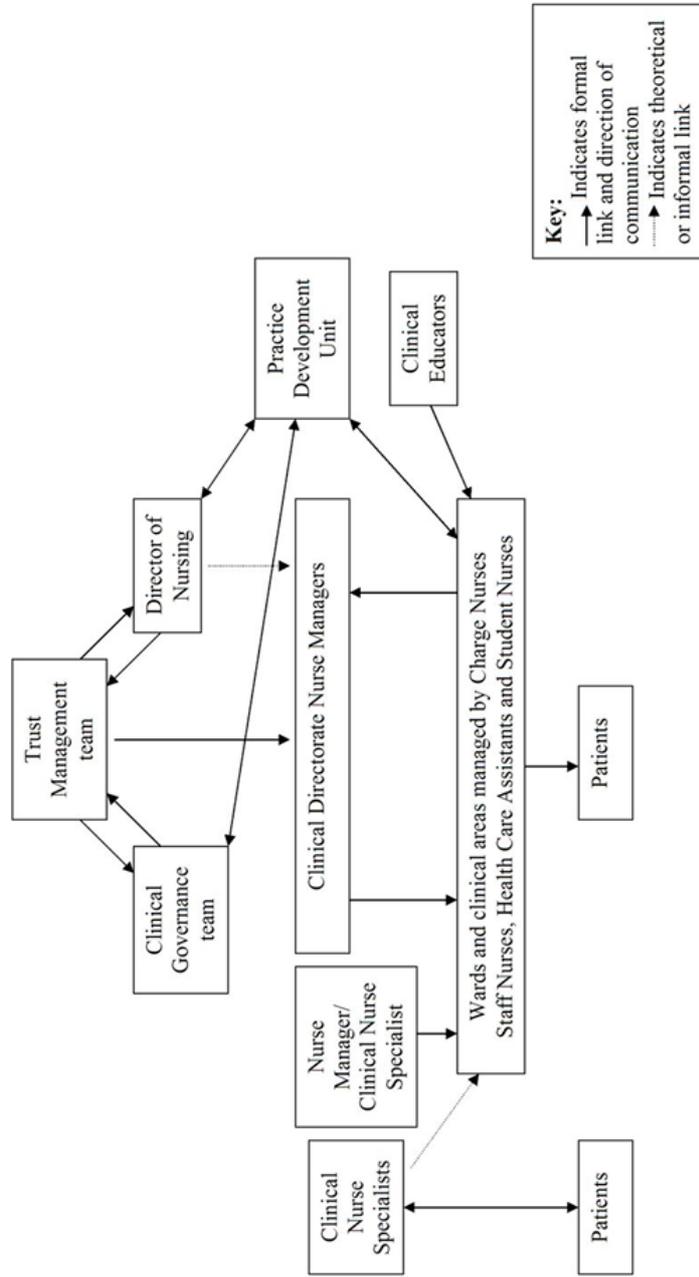
three separate Trusts between 1990 and 1999. Staff from the three hospitals were interviewed. Information relating to the organisational structure of the Trust was gathered from staff during interviews, from direct observation while in Trust headquarters and from CSBS data relating to the assessment visits that had been undertaken within the Trust. Figure 4.1 (overleaf) shows the organisational structure of Case A, relating to nursing. Some further explanation is provided to facilitate the contrast and comparison of this case with those that follow, where structures vary.

In Case A, the Director of Nursing was an equal member of the Trust management team. The Director of Nursing did not directly manage any of the directorate nurse managers, but did have responsibility to oversee the professional aspects of their role. The NMs were kept abreast of Trust management decisions through communication with the Director of Nursing. The Director of Nursing also had good links with the senior practice development nurses, many who had formerly been NMs. Some of these staff, depending on their role, were involved on an 'as required' basis with the clinical governance team. For example, the senior practice development nurse with a remit for quality, would link to the clinical governance team on matters of health and safety relating to nursing practice.

The practice development unit was well staffed, with four senior practice development nurses, each in charge of specific areas of practice, for example, quality or education. Each of these nurses had previously held senior posts within the Trusts, either in management or they had held posts in higher education. Working in the unit with them, were three other nurses, with varying job titles, within specific areas of practice. One, with the job title of clinical educator, was responsible for teaching and updating clinical skills for junior doctors and nurses, relating to venepuncture. In addition, her role had expanded to encompass the implementation of nursing best practice statements and the development and implementation of integrated care pathways. The Director of Nursing explained that this post had been funded through the '*imaginative use*' of nursing budgets and by bidding for national funding for practice development. The practice development unit also relied upon nurses from the clinical area contributing to specific projects, such as developing nursing guidelines. These link nurses were nurses with a specific interest in or expertise in aspects of practice, such as infection control, or clinical conditions. They were not CNSs, but



Figure 4.1: Case A organisation chart



main grade nurses with the link aspect of their role being voluntary. The senior practice development nurse with overall responsibility for the development of nursing practice had informal links with some of the clinical directorate managers (mainly based on their previous relationship as colleagues) relating to the assessment of practice and requirements for practice updates.

Within the Trust, there were two other clinical educator posts, both entirely different from each other and separate from the one employed in the practice development unit. One, based in the intensive care unit, had sole responsibility to write guidelines for practice relating to that unit. She had no previous experience of education or of practice development, but had an interest in ensuring that staff in the unit were able to use the equipment appropriately. The technical nature of intensive care nursing was given as the rationale for the development of this new post. She had no links to the other clinical educators nor to practice development staff.

The other clinical educator had no links to the practice development unit either. His post had developed from outwith the Trust, from the higher education provider of nurse education in the area. His role, as he described it at interview, was unrelated to EBP, but focused on supporting student nurses in the clinical area, while on placement. Other Trust staff were of the belief that his role concerned EBP.

The five clinical directorate NMs (two based in the district general hospital and two based in one of the two community hospitals and one in the other, smaller community hospital) were managed by the medical director of each clinical directorate, although, as noted above, the Director of Nursing had a role to oversee any professional nursing issues for these staff. They were responsible for operational management of the directorate, such as ensuring adequate staff cover and resource management. They had formal links with the wards and clinical areas in their directorate, but saw charge nurses as having sole responsibility for these, as the budgets were devolved to this level.

The Trust had two joint NM/CNS posts, one in intensive care nursing and one in cancer services. Each managed a unit with charge nurses and staff nurses directly responsible to them. As well as overseeing the management of these clinical areas, each also had CNS responsibilities, acting as independent practitioners with their own patients and providing expertise and information for their staff. Although they worked closely with the medical staff involved in the care of patients in their units, they were more closely linked to nursing than other CNSs in the Trust.

Other CNSs within the Trust were not linked to the nursing structure or hierarchy. Instead, reflecting the way in which many similar posts developed in other Trusts, they worked within their own clinical speciality, seeing their own case load of patients and working closely with consultant medical staff, to whom they were responsible.

#### *Other aspects of inner context*

The District General Hospital had a stable workforce and had no problems with recruitment or retention of staff, however this was not the case in the community hospitals where it was difficult to fill vacancies and to retain all types of staff. This was thought by staff to be due to their geographical location. While a stable workforce was thought of as an advantage, it was also recognised by staff that there were drawbacks associated with this, in particular, that no 'new blood' or fresh ideas came into the Trust.

Trust management was relatively stable with the Chief Executive having been in post for a number of years. The Director of Nursing had also been in post for eight years. Staff described this as important and they felt that it provided stability, support and strong leadership. The Director of Nursing described a good working relationship with the Chief Executive and medical managers. Under the general management structure, NM posts had been abolished in 1996, but were re-introduced by the Director of Nursing in 2000. Although NMs continued to be managed under the general management structure, they retained close contact with the Director of Nursing, an arrangement that both parties felt was successful.

Many of the NMs had spent their whole career working within the Trust and had seen considerable changes to the roles and job titles in that time. This appears to have led

to the post holders having considerable scope to develop their posts to best reflect their own interests and abilities. As a result, no two posts were the same despite having the same job title. To illustrate the number of changes the posts had undergone and the changes to remits and responsibilities, the following example of one NM's experience is provided. She described her training in the hospital, her appointment as a theatre sister and subsequently as a nursing officer for theatres. After many years in this post the structure of nursing management changed and she became a clinical nurse manager for surgery, taking on responsibilities for a wider sphere of nursing than her own area of expertise. This trend had continued as her role changed again to directorate staff manager, having responsibility for operational aspects of clinical areas only, but having greater responsibility for managing medical, administrative and ancillary staff. With the re-introduction of the NM posts, she applied for and was appointed as directorate NM, but with a larger sphere of responsibility once more, although her role for managing administrative staff had gone. Her own interest in theatres and surgical nursing remained and she had tried to make this the greatest focus of her role, but found this impossible to manage given the 12 other clinical specialties that she was responsible for. This NMs experience was not atypical and others also related the number of 'incarnations' that the NM role had undergone over a relatively short period of time.

In one of the other hospitals, the NM had previously been a nursing unit manager and although she now had responsibilities to deputise for the clinical director and what she described as 'Board' responsibilities, she had negotiated with her manager to retain one clinical session each week, to reflect her desire to continue to nurse patients.

The changes to the NM posts over time had meant that many responsibilities had been devolved to charge nurses and as a result they were responsible for all aspects of ward management, including budget holding. They were also responsible, on a rota basis, for providing NM cover for the hospital outwith office hours. This involved ensuring that there was adequate staff cover, attending any emergency situations, dealing with complaints, liaising with the media, if required, and being the first point of contact in major incidents until more senior staff arrived. When charge nurses were 'on call for the hospital' as this situation was known, they were not supernumary to the staff complement on their own ward, but were expected to be involved in routine nursing duties unless required.

The Trust comprised five directorates over the three hospitals, each with a NM, who found the size of the directorates difficult to manage. As noted above, one NM in the district general hospital was responsible for managing 13 different clinical specialties, which she described as being 'half the hospital'. All of the directorates contained a number of different clinical specialties and the community hospitals each had a NM responsible for all of the specialties in that hospital. Although each had their own clinical background and area of interest, neither found it a problem to be responsible for other clinical areas as they felt that their clinical expertise was not a requirement of their role.

It was also recognised by staff that the geographical location and spread of the Trust led to difficulties with communication between hospitals and in providing Trust wide education or providing access to national education activities. Within each Trust site, communication was said to be good, but staff in the community hospitals felt isolated and often 'out of touch' with what some staff called 'headquarters', that is the District General hospital. Much of the communication took place by email, with electronic newsletters being sent out to staff each month. Their ability to access these varied.

Communication within directorates was limited to clinical specialties, each operating as an individual unit, and there was little communication with other specialties. Although the directorates were organised on clinical themes, such as surgery or medicine, within each specialty, for example, acute surgery, orthopaedics or theatres operated entirely separately. Even two general surgical wards worked independently from the other.

Nurses had access to statutory education updates within the Trust and educational opportunities outwith the Trust were supported and encouraged. The practice development unit also had links to the local university providing undergraduate nurse education, through joint posts and link posts.

Despite the structures for progressing clinical governance and developing practice in the Trust, the CSBS noted that the Trust had no strategy for clinical governance and that it was not seen by staff to be an integral part of either management or practice.

While staff in the practice development unit were immersed in trying to progress practice and saw some links to clinical governance, these may not have been clear to all staff. The CSBS findings may also reflect the existence of teams such as a clinical governance team and a practice development team, which lacked formal links and coherent plans for all aspects of clinical governance, not just EBP. The Trust was trying to address this by the time of this study.

### ***Case A, in sum***

The above section has shown that Case A had specific structures in place dedicated to practice development and also had staff with specific practice development and EBPI roles. In addition, the joint NM/CNS posts were seen as having an important role in EBPI. Although the Trust covered a wide geographical area, the NMs were supported by the Director of Nursing who saw them as having a significant role in nursing. A more detailed exploration of this and other issues related to EBPI is provided in the cross-case analysis at the end of this chapter.

### **Case introduction: Case B**

#### ***Organisational setting and structure***

The Trust provided health care to a mixed rural and urban population. The complement of acute medical and surgical beds in 2003 was approximately 600. Services were provided from two District General hospitals, within easy travelling distance of each other. These were two separate Trusts prior to 1999. They had previously developed different services and the legacy of this remained today. Different management styles had been in operation in the two Trusts and this had also had a lasting impact on the current Trust. Staff described differences in structure, culture, development of services and variations in practice between the two. Trust headquarters were based on one site but the clinical directorates covered both hospitals. Nurses were based in one or other hospital, but more senior staff, such as NMs and some practice development nurses worked in both hospitals. Figure 4.2 overleaf, outlines the organisation of the Trusts in relation to nursing and EBP structures.

The Director of Nursing was an equal member of the Trust management board. Information from the board was disseminated via the Director of Nursing to the NMs

and information from them fed back to the board via the Director of Nursing. There were four clinical directorate NMs, with the directorates and therefore the NMs, covering both hospitals, although they were based in one or the other. They described their roles as operational management, but did not include management of the clinical areas. This was the sole responsibility of the charge nurses, who had devolved budgets and also had out of hours 'on call' responsibilities to provide cover for the NM at evenings and weekends, as in Case A.

The Trust had a small practice development unit, which had recently undergone restructuring as a result of the resignation of the two previous practice development nurses. With one senior practice development nurse (H grade, a grade between charge nurse and NM) in charge of the unit and responsible for developing a strategic plan for practice development, the other three nurses were responsible for different aspects of practice development. One was based in one hospital and worked only from this base, another in the other hospital and worked only from her base and the third had a remit that involved both sites. She was responsible for implementing EBP and in particular had to focus on the implementation of NMPDU best practice statements. There was no overlap of the work undertaken by the staff and they had no plans to develop any generic areas of work. The new posts had been created to reflect the changing educational needs of staff, largely to accommodate expanding nursing roles to meet the needs of the changes to junior doctor hours. Of the other two practice development nurses, one was responsible for education, in particular, the provision of clinical skills updates (such as venepuncture and cardiopulmonary resuscitation skills) and the education of health care assistants. The remaining practice development nurse (formerly a NM within the Trust) described a less clear remit, but explained that her role involved updating procedures and nursing protocols and ensuring that practice was up to date. The main focus of the unit at the time this Trust was visited, was to concentrate on building the new staff team and appraising the work undertaken previously.

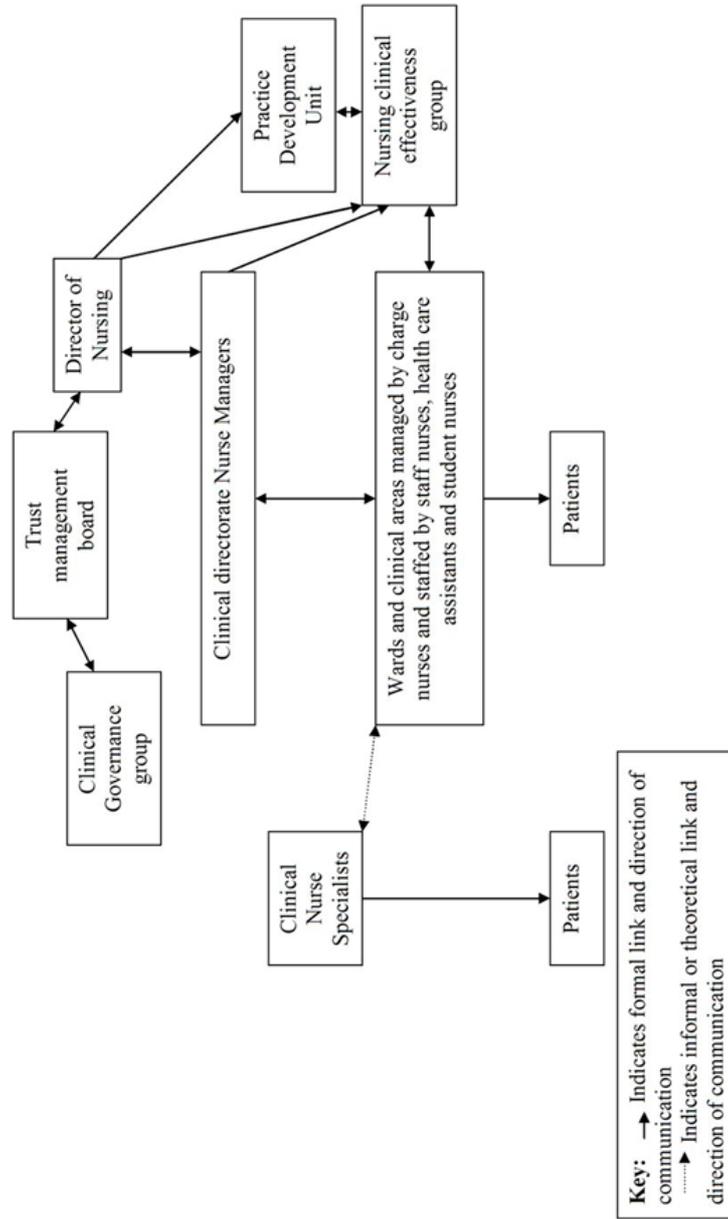
Staff from the practice development unit did not have automatic access to wards, but required permission or an invitation from the charge nurses to go onto the wards. However, some dialogue between them was possible through the nursing clinical effectiveness group. This group was attended by the Director of Nursing, NMs (when

work demands allowed), at least the senior practice development nurse (and the others when work demands allowed) and charge nurses or staff nurses nominated to represent their ward or clinical area. While attendance at the group was not compulsory, according to practice development nurses, it was encouraged. None of the staff interviewed were able to give a clear explanation of the purpose of the group, except that it concerned nursing issues, relating to improving or updating practice and that it was not linked to the wider Trust clinical effectiveness group, which was a subset of clinical governance staff. It was not thought by the staff interviewed to be involved in EBPI. The CSBS described the Trust clinical governance structure as 'robust', but it was entirely separate from the nursing structure. Not only was there a lack of overlap or connection between the two, but there was some duplication, such as the nursing clinical effectiveness group described above and a separate clinical effectiveness group for other staff. Many of the staff interviewed in Case B remarked that multi-disciplinary working in the Trust was non-existent. One member of the clinical governance team interviewed did not see himself as having a role in EBPI and had no links to nursing within the Trust.

The Trust clinical governance group represented a substantial structure in itself comprising, for example, clinical effectiveness co-ordinator posts, health and safety officers, audit co-ordinators and a number of clerical support staff. None of the staff were nurses or had a nursing background.

CNSs within the Trust were not managed through the nursing structure and their posts were financed through clinical directorates, rather than from the nursing budget. CNSs worked within their specialty, most closely with medical consultants and had no formal links with ward nurses. They had their own caseloads of patients and while ward staff could in theory, access their expertise, this rarely happened as they had no way of knowing who to contact, or how to contact them. NMs viewed them as a lost resource as they were not seen as actively trying to integrate with ward nurses. It was not possible to interview any CNSs as the Director of Nursing did not consider them to have a role in implementing EBP within the Trust.

Figure 4.2: Case B organisation chart



### *Other aspects of inner context*

The Trust had some difficulties with recruitment and retention of nursing staff in both hospitals, thought by the Director of Nursing to be due to the relative proximity and competition of large teaching hospitals in other regions. Apart from the problems of filling main grade nursing vacancies, this had had an impact on their ability to fill NM posts and to retain staff in these posts for any length of time. This in turn led to nurses 'acting up' in senior posts for long spells, which then had repercussions at ward level, increasing staff shortages there. The two NMs interviewed had only been in post for three months, after the posts had been vacant for some considerable time, although one had worked in the Trust as a charge nurse prior to her appointment as NM.

NM posts had been abolished in 1996, but were re-introduced by the (then) new Director of Nursing in 1999. According to her, the NM posts were the same across the directorates in terms of their roles and responsibilities, however the post holders described their roles in varied terms with only some broad overlap. For example, the surgical NM described her role as being operational, that is, it related to ensuring that there was adequate nursing staff cover for each shift, trying to fill nursing vacancies, retaining an interest in practice by encouraging charge nurses to 'use' her as a resource (although she did admit that her knowledge was quite specialised), providing induction programmes for all grades of new staff and administration tasks which comprised a large part of her workload.

Her medical counterpart, described her role as strategic, working with the Director of Nursing to plan the development of nursing for the Trust, developing new nursing roles and seeking funding for these, taking an interest in practice development (her previous post in another Trust had involved nursing protocol and guideline development) and undertaking administrative tasks relating to the directorate. Neither post involved EBPI activities.

The Trust recognised the challenges of making and sustaining communication links between the hospitals. This had been hampered by the pre-merger separate information technology teams responsible for communication and the problems resulting from these remained unresolved four years later at the time the Trust was visited. Most of the communication within the nursing hierarchy took place at

meetings with written communication being disseminated via what staff described as a matrix system. Although this system was also noted by the CSBS as the main way by which clinical governance information was disseminated, staff were not able to describe this more fully or to provide a written example of this. This appeared to be effective within each hospital, but communication between the two remained problematic.

Nurses had no opportunities to access education outwith the Trust unless funded by themselves and undertaken in their own time, as this was not supported by the Director of Nursing. Education provided from within the Trust was mainly related to statutory updates of essential clinical skills. The practice development nurse responsible for education had to give priority to the education of health care assistants, to ensure that they had the practical skills necessary for work in the clinical area. Links to local education providers were not as formal as in previous years, with link nurse posts and joint appointments not being filled.

While EBP was mentioned by all of the practice development nurses, it was largely seen as the remit of the one nurse employed to implement EBP throughout the Trust and was not seen as a corporate responsibility. The Director of Nursing saw EBP as being related to research and felt that there was not a research culture within the Trust although she did view the Trust as providing good basic care. However the CSBS noted that due to the inadequacy of data information systems, it was difficult for the Trust to demonstrate the delivery of care of adequate quality. There were also specific challenges for the Trust relating to the implementation of initiatives (not specifically related to EBP, but for example, the results of a large patient survey), problems with planning and managing under-performance, learning from significant events and the need to improve staff communication skills as a matter of urgency. Each area was seen by the CSBS as needing attention and so the Trust had some significant challenges to address.

### ***Case B, in sum***

The above section has shown that although a more compact Trust than Case A, challenges for EBPI still existed. A practice development unit and the allocation of specific roles for EBPI existed alongside clinical effectiveness groups. The NM role

was seen by the Director of Nursing as important. The CSBS reviews highlighted some specific challenges for the Trust in relation to communication and implementation of initiatives and a need to focus on implementing national guidelines, rather than just disseminating them.

### **Case introduction: Case C**

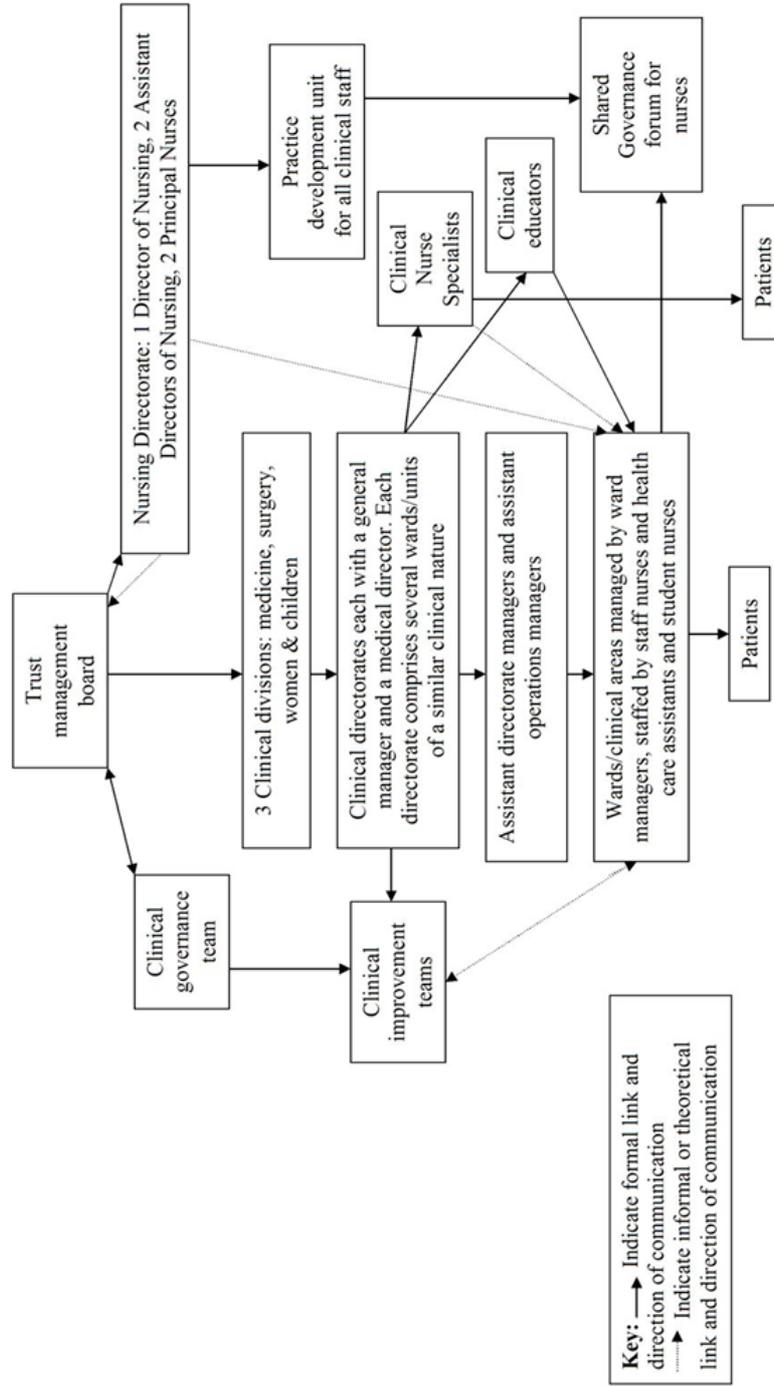
#### ***Organisational setting and structure***

This Trust provided health care to a large urban population and comprised seven hospitals, formerly part of three separate Trusts, the amalgamation of which was described by one of the principal nurses as *'not so much a merger as a major upheaval'*. In 2003 the complement of acute medical and surgical beds throughout Case C was approximately 2000. With the Trust merger in 1999 services were reconfigured to avoid duplication and staff were given the option of moving hospital base to remain within the same specialty or changing specialty to remain within the same hospital base. The complex organisational structure as it related to nursing is shown in Figure 4.3 overleaf.

The Director of Nursing, although a member of the Trust board, did not have equal status to that of other members. She explained that her role was one of 'advisor' and that other members of the board were not obliged to act upon her advice. While she received information from the board, she was not in a position to represent nursing at board level in her advisory capacity. Two assistant directors of nursing were in post, each based in one of the large hospitals in the Trust, but with remits that covered all sites.

The structure of the nursing hierarchy had changed considerably after the Trust mergers with the creation of two new senior nursing posts, those of principal nurse, and the introduction of a divisional level above that of directorates. The divisions were large groups of directorates, medicine, surgery and women and children's health. Each principal nurse was responsible for one division and both were based in separate hospitals, the largest two in the Trust (the third clinical division was overseen by a senior midwife in a different hospital and was not the subject of this research). This structure was not at all clear to the staff interviewed and was further complicated by

Figure 4.3: Case C organisation chart



the number of different titles used to describe the same posts in different divisions and directorates.

The principal nurses had strategic roles involving nursing and nursing development and also had a role overseeing the professional aspects of nursing practice and nurses within their divisions. For example, concerns about professional conduct or a complaint against a nurse would be investigated not by their line manager, but by the principal nurse. This resulted from the way in which the clinical directorates were managed. Each had a clinical director, who was a doctor and an assistant directorate manager (in the medical directorate) or an assistant operations manager (in the surgical directorate) who did not necessarily have a nursing background as it was not seen as necessary for the post. Although their job titles varied, their roles were similar. While many of the post holders were nurses and had previously been NMs when the posts existed in the Trusts, this was not necessarily so. The staff interviewed in Case C held equivalent positions in the Trusts to those in the other cases, in that they were line managers of nurses above ward level and below Director of Nursing level. The differences in job title between the directorates did not denote any differences in role or responsibilities. To reduce the complications arising from the use of additional terms and to facilitate contrast and comparison across the cases, the term nurse manager has been used to describe these post holders in Case C.

The ways in which these changes to NM posts had taken place were reflected in the way that several staff described them and the strength of the feelings that these had evoked were still evident:

*'I was told that I was going to lose my clinical nurse manager status because a nursing qualification wasn't needed for a management job. It's like saying that everything you've worked for all your life is useless and valueless'. (NM)*

*'We weren't given a choice really, I was just told that I was being moved from my clinical specialty in [hospital named] to manage in a different directorate in a different hospital. It was a 'take it or leave it' situation. There was no regard for clinical experience or interest, because we were*

*told they weren't needed for management. The way the whole thing was handled left a bitter after taste for me'. (NM)*

*'I had to get the union involved because I was told that I'd have to take a cut in pay. I was on an I grade as a CNM, but we were being swapped over to general management scales and I would have lost out. I was told that nursing experience wasn't necessary or relevant to the new post. However, the union said that 95% of what I'd be doing was managing nurses, so my appeal was upheld. I did OK out of it, but not everyone did and it caused a lot of divisiveness and ill feeling for a long time afterwards. I was practically ostracised by some of my former colleagues, it didn't make for good working relationships'. (NM)*

*'I was called to a meeting with my boss, out of the blue. None of us had seen it coming. Before I'd even sat down he said "CNM posts are being done away with". I mean, it was such a graphic choice of phrase and that was how it felt really, 'done away with'. He went on to say that I didn't have to be a nurse to manage nurses, in fact that it was a "sheer fluke" that I was, it was irrelevant. It really was a return to the ruthless Thatcherite management style of the '80s'. (NM)*

NMs from both directorates described their roles as operational, in that they did not have clinical responsibilities and although they held the budgets for the wards and clinical areas that they managed, they were not involved in practice issues other than ensuring that there were adequate staff available or liaising with other assistant directorate managers if there was a lack of beds available for patients.

Wards and clinical areas were managed by ward managers or charge nurses (same role but different titles in different directorates), who had previously held the budgets for their own wards until these had been withdrawn as a means of managing the considerable Trust financial deficit when the current Chief Executive had taken up his post. As in Cases A and B, charge nurses had 'acting up' responsibilities for the NMs out of hours.

The Trust had previously had a large and (in the eyes of its staff) successful practice development unit. It comprised a senior nurse and four other practice development nurses, each with a different focus, for example, co-ordinating and monitoring nursing research, providing education for health care assistants, providing education for junior medical staff or developing higher education modules related to practice and practice issues in conjunction with local universities. Information came into the unit through the nursing directorate, although both the Director of Nursing and the unit staff recognised that this link was not always successful in this regard. The staff had worked closely with former clinical educators who worked in the clinical areas, supporting them and providing them with education and information relating to current practice and new developments and saw this as a valuable two way link. However, due to a change in Trust policy the clinical educator posts were abolished as a means of achieving cost savings and this close link between the unit and practising nurses ceased. All staff saw this as a loss, particularly those working in practice development, as it was a role that was seen as crucial in progressing EBP. Although the role of the clinical educator had been abolished in 1999, the medical directorate had re-introduced two posts (both in different hospitals) in 2002. This had been possible through the successful application to the Scottish Executive for practice development funding. This reflected the value that was placed on the role, but the focus of this had changed considerably. The new post holders had a remit that reflected Scottish Executive policy aims, to work with student nurses and to support newly qualified staff nurses on wards. They were no longer responsible for introducing EBP or identifying areas of practice for improvement. They had no links to the nursing directorate nor the practice development unit.

The practice development unit had also recently undergone a restructuring, changing its focus from education and practice to the provision of skills training and updating. The changes to junior doctors hours through the implementation of 'New Deal' working practices had placed a considerable burden on nurses to absorb many of the clinical tasks previously undertaken by them. This in turn, had necessitated the provision of training in these skills and for regular updating of these and similar skills required for practice. The staff were of the belief that they had no responsibility for EBPI or to identify areas of practice which had scope for development. They saw their new roles as ones of teaching clinical skills and ensuring that these were updated

regularly. In a Trust of this size, this would be a full time job for the practice development nurses, without other responsibilities.

Re-organisation of the Trust structure had seen the development of a shared governance forum in 2001, comprising three councils: research and development, quality and clinical effectiveness. The Director of Nursing considered it to have been successful in one of the previous Trusts as a way of nurses developing EBP. This was solely a nursing initiative and it was not clear how this linked into other initiatives in the Trust such as the clinical governance team or the clinical improvement teams within the directorates. Neither did it appear to have any formal links to the practice development unit, although one practice development nurse led the research and development council. Initial enthusiasm for the shared governance forum had waned and it was no longer meeting. It had not been as successful as hoped in relation to progressing the EBP agenda for or by nurses.

As the shared governance forum disintegrated, a new means of involving staff in EBP was beginning, the clinical improvement teams. While these were described as new by staff interviewed, the CSBS reports show that these had been in place for at least 18 months, by the time this Trust was visited for this study. Each directorate had formed a team, led by the clinical director. While these teams were aiming to involve all staff, including ward nurses, it was not possible to interview any nurses involved, as no-one could identify any. Practice development nurses saw these teams as very '*medically orientated*'. The hope was that these teams would know the clinical issues that were important to them and could work with the clinical governance team's guidance to identify practice that needed to become more evidence-based. The rest of the process was vague, as it had not yet been fully operationalised, but the Director of Nursing suggested that it might involve writing protocols for all staff to adhere to, or producing guidelines for practice.

Other than the theoretical link between the wards and the clinical improvement teams and clinical governance team, there were no formal links between nursing and the clinical governance team. The principal nurse for the surgical directorate had a theoretical role as Chair of the clinical governance team and as a link between it and nursing. However she explained that she had never acted in this capacity and the role

of Chair had been adopted by the medical director of the clinical governance team and the clinical improvement teams worked entirely independently.

Each directorate also had CNSs working within it, although their link was not to the nursing hierarchy, but with the medical staff or clinical director. As in other Trusts, the development of these posts had been driven by medical staff and as a result, these nurses remained more closely allied to medicine. They had their own case load of patients and had few links with wards, although they might attend medical ward rounds. The demands of their own roles meant that for many, it was impossible to have closer links to wards. For example, the tissue viability nurse specialist, whose role encompassed a number of clinical areas, was geographically remote from many of these wards, as a result of her office base and this necessitated a considerable amount of travelling to see patients throughout the Trust.

The organisational complexity of this case was further exacerbated by the number of hospitals in the Trust. Staff could be based in any of the seven hospitals and many worked between several, although had an office base in one. The extreme financial situation in which the Trust was operating had impacted on the way in which it was able to approach EBPI, for example, abolition of posts and the re-development of the practice development unit.

### ***Other aspects of inner context***

The Trust was suffering from the consequences of '*a continual and serious overspend*'. (Director of Nursing). As a result it had been told by the Scottish Executive that it must find ways of saving a million pounds from the nursing budget alone and the decision had been made to lose posts as a means of achieving this. In some ways this was relatively straightforward as recruitment to all levels and types of post was a significant challenge in this Trust. As a result they had a considerable number of nursing vacancies. This was thought by senior nurses to be the result of changes to the main hospital site and the lack of affordable housing in the area for staff. The Director of Nursing had tried to tackle this by offering staff very flexible working patterns, but with limited success. There were also vacancies at management level, with staff 'acting up' in posts and there was a significant turnover of staff at this level, including three new Chief Executives within six years. This lack of continuity

had had repercussions throughout the Trust in terms of the number of re-organisations that had taken place. The Director of Nursing had been in post since 2000, having been in the same position in one of the former Trusts previously, she had been approached to apply for the post which had been vacant for some time.

Due to financial constraints, no outside education could be funded through the Trust, but prior to the re-organisation of the practice development unit, post-registration modules and higher education modules had been provided on a shared basis by the Trust and a local university, at a reduced cost.

The most significant challenge for this Trust was the number of hospitals brought together under the merger. Problems had arisen from the differences in previous structures, cultures and styles of management. Trust-wide change had been very slow and had been hampered by vacancies at senior management level and the number of new chief executives. Many nurses felt that they had not been, and were still not, working in a culture that valued nursing. This was acknowledged by the Director of Nursing who explained that she had fought to re-introduce NM posts, with the emphasis being on the need for postholders to be nurses, as she felt that it was vital for nursing, but she had been unsuccessful.

Problems relating to communication and the lack of a consistent approach to care were highlighted by the CSBS and this was borne out in interviews with staff. There were no clear lines of verbal or written communication within the nursing hierarchy. Staff were clearly struggling to grasp the Trust structure and this has been exacerbated by the number of recent re-organisations within a relatively short period of time.

### *Case C, in sum*

Case C was a large Trust with a complex organisational structure, further complicated by the number of different titles in use to describe the same roles. It had no clinical NM posts, with nurses being line managed by staff who did not necessarily have a nursing background. These NMs were still responsible for aspects of clinical care, but not professional nursing issues. The practice development unit had undergone a recent re-organisation, removing much of their EBPI focus and giving them a greater responsibility for education and training. A shared governance forum introduced to

facilitate EBPI had fallen into abeyance and directorate based clinical improvement teams had been developed to progress EBPI. The CSBS reviews highlighted a number of challenges for the Trust in relation to communication and a need to focus on better dissemination of clinical guidelines as well as considering implementation strategies.

## **Case introduction: Case D**

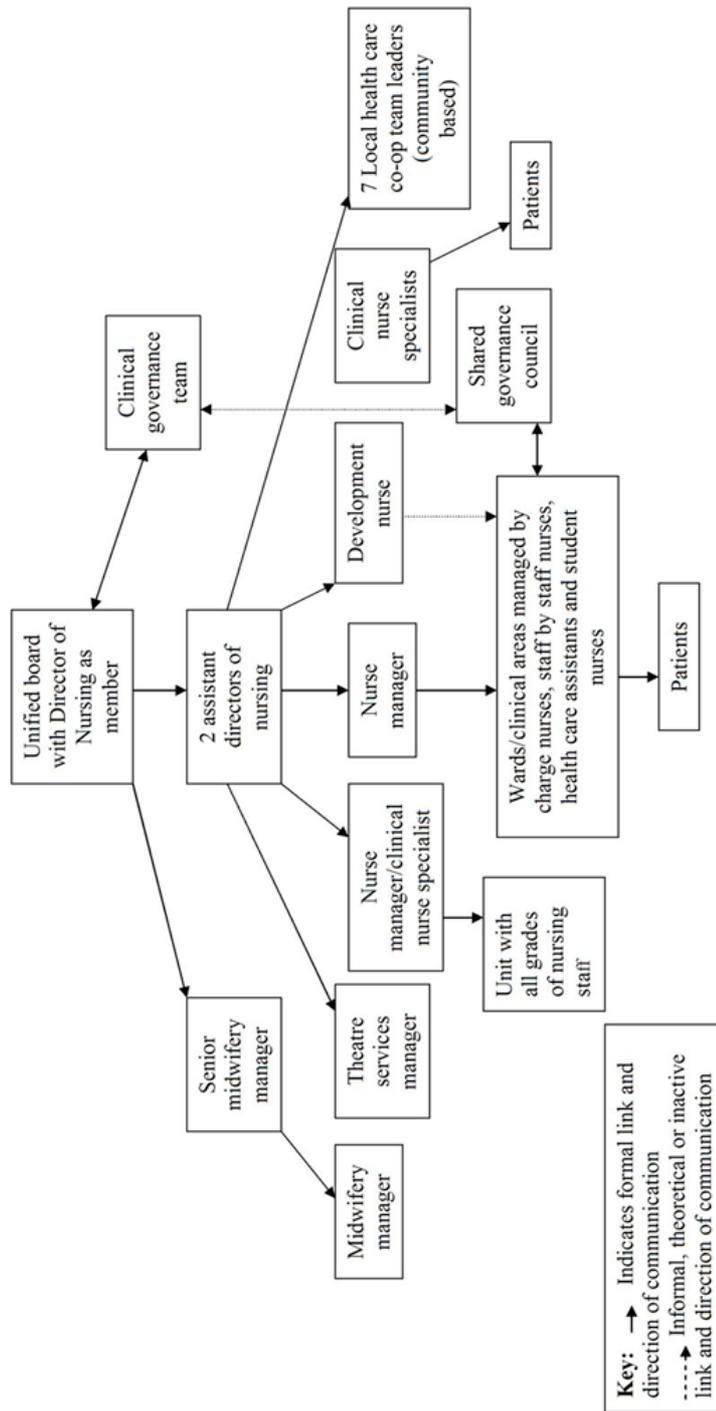
### ***Organisational setting and structure***

Trust D ceased to be a Trust in the same sense as Cases A-C in April 2003, having become one of the first unified Health Boards, after merging with the local Primary Care Trust. Prior to this, there had been no merger in 1999 and this had provided a long period of stability, but the unification had brought with it many of the changes that other Trusts had faced as a result of the 1999 mergers. This research only focuses on the acute aspects of the Trust and did not involve any of the community staff who had been part of the recent merger.

The Trust provided health care across a wide, largely rural area. It comprised two hospitals, one District General hospital and one community hospital, both of which functioned entirely independently of each other as a result of geographical distance. The complement of acute medical and surgical beds available in the Trust in 2003 was approximately 300. Staff worked only in one site or the other. The organisational structure of the Trust can be seen in Figure 4.4 overleaf.

Staff described the organisational hierarchy as 'flat' and in contrast to Case C, it was much less complex. The unified board, comprising members of the former acute and primary care Trusts, had the Director of Nursing as an equal member. Two assistant director of nursing posts had been newly created at the merger and so both post-holders were new to their roles although both had previously worked in the Trust. They had large strategic development portfolios, encompassing both acute and primary care. A senior midwifery manager, at the same level, was responsible for strategic management of midwifery services and managed a midwifery manager. The two assistant directors of nursing had nine managers responsible to them, seven of which were community based. Within the hospital, there was a manager responsible for theatre services and one NM, who was responsible for overseeing operational management of wards and clinical areas.

Figure 4.4: Case D organisation chart



As in the other Cases A and B, charge nurses were responsible for the ward budgets and for providing 'out of hours' NM cover, such as arranging staff cover, managing bed shortages or dealing with large scale emergencies until more senior staff arrived on site.

There was also one joint NM/CNS post in the renal unit, where the post holder managed a small team of charge nurses, staff nurses and health care assistants, as well as having specialist clinical input and working closely with medical colleagues.

The Trust had no practice development unit, and although it had previously had one practice development nurse and one practice development midwife (this post still existed), the nurse had been promoted to assistant director of nursing and it was not thought to be necessary to maintain the post. A development nurse, a former clinical teacher, (until the post became obsolete many years before), had the principal role for developing policies, protocols, procedures and guidelines for nursing in the Trust. This was a very part-time post (6 hours per week). She had no role in implementing or monitoring these. She was, in theory, managed by one of the assistant directors of nursing, but had no formal links to either the wards or clinical areas, the shared governance forum or the clinical governance team. She worked entirely independently and her manager felt that due to her inexperience and the considerably greater experience of the development nurse, it was not really possible to 'manage' her in any real sense.

The clinical governance team was entirely separate from the nursing structures within the Trust, although the clinical governance director did have the right to sanction or veto any work produced by the nursing shared governance forum. This forum, comprising three councils, had been initiated as a means of involving ward nurses in developing practice. Introduced in 2001 it had been seen as the main way of developing EBP. The forum was run entirely by nurses, although the chairperson did attend clinical governance team meetings, as necessary. Efforts to involve medical and other staff, such as physiotherapists and occupational therapists, had been unsuccessful as they viewed it as a nursing forum. All staff interviewed admitted that they had had very limited success overall and after the initial enthusiasm dissipated it had proved difficult to maintain the forum. Some evidence-based products developed

by the forum had not been accepted by the clinical governance team as suitable for implementation throughout the hospital. At the time the Trust was visited, the shared governance councils and therefore the overall forum were all in abeyance.

At the time this case was visited, one assistant director of nursing explained that as a Trust their priority was to adjust to the changes in structures and working arrangements, rather than focus on EBP.

Nurses had limited access to educational updates and courses. A few nurses had been supported to complete MSc in Nursing degrees, with the finance and time being shared between the Trust and the nurse. Arrangements with the nearest (although not particularly local) university gave access to individual modules and while there had been some finance to support this, staff had been told that this would not be sustainable after the merger.

Prior to unification, the Trust had no electronic communication infrastructure. This had been recently introduced and staff were confident that it would bring about significant improvements. The lack of electronic communication was also given as an explanation of why the two hospitals worked so separately from one another.

The introduction of the unified board brought about significant changes to the NM structure and personnel: although some had worked in the hospital for a number of years, all were very new to their current posts at the time this Trust was visited.

Senior hospital managers had all been in post for a number of years, including the Director of Nursing who had been in post for 10 years and had only ever worked within the hospital. One of the changes resulting from unification was a move of office base for the Director of Nursing and staff were concerned that this would lead to an even greater distance developing between the Director of Nursing and themselves in practice.

NM posts had existed for as long as anyone could remember, the original four posts had gradually been reduced to one covering the entire District General hospital (managing 900 whole time equivalent nursing staff). While this post remained and

the NM who held the post prior to the restructuring was still in post, it was not possible to interview this NM due to long term sickness. Staff co-ordinating research access felt that it would not be beneficial to interview any staff in the new posts as they had not previously worked within the Trust and their roles were different to that of the NM. Despite the length of time that there had been a NM in post, nurses were largely unaware of what the role involved.

#### ***Case D, in sum***

The Trust was very much still coming to terms with the significant changes brought about as a result of the unification. As such, EBP was not considered to be a current priority for them. Despite the inability to secure interviews with either the Director of Nursing or any of the NMs it was still possible to obtain rich data relating to EBPI in the past and the role of the NM in this from interviews with other staff. The Trust had no practice development unit and the shared governance forum, developed to progress EBPI in nursing, was in abeyance at the time the Trust was visited.

### **CROSS-CASE COMPARISON OF CONTEXTUAL FACTORS**

The brief case descriptions have provided an overview of each case and serve as a background to consider EBPI and the role of the NM in more detail. A cross-case analysis of contextual factors follows, highlighting the contrasts and comparisons between cases, building on and adding to the data already presented. It is subdivided into themes derived inductively from the data: organisational factors and the management-practice gap. These focus on contextual factors in relation to the ability of NMs to engage with EBPI. By way of an introduction, Table 4.1, highlights the main points of contrast between the cases.

#### ***Organisational factors***

Each of the cases had undergone some type of organisational re-structuring in their recent history and staff recognised the impact that this had had on their ability to concentrate on EBP. This was a significant problem in Case C, where they had not only faced wholesale changes due to the substantial mergers in 1999, but also had to come to terms with three new Chief Executives in six years, each of whom had brought fresh ideas for the organisation and service redesign. As a result staff spoke of ‘...*putting evidence-based practice on hold*’ (NM) while they came to terms with

the changes taking place under service re-design. In Case D, staff also spoke of EBP not being important for them at that time as they had new roles and responsibilities to adapt to, '*...evidence-based practice just isn't a priority for us at the moment*'. (NM) In Cases A and B, where there had been relative stability, they seemed more able to focus on EBP as part of everyday work, that is to say, it did not have to compete with large scale organisational change for staff time or energy.

However, problems with recruitment and retention of staff also had an impact on their ability to engage with EBP and this was particularly noticeable in Cases B and C where both were a problem. In both sites vacancies at senior level were filled on a temporary basis by staff 'acting up' in the post until it was filled. This led to vacancies further down the nursing hierarchy, most often at ward level, where staff could not be spared to be involved in EBP related activities or educational opportunities. This left staff with no capacity to take on anything that they considered an addition to the day to day work of patient care. With no time available within work to take the EBP agenda forward several staff recognised that it would fall to them personally to do so '*...as usual it'll all have to be done on a shoestring and on my own time*'. (CNS, Acting NM). Staff in all cases who were or had been involved in EBP, mentioned the amount of time they had spent out of work hours working on this. There was a general feeling that while this was unacceptable and should not be expected of them, it was sustainable in the short term. This reliance on staff to undertake work in their own time was a means of achieving EBP in all the cases. Although Case D had seen relatively long periods of stability as an organisation and also within nursing management and did not report any difficulties with recruitment or retention of staff, they did appear to have some difficulties with succession planning in relation to EBPI. In addition, the nurse who held the position of Chair of the shared governance forum was into her third term of office, against her will, because '*...no-one else wants the job*'. (CNS).

Staff changes in Case B had also had an impact on EBP: when a former practice development nurse left her post, other staff were not able to continue her previous work and this had led to a re-organisation of the entire practice development unit. In Case A stability of nursing management and a stable and well qualified nursing workforce was recognised as being an advantage. However their greatest problem in

**Table 4.1: Summary of contrasting contextual factors**

<b>Organisational factors</b>	<b>Case A</b>	<b>Case B</b>	<b>Case C</b>	<b>Case D</b>
	Stable senior nursing management & NMs	Stable senior nursing management	Several major changes in senior Trust and nursing management in recent years.	Stability in senior management & nursing management.
	Stable nursing workforce 1999 merger had little obvious impact	Difficulties with recruitment and retention of all grades of nurse and NMs. Current NMs newly in post	Ongoing organisational change due to the above.	Stable nursing workforce No 1999 merger, but 2003 unification of Acute and Primary Care Trusts.
	Challenges of geography of Trust	1999 merger had brought challenges due to different cultures and management approaches. Ongoing impact of these.	Difficulties with recruitment and retention to all grades of nursing post. Non-clinical NMs in post	Re-organisation of nurse management structure to accommodate changes resulting from unification. Challenges of geography of Trust.
			1999 merger had been complex and had a lasting impact due to the number of Trusts and hospitals involved.	



**Management-practice gap**

**Case A**

Increasing specialisation of wards and increasing generalisation of management

NMs responsible for large disparate areas of care

Credibility gap between management and practice

NM/CNS bridging gap in their own area of practice

**Case B**

Difficulties of managing directorates across sites acknowledged by NMs and seen by them as significant

Increasing specialisation of practice and generalisation of management

**Case C**

Non-clinical NMs seen as a significant hindrance by nurses and NMs.

Credibility gap between nursing and NMs

Different priorities for nursing and NMs

Increasing specialisation of practice and generalisation of management

Difficulties of managing large directorates over more than one site

**Case D**

Concerns expressed by nurses that NMs are 'afraid' of more highly qualified nurses

Concerns that changes to NM structure would further distance NMs from practice

Different priorities for nurses and NMs

NM/CNS bridging gap in their own areas of practice



relation to organisational factors was the geographical spread of the Trust. In Cases A, B and C there were problems of duplication of effort in all the hospitals within the Trusts, although this was not necessarily recognised by them. Some of this predated the mergers, but some was specifically related to EBP and this had become apparent after the mergers had taken place. In Case C, nurses in different hospitals were working on the same tasks, for example, updating clinical skills, but although they were all working within the same Trust, there was no connection between their work. They were unaware of the work being undertaken by their colleagues.

To some extent the isolated nature of each individual hospital, even within the same Trust, was explained by staff as due to differences in culture. Culture was also seen as important by the Director of Nursing in Case B who felt that one of the difficulties relating to the development of EBP within the Trust was that there was '*...not much of a research culture here, but we're good at the bread and butter care*'. She also admitted that she had no knowledge of, or interest in research herself. The attitude of NMs and the Director of Nursing to EBP was important and was acknowledged by staff as being positive in Case A and less so in Case D. Staff in B and D were unaware of the attitude of either their NMs or the Director of Nursing to EBP.

In each case there were organisational structures in place to progress EBPI. Some of these, such as clinical governance teams, were a requirement of NHS Quality Improvement Scotland, while others such as the shared governance forums in place in Cases C and D had been chosen by NMs as a means of progressing the EBP agenda. Cases A, B and C also had a practice development unit, although these varied considerably in size (i.e. the number of staff in the unit) and in their remits. Each case also had CNSs in post, many of whom were involved in developing evidence-based products. The links between each of these structures were rarely clear, although in Case A, the practice development unit had considerable influence and more of a co-ordinating role, and staff from the unit were also involved in, for example, the clinical governance team or would be asked to contribute to meetings of other groups that concerned their particular remit. In the other cases there appeared to be little internal communication between these structures and although all of the Trusts were able to provide or draw diagrams of how these fitted together, staff did not have a clear idea of this. The remit of the practice development unit in Case C had recently changed

considerably and it was no longer involved in EBP, instead having a much greater role in staff training and skills updating. The clinical improvement teams set up to take forward the development and implementation of EBP within directorates were very new and it was not possible to conclude how effective they would be in this task.

### **The management-practice gap**

In all cases there was evidence of increasing specialisation of clinical areas. In the past most medical wards were general, caring for patients with a range of conditions. However more and more it appeared that this was no longer the case. For example a charge nurse in Case A described his medical ward as specialising in rheumatology and diabetes. Staff from surgical wards described the same phenomenon. At the same time NMs described how their role had changed over the years from managing quite discrete specialised areas of care to managing large areas with a wide range of specialties included, often bearing no relation to each other. While some NMs saw this as an opportunity to learn about the wider organisation, others found it daunting:

*'I now cover half the hospital, I can't possibly be expected to know everything about 13 different specialties, none of which was my own clinical background' .(NM)*

Ward staff in all cases suggested that NMs were not in touch with clinical practice and were not able to know about day to day ward life as a result of the number of wards that they covered. In Case A one NM felt that the staff most likely to make evidence-based changes to practice would be students and newly qualified nurses. In reality they are the least empowered of all staff and this suggests that there is a knowledge gap between the realities of management and practice.

The pace at which practice is changing was also cited as a contributing factor to the gap between management and practice, or NMs and practice. Several staff spoke of the need to have additional educational qualifications in the clinical area to keep abreast of changes and suggested that many charge nurses would be more highly qualified and more knowledgeable about EBP than their managers:

*‘...I sometimes feel that some of the nurse managers or higher grade staff sometimes feel quite threatened by the fact that some of the more junior members of staff are more proactive, have a good knowledge base and are keen to get on. I know a lot of staff here have done degrees and other qualifications and some of the more traditional managers feel quite threatened’.* (Charge nurse)

In Cases A, C and D some nurses felt that the lack of clinical credibility would be a barrier to them approaching their NMs for help and even staff who were experiencing difficulties in relation to EBP had not sought the help of their NM either because they did not consider this necessary or helpful.

Despite this, the NMs were often the formal link between management and practice, by dint of their position within the nursing hierarchy. This often involved activities specifically related to EBP, such as being involved in shared governance meetings, charge nurses meetings or through informal links with practice development staff.

In Cases B, C and D, staff felt that one of the biggest problems relating to the gap between management and practice was due to their differing priorities. Those of practice were described as ‘getting the job done’ and having access to education and to clinical skills development, whereas for NMs, their desire was to achieve organisational goals, survive re-organisation (i.e. still have a job at the end of it), meet financial targets and be ready for the CSBS visits. EBP was not on either agenda.

CNSs, as noted above, were the most autonomous staff and the most likely to be involved in EBP. However due to the historical development of their role, most were managed by medical consultants and were not tied into the nursing hierarchy. As a result they were considered by several managers, in all sites to be, ‘...lost to nursing’ (NM). NMs were not able to access their considerable expertise and in Cases B and C the ward staff did not have access to this either. Although no formal links existed in Cases A and D between the CNSs and ward staff, personal networks and hospital size were seen as facilitating good relationships between some CNSs and ward nurses. However these were not the only factors which impacted on these networks as Case B

was also a compact Trust with modest sized hospitals and yet no such networks existed.

The impact of the changes to the NM role which had taken place in all sites during the 1990s had affected the way in which the roles had subsequently developed. Cases A,B and C had been without NMs for a number of years, before the re-introduction of the role in Cases A and B, though not in C. In Case D, NMs had remained in post, but the number of posts had been significantly reduced and they had something of a vestigial role until the recent Trust re-organisation and increase in the number of NM posts. In Case A and to a lesser extent in B, NMs had had some flexibility in the way in which their role and responsibilities had developed. While these clearly reflected the knowledge and skills and to some extent areas of interest, of the post holders (one NM in Case A was still able to undertake work in the clinical area one day per week), this also seemed to have an impact on the extent to which they were involved in EBP related activities. For example, one NM in Case B, was particularly interested in developing evidence-based products and had done so in a previous post. She wanted to remain involved in this and although new to her post in Case B, stated that once her workload had '*settled down*' she would seek ways of doing so. It was not a specific part of her NM remit.

Despite the difficulties surrounding the CNSs, one role seemed to bridge the gap between management and practice. In Cases A and D joint NM/CNS posts had been developed. These specialist nurses were also managers of smaller, discrete areas of nursing, such as intensive care, chemotherapy or renal services. All acknowledged that it was difficult balancing both roles:

*'It's always a balancing act, it should really be two jobs, it's not a happy marriage, because it's nearly always the clinical component that gives'.*

(NM/CNS)

They also recognised that they were best placed to implement EBP. They had a good knowledge of their staff and the clinical area and also of the theoretical and clinical knowledge relating to their specialism. They were well respected by other staff and

had a credibility and good professional networks with medical staff that made it possible for them to introduce change successfully within their own areas.

### **SUMMARY OF CONTEXT FACTORS AND THEIR IMPACT ON EBPI**

These contextual factors either in isolation or together have had an impact on the role of the NM in EBPI. Organisational factors such as mergers and other re-organisations affect, to a significant degree, the ability of staff to concentrate on other issues, such as EBP. Ineffective organisational structures, or structures that were not well known or understood by staff were still relied upon by NMs as the means by which evidence would become integrated into practice.

CNSs were most involved in developing or using EBP in their own sphere of practice, however this was not extensively shared as they were not part of the wider nursing structures in any of the cases. With greater autonomy and authority, either assumed or agreed with their medical managers, they worked on areas of their own interest, using evidence in their own practice. Cases A and D had developed a joint NM/CNS role and these individuals were able to undertake EBPI in their own clinical areas. They did not need permission from other NMs to allow them to make changes to practice. This role provided a bridge to the gap that was identified between management and practice. A gap of knowledge and understanding of EBPI and of different goals.

Individually and in combination these factors have had an impact on the ability of NMs to undertake EBPI. These, in turn, interacted with content and process factors to facilitate or impede the process. The content factors are explored and explained in chapter five.

**CHAPTER FIVE**  
**RESULTS (2): CONTENT**

***Evidence and evidence use in cases***

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**INTRODUCTION**

The second aspect of Pettigrew's framework (1985a, 1988a) concerns the content of change within organisations. With regard to EBPI, content represents the 'what' of change, that is, it concerns both the types of evidence used in the cases, the changes that should flow from them and the initiatives that were used in relation to securing more and better evidence use. The boundary or interconnection between content and process is often indistinct and it is not always possible to completely separate content and process and still tell a coherent story about EBPI. Where aspects of process are contained within the content section, this is highlighted and the rationale for this is provided. However, overall, these two aspects of the framework have been delineated by viewing content as the 'what' of change, and process as the 'how' this has occurred. The data are presented on a case by case basis to aid contrast and comparison. This is followed by a cross-case analysis that considers aspects of similarity and difference between the cases regarding aspects of content.

In undertaking this research no specific definition of evidence was sought and participants were able to define evidence themselves. This accounts for the number and variety of types of evidence included in the case accounts. Prior to the case by case accounts, a brief overview of the research participants' views of evidence provided.

**Definitions and use of evidence**

It became clear very early on in the fieldwork that one of the biggest problems relating to EBP was the number of different definitions used to describe evidence. Some staff had a clear understanding and could describe (usually) national evidence-based guidelines or NMPDU best practice statements. However, others had either a clear (to them), but inaccurate understanding or a very vague sense of evidence and

often described the implementation of organisational change rather than EBP, for example:

*'We've just introduced a new shift pattern, new off duty. It's taken a while to get everybody on board but now we've done it.'* (Charge nurse)

This was in response to a question asking for examples of EBP that they had implemented on the ward. Not only was this example not related to patient care but the nurse was unable to describe the evidence on which it was based. There was no shared definition of evidence either within or across cases. Practice development nurses in Case A had the greatest shared understanding of the concept although this was not universal within the unit. Some staff in all cases were able to state types of evidence, such as national guidelines, but many were unaware of other types of evidence apart from 'journal articles'. This suggests a less than firm grasp of the concept and that if they were not familiar with it, it was not in regular use within their Trust. There was widespread agreement within and across Trusts that clinical experience was a type of evidence. Although it was not always expressed in these terms, it was clear that nurses working in the clinical area felt that this was the source of evidence that they relied upon the most to make decisions about practice. This experience was not always their own; charge nurses spoke of discussing particular clinical problems with medical staff or occasionally with CNSs. Some wards had link nurses, nurses with a particular interest in a specific subject, such as infection control or wound care products, and their expertise was valued by charge nurses and viewed as evidence. The ways in which this kind of evidence was used beyond individual practice, or integrated with other types of evidence were not known.

While ward staff were not always clear about the nature of evidence, NMs also spoke of changes to practice in terms of re-structuring, service redesign and staffing changes. This was most noticeable in Case C where not all the NMs had a clinical background. CNSs were most likely to be confident and knowledgeable about using evidence as a basis for practice and described the use of SIGN guidelines as a basis for practice. Nurses working in practice development were also knowledgeable about EBP, citing either SIGN guidelines or NMPDU best practice statements as evidence. Staff with educational roles, were also familiar with the term 'EBP', but were not

always so confident about describing its use in their work. One clinical educator saw his role with students on clinical placement as being unrelated to EBP. This was in stark contrast to his role as viewed by other staff, who saw him as having a significant role in teaching about and encouraging the use of evidence in practice. In Case B one charge nurse described evidence as what she could provide in terms of hard copies of protocols or procedures if required to justify practice, interpreting evidence in judicial terms. She discussed the role of evidence to support nurses in litigation, rather than as a basis for everyday improvements to patient care. She also described evidence as ‘...collecting journal articles for the folder’. Definitions of evidence varied within roles, i.e. all practice development nurses did not necessarily describe evidence in the same way and evidence was not necessarily seen as relating to patient care, but to any change that was being introduced within the Trust. Given such a variety of understandings of evidence, it is not surprising that the content of change addressed under EBPI varied widely across the cases. This is now explored.

#### **CASE A:**

##### ***Types of evidence: National guidelines and standards***

The types of evidence presented by staff varied and to some extent reflected their post, their own involvement with EBP initiatives and the extent of this. The senior practice development nurse reported that it was Trust policy to concentrate on national guidelines but the difficulty in taking this forward lay with the numbers of guidelines coming into the Trust. It was also felt that while national guidelines were the priority, it was not possible to further prioritise among them, so the workload of managing these became impossible. Despite this Trust policy, not all staff interviewed for this study, or those who participated in the CSBS review visits, were aware of national guidelines (such as SIGN guidelines). The impetus for using SIGN guidelines was not always related to priority or clinical practice with one NM recalling her own reason for trying to encourage their use:

*'We'd had a visit from one of the local councillors and there were comments made about the number of pristine copies of SIGN guidelines in a number of offices, including mine, and how public money was being spent. I decided to do something then to pre-empt a rap on the knuckles'.*

Her response had been to send a memo to staff to remind them about SIGN guidelines.

Nurses' knowledge of SIGN guidelines varied, with some being unaware because "They haven't made their way down to us yet" (CN). However, CNSs were more likely to be aware of and using them in their practice, with one feeling that this was relatively easy to do since the nursing aspects of many of the guidelines were quite discrete and therefore not onerous. In addition, the relatively small number of guidelines that were relevant to specific clinical specialties made this possible.

In addition to SIGN guidelines, speciality based guidelines, such as those from the British Association of Gastroenterology and national standards, such as those developed by the CSBS were used as the basis for practice.

#### ***NMPDU best practice statements***

National nursing best practice statements were available throughout the Trust, having been disseminated through the practice development unit, but no specific plans to implement these were in place, with the exception of a recently appointed practice development nurse with responsibility to take this forward.

Although the NMPDU best practice statements were not in routine use within the wards, one practice development nurse had used some of the statements as a basis for education, to ensure that the practice he was teaching was evidence-based.

#### ***Procedure manuals***

Each ward or clinical area was reported to have a copy of the *Marsden Manual*, a book containing nursing procedures. However, not all staff interviewed were aware of this and although some had seen these in the past, they did not view them as the basis for care in their ward. The senior practice development nurse also expressed concerns about the number of different editions that were still in use on the wards, some quite

outdated. She was also unclear as to whether this was the definitive guide or if other local procedures or national guidelines had superseded it. The CSBS noted that it had been used as the basis for some cancer policies and protocols.

### *Other evidence-based products*

Clinical procedures, protocols and policies were also locally developed, most often by medical staff to provide guidance for managing the nursing care of their patients. Several staff explained that these were not based on external sources of evidence, such as guidelines or best practice statements, but were based on local practice written into a protocol format as means of formalising and standardising expected practice. Nurses were made aware of these in one unit through a ‘protocol of the month’ launch held by doctors to ensure that all staff were aware of these. This approach had resulted from a critical incident when a new protocol had not been followed by a nurse, unaware of its existence.

Some development of nursing procedures was said, by other nurses, to take place through the practice development unit but no-one could describe the evidence-base for these and who would be involved in this. However once complete these were reviewed by the clinical governance team:

*‘They are all signed off, so there is a formal process in place to make sure that they are factually correct and up to date’.* (NM)

The CSBS noted that CNSs had developed local policies and protocols for management of pain relief for patients with cancer as previously none had existed, but the review team were not able to see them or see them in use.

One nursing guideline had been developed locally. Led by a CNS and involving several other nurses, the process had taken two years to develop an evidence-based guideline on the use of aromatherapy for patients with cancer. While the CNS acknowledged that there was very limited research evidence on this, the group had amassed a considerable amount of information relating to patient experience and preference for this and several of the nurses had undertaken specialist qualifications in their own time and without funding support, to develop the skills necessary to provide

the aromatherapy. Once the guideline was complete, it went to the clinical governance team for ratification and was rejected due to lack of evidence. No other examples of the local development of nursing guidelines were provided.

The Trust had a large policy and procedure manual on their intranet. It was comprehensive but it was not possible to determine the evidence-base for these. Although each had a completion date included, none were within the previous five years. Many had passed the review date that was included in the procedure and it was not clear if these procedures were to be used instead of others also available in clinical areas. It may be that this has become obsolete with the introduction of the *Marsden manuals* and locally developed products. Although this procedure manual was mentioned by the senior practice development nurse, none of the other staff interviewed made mention of it, so it may have fallen out of regular use.

### **Initiatives and approaches to evidence use**

This section combines aspects of content and process that are difficult to separate because the boundaries between the two overlap and this reflects the interaction between the factors described by Pettigrew (1985a, 1988a).

### ***Adoption and adaptation of national guidelines***

It was clear that the Trust had made a commitment to using national guidelines either by wholly adopting them, for example the guideline related to patient discharge documentation, as it is also a requirement for the CSBS, or by using parts of them, where appropriate. This adoption was described by the cancer CNS who remarked that the nursing aspects were 'small' enough to take on board. She also remarked, however, that the guideline was not substantially different to her current practice which had made this easier to do. There was less evidence of adaptation of national guidelines, but these may have been used as the basis of some of the local development initiatives used by the practice development nurses. Adoption and/or adaptation of the *Marsden manual* had been the basis of some cancer care policies and protocols.

### ***Local development of evidence products***

Local development of policies, procedures, protocols and a single guideline for nursing had taken or was taking place within the Trust. The evidence-base for these varied from research and national guidelines, to local custom and practice and practitioner evidence/expertise. One of the problems of this approach was highlighted by the CSBS visit in relation to health care associated infection. The policies and protocols presented for review were found to be neither evidence-based nor up-to date. They did not reflect current best practice and the CSBS remarked that evidence and guidance about best practice relating to hand hygiene was not only topical, but easily obtained and crucial to the management of the significant problems faced by the NHS at that time. So although the Trust felt that it had a robust process in place to take care of these aspects of local product development, it was not entirely unproblematic.

### ***Dissemination***

Dissemination of guidelines and best practice statements was undertaken either by the clinical governance team or through the practice development unit, but appeared to be variable. While the practice development nurses thought that the system worked well, they did mention that staff could access copies of guidelines and best practice statements in the library, if they had not arrived on the ward. One charge nurse was unaware of the best practice statements. However a charge nurse colleague also commented although they had arrived on the ward, they did not come with any information as to their use. Dissemination appears to have been patchy. The sense that there was a lack of information about the use of the best practice statements was noted by another charge nurse who felt that dissemination was unreliable but also that staff needed more information, such as detailed protocols, not just guidelines, because many staff needed to be “*told what to do*” (Charge nurse).

CNSs often had their own copies of SIGN guidelines particularly if they had been to the national launches of these or if they or their medical colleagues had been involved in the development of them. Other nursing staff did not mention having immediate access to hard copies, but this was not seen as a problem, because SIGN guidelines were viewed by them as being very medically orientated and not related to nursing. They were aware that they could be accessed via the internet but there would be

practical issues in doing so, such as securing prolonged access to a computer that was not simultaneously required for patient data.

### ***Monitoring and audit against evidence***

Monitoring and audit of nursing practice were not undertaken in the Trust on a planned or regular basis. The principal means of monitoring and auditing practice overall, which included some very specific aspects of nursing practice, was the CSBS reviews. It is important to acknowledge that apart from the generic standards for clinical governance, the other standards were much more medically orientated in nature as they concerned specific disease management. The CSBS made some comments relating to the overall approach to audit within the Trust, noting that the focus was on achievement in the nationally required audits and that very little other audit activity was taking place. In addition it was noted that the results from audits were not disseminated and that linkages between related teams such as clinical governance and nursing were poor. For example, nurses were employed to work on specific audits required for national projects (such as the Scottish hip fracture audit), but these were not linked to nursing in any way. The audit team, a subset of the clinical governance team had no links to nursing and therefore dissemination of results to nurses did not occur.

Several staff remarked that audit was a new concept to the Trust and this was supported by the number of views of audit that arose during interviews. It was described as research, doing surveys, completing questionnaires and related to data collection. There were also perceived problems with audit:

*'It's difficult for us to do audits here because gathering and appraising evidence is too much for one person'. (NM)*

Several staff also viewed audit as a problem because there was a lack of knowledge, skills and interest in it.

However, a novel approach to nursing audit was described by one NM and the senior practice development nurse. They described a 'walk round audit' when together they would visit a ward to observe a specific practice, giving the example of blood

transfusion. This would be precipitated by the publication of a new guideline or best practice statement. Having observed the practice, they would then review it in relation to the new guideline and decide whether changes needed to be made and the best way of tackling this. They gave the example of providing updating sessions for clinical skills for the blood transfusion procedure. They did not discuss ‘closing the loop’ by re-auditing after a given time. This approach to audit was informal, it did not involve keeping any written data or formal recording and it did not occur on a regular or planned basis. However it was a clear attempt to assess current practice against evidence and provide a practical, if not robust, method of achieving this.

While this approach only provided a snapshot view of one nurse’s practice, it was the stimulus for reviewing practice against evidence and was the basis of provision of evidence-based clinical skills teaching to update practice.

### ***Education based on evidence***

The use of evidence in teaching also occurred in the provision of education for healthcare assistants in the Trust. The practice development nurse responsible for this used the NMPDU best practice statements as the basis of his teaching sessions. This involved the adoption, adaptation and embedding of evidence into education. The healthcare assistants were not made aware of this in the hope that they would view the practices promoted as local rather than national to encourage their use. The practice development nurse was clear about his aim in taking this approach:

*‘We wanted to change the focus away from “we do it this way because we’ve always done it this way” to try to look a bit deeper at “why are we doing this?” That’s what’s important to get over, rather than where it comes from’.*

### ***Designated EBP roles***

Within the Trust EBPI was seen by other staff, as mainly the remit of practice development nurses. In terms of Pettigrew’s (1985a; 1988a) ‘what’ of change, there were several examples that illustrated their involvement in aspects of the initiatives described above. However, it was not solely their remit: other staff, such as, clinical educators were viewed as having a role in teaching EBP or CNSs in developing

guidelines or policies. The difference was that very few staff had it as their designated role, whereas several staff, or groups of staff, were viewed as having EBP related activities, such as procedure development, as a normal expectation of their role or nursing grade. Others who may have had a role related to EBP, such as audit, were not linked to the nursing hierarchy and were therefore not seen as being involved. There was a widespread expectation from NMs that all nurses should be involved in EBP, because it was not an additional responsibility, but should be a part of everyday practice. They were also of the belief that charge nurses were responsible for ensuring this at ward level. However for some staff, remit, skills or experience were not seen as the crucial element:

*'It's personalities that make it work, personal characteristics, being able to win people over, especially the doctors, that's where the success lies'.* (Practice development nurse)

Overall, involvement in EBP initiatives and approaches seemed to be a combination of designated roles, such as practice development nurse, and within this group there were individuals who had been employed specifically to focus on EBP. Beyond this, there was a sense from NMs that every nurse was responsible for EBP and some, such as charge nurses and CNSs, would be more heavily involved than others because of their grade and expertise.

### **Case A, in sum**

A number of different definitions of evidence emerged in Case A and there was also a number of different types of evidence. The ways in which these were used varied with the adoption of national guidelines and the adaptation of these and the incorporation of the evidence contained in them into locally developed products. No specific initiatives had been used in Case A to promote EBPI, other than those noted above such as the incorporation of evidence-based products into teaching.

The practice development unit in Case A had a significant role in all aspects of content; co-ordinating and prioritising the dissemination of SIGN guidelines to nurses, some EBP product development, the use of national products in education and creating specific EBPI roles. However, the CNSs were undertaking most work in relation to

EBP content, developing products, and using a variety of EBP products in their practice and in some wider nursing practice. They had the greatest skills and authority and autonomy to do so.

The wider lack of consensus about the nature and types of evidence may have hindered some EBP content aspects and approaches to evidence use.

## **CASE B:**

### **Types of evidence: National guidelines and standards**

A number of different types of evidence were in use in Case B. The extent to which these were known about and to what level of detail, depended on the role of the staff interviewed. For example, the Director of Nursing mentioned that SIGN guidelines were used in the Trust, but could not be specific about their relevance to nursing. The CSBS reports indicate that disease specific guidelines were in use in the Trust, as well as generic guidelines, such as the SIGN patient information on discharge guideline, which were required to meet the CSBS standards. Disease specific guidelines were also reported by the Trust to be the basis of managed clinical networks used in the Trust, but this was not raised by any of the research participants. The medical focus of many national guidelines, in particular SIGN guidelines, was mentioned by several nurses.

### **NMPDU best practice statements**

According to the Director of Nursing, NMPDU best practice statements had been adopted by the Trust as a means of guiding nursing care but were not in use at the time this Trust was visited. The five that were available early in 2003 had been sent to every charge nurse, but without any information as to the priority to be given to them or whether they should replace local guidance. One NM explained that these were not in use because the Trust had its own nursing guidance documents. However there was some ambiguity about this:

*'No, we're using them within the hospital, I think everyone is. I'm using the trachy [tracheostomy] one, well, not every day, you understand, but*

*we do get patients with trachys. I think I might even have my own copy of that one'. (Charge Nurse)*

Of the NMPDU statements available in 2003, none related to tracheostomy care, which suggests that the charge nurse was confused about what they were or was genuinely mistaking them for other guidelines. Review of the best practice statements showed that there was no duplication of subjects and therefore both could have been in use without conflict. One charge nurse explained that they were not in use (but did remark that all wards had been sent copies of them) because they were community focused. This was not the case, with only one of the five being related to aspects of home care for patients. Of the remainder, three were related to generic nursing issues, such as nutrition and pressure care, while the fifth was specifically related to the area of nursing in which this charge nurse worked.

Previously, small groups led by a practice development nurse (and most often undertaken almost entirely by her) produced disease specific and generic guidance based on evidence. The Trust was not prepared to call these guidelines as there was some concern about their legal standing. Instead, they were known as guidance documents. While there was no standard format for these, some had graded recommendations, while others were more of a step by step guide to a procedure. All contained references to the evidence used and a completion and review date one year from completion. The Director of Nursing felt that while these were useful documents, many of them were disregarded by nurses because the evidence grades were low and many were graded from expert opinion. One NM agreed that the grading was problematic because nurses didn't fully understand it and therefore were not confident about the quality of evidence. This was illustrated by one charge nurse:

*'I'm not sure what the difference is between the letters [evidence grades]. I always presumed that it was how much information that's there and whether it's correct or not - you know like grading exams'.  
(Charge nurse)*

The lack of a standard format for each was also thought by NMs and charge nurses to hinder their use. They were thought to be too vague and they believed that nurses

needed very clear information about what to do, rather than statements without instructions. Each document also included a statement explaining that these should be used as the basis for practice and if not, justification for the decision should be documented in the nursing records. Although developed by small groups or the practice development nurse, these were endorsed and 'signed off' by the Director of Nursing.

There was an acknowledgement that there was still a considerable amount of duplication of local policies, protocols and procedures, some as a result of the previous merger and some the result of the desire to produce something that was 'home grown' and would be directly relevant to their nurses. Review of these by the researcher confirmed the duplication issue and also the concerns raised by the CSBS, that many (such as the pain assessment and management protocol) had no clear evidence base. As a result the Trust did not meet this standard across all the cancer specialties reviewed. The CSBS recommended that the Trust should first consider nationally produced evidence-based products and if none were available, then local development would be appropriate, as a means of ensuring quality and best use of resources. Other work that had been devoted to the development of protocols, for example, that relating to 'breaking bad news' was commended by the CSBS from review of the written submission, but at the review visit, staff were unaware of the protocol and the CSBS remarked that it needed to be formalised and properly disseminated.

The quality of evidence was also a concern for one charge nurse who produced 'teaching packs' for nursing students who were on placement on the ward. These packs included Trust information and details of national guidelines (although not the guidelines themselves) relevant to the clinical area and patient information leaflets produced by national organisations. The evidence included by the nursing staff were journal articles or articles from the internet and did not entirely meet the charge nurse's vision of an evidence-based teaching pack:

*'They [nurses] obviously collect evidence-based practice and put it in the teaching pack and they can just add whatever they want as time goes by. I've asked for a bit more about anatomy, the subject of an illness or*

*disease. That's what the folders should be about. That's evidence-based practice'. (Charge nurse)*

The charge nurse was concerned that information from the USA included in the pack was not evidence, because she was unsure “*just how it stands up yet*” and reported that she had asked the staff nurses not to include this in the future, so there was some notion of the potential for different grades or quality of evidence, even though it might not have been articulated as such and might have been erroneous. She was of the belief that any article published in a nursing journal was evidence, otherwise it would not have been published.

A CNS had developed a pressure risk assessment tool for use throughout the hospital but not all staff were confident of its evidence base. Others felt that it was not as useful as nationally available tools and so did not use it. Again this highlighted the partial desire for local development of products when good quality patient products were already available.

One NM spoke of the use of ‘patient stories’ as evidence, from her time in post in the Trust as a charge nurse. Promoted through the Royal College of Nursing leadership course, it was a means of getting patient views and comments on aspects of nursing, usually more related to service delivery than clinical care. She had sought views on staff being more proactive in their approach to patients’ relatives during visiting and had attempted to make changes as a result of their views. She was disappointed that her staff did not consider patient surveys, questionnaires and ‘stories’ from visitors and relatives to be evidence.

There was also a recognition that much of the focus of the current work within the Trust, in terms of the content, was on nurses, rather than nursing, for example:

*‘Clinical supervision, portfolio building, developing leadership skills and a clinical competency programme - these are the main things that we’re concerned with in the PDU. I know it’s not exactly evidence-based practice, but at a stretch you could say that these things are an important foundation for practice’. (Practice development nurse)*

This reflected some of the focus of the national nursing and midwifery strategy but failed to acknowledge that EBP was also a significant aspect of this.

Staff interviewed assumed that evidence would be used as the basis for teaching clinical skills, but this was not mentioned by the practice development nurse who was responsible for this.

### **Initiatives and approaches to evidence use**

#### ***Adoption and adaptation of national guidelines***

As explained above, the Trust had adopted some national guidelines in their entirety, but with others, parts had been incorporated into specific areas of work. The medical focus of many of the SIGN guidelines was given as a reason for their lack of use by nurses. The national nursing best practice statements had been adopted by the Director of Nursing as something that should be the basis for practice but this was not clear to all staff and information as to how they should be used was needed. It was not clear if they were to be used in their entirety or if specific aspects were to be the main focus in the first instance. While the CSBS standards are not guidelines in themselves, they are evidence based and many are based on SIGN guidelines. The Trust was working to these standards and had adopted them as the basis for care in the areas reviewed although none of the staff interviewed mentioned this.

#### ***Local development of guidelines***

There had previously been a considerable amount of work undertaken across the Trust and in nursing to develop local guidelines. This work had been suspended after the reconfiguration of the practice development unit and would not re-commence until they had formed a strategy for development, implementation and monitoring of their use. The guidance documents previously produced showed that evidence had been both adopted and integrated into these documents and adapted for use in them. However, not all were related to clinical care and the inclusion of graded evidence in them seemed slightly incongruous. For example, guidance as to '*Management of patients own clothes*' had expert opinion grades to explain the importance of labelling a bag containing patients clothing. One nurse interviewed remarked on this:

*'They had one nurse full time developing these and they're just policies, policies, policies, by any other name. I don't need someone to tell me how to manage patient valuables with evidence grades, it's common sense really. But their excuse is that these are the things that hold a big institution together. It's no wonder that people think evidence-based practice is rubbish when they're churning out things like that'. (Charge nurse)*

As a result of her disillusionment with the Trust's own nursing guidance documents, this charge nurse had begun to develop some of her own at ward level:

*'Just for our own ward, we've done guidelines for new staff and students. We get a lot of bank staff - it's good for them too. We have a 'ward routine' guideline which is old fashioned, I know, but at least it tells them what to do and when'.*

It seems as if she may have misunderstood several aspects of EBP, suggesting that producing a guideline for a ward routine was EBP. While such a guideline might provide information, a significant aspect of EBP is promoting individualised patient care, based on evidence, rather than promoting old fashioned (as she recognised) routine driven care.

The senior practice development nurse explained that since there was often a considerable gap between current practice and evidence, evidence was 'amended' or selected to reflect practice and encourage its use in practice. Rather than adapt practice to reflect evidence, this Trust was taking the approach of selecting evidence on the grounds of its similarity to practice.

*'We would look at the evidence and at practice but sometimes the gap is just too big, there's too much of a difference between the two really. We've found that the only way to get round that is to cut them out or ignore those parts and concentrate on the bits where we might actually be able to make a change'. (Practice development nurse)*

While the Trust programme for developing nursing guidance documents was suspended, one charge nurse was still involved in developing a local guideline, having been asked by the consultant to do so. She was unsure of the way to tackle this and was not certain about using any national products in this as she was sure the consultant would have identified and rejected these first if he was asking for a local guideline. The ways in which evidence was going to be used in this guideline were unclear. The evidence base for some local guidelines was not evident.

### ***Dissemination***

The availability of Trust guidelines, procedures, protocols and policies on the Trust intranet was seen as the main means of dissemination by those interviewed. While the NMPDU best practice statements were also available on the NMPDU website, hard copies had been sent to all charge nurses, but this did not guarantee their availability to all nurses. One charge nurse had pinned them to the ward noticeboard as a means of disseminating them more widely in her ward. The difficulties of nurses' access to computers to view national guidelines and best practice statements or to download copies were mentioned by several staff. Presumably these would be the same for accessing locally developed products also available on the intranet. The locally developed nursing guidance documents were reported by the Director of Nursing and practice development nurses to be held in a folder on each ward, but these were not readily accessed in the wards by the two charge nurses interviewed. Likewise, the teaching pack described above as being an evidence-based resource for student nurses was stored in a locked cupboard outwith the clinical area in the ward where it had been developed which suggests that ready access might have been complicated for students. Problems with dissemination of local products were noted by the CSBS in relation to several protocols where staff knowledge of them was poor.

### ***Monitoring and audit against evidence or national standards***

National monitoring of performance against national standards was carried out by the CSBS and these reviews included aspects of nursing practice. Audits completed for the CSBS reviews were undertaken by audit staff in the clinical governance team. These were mostly in relation to CNS activity in specific cancer specialties. Local monitoring of the use of evidence products was raised only by the Director of Nursing in relation to the NMPDU best practice statements and was planned but had not taken

place because they had not been widely implemented, if at all. Having disseminated them to each of the charge nurses, she then wrote to them to explain that she would be visiting each ward to ensure that they were being used. No further detail was given as to exactly how their use should be demonstrated or would be monitored. As noted above, one charge nurse responded to this by pinning them to a noticeboard in a prominent place on the ward so the Director of Nursing would see them. Another had taken no action as she did not consider them to be relevant to her ward.

Audit was not seen as a necessary requirement of EBP by nursing staff, although the practice development nurses felt that previously, it had not been given a high enough profile and should be seen as an integral part of EBP.

*'We have the Waterlow charts and now everyone is waterlowed [has an assessment chart completed] on admission. It's an unwritten rule and they're used across the board, so I don't think audit would show anything different'. (Charge nurse)*

While this may have been the case, there was no willingness or strategy to demonstrate it objectively through audit.

The senior practice development nurse was very aware of the lack of audit that had taken place since the development of the nursing guidance documents. There was a recognition that the focus had been purely on development and this had not ensured use of these in practice. The problem was seen as two fold. Firstly, there was an issue of ownership. Most had been developed by a single practice development nurse or a very small group of nurses and local adoption of these had faltered as a result. In addition, the current practice development nurses thought that the lack of audit tools specific to these documents had hindered their use and subsequent audit. There was also an acknowledgement that nurses lacked the skills and knowledge to undertake audit and saw it as a task for those with 'specialist' roles, such as practice development nurses. A review of their overall strategy was in progress and they were determined to ensure that any new products were produced with audit tools to address previous problems.

### *Designated EBP roles*

The re-organisation of the practice development unit had seen the introduction of a new practice development nurse post with a remit to implement the NMPDU best practice statements. This had been conceived and arranged by the Director of Nursing. However, this nurse, who had no previous experience of this nature, had been given no direction as to how to tackle this across the Trust and did not have automatic access to wards. She could not go onto wards without permission or an invitation from the charge nurses. One charge nurse made it clear that she would not be willing to allow the practice development nurse onto her ward. She explained that this was due to her belief that practice development nurses were out of touch with practice and would have nothing to offer.

The other practice development nurses did not see their roles as being specifically related to EBP, but acknowledged that they might use evidence in the course of their work, for example, teaching clinical skills. All the practice development nurses and NMs felt that every nurse had a responsibility to use EBP. There was ambiguity about whether this was contained in nursing employment contracts and observation of an E grade staff nurse contract showed that it was not explicit but referred to 'keeping practice up to date'. One NM believed that the problem lay not with the contracted duties but with the widespread view that EBP was not an integral aspect of contemporary nursing but an additional responsibility that nurses had been given.

*'I'd like evidence-based practice to be nation wide, but you need a proper team to do it. After nurses come out of education they stop using it, so you'd need a dedicated team because it's way more than we can do day to day. We just can't take on any more'. (Charge nurse)*

Overall, there was a greater sense in Case B that EBPI was the responsibility of a few nurses with a dedicated remit. In effect, even within the practice development unit her practice development colleagues saw this as the responsibility of the one nurse, although her remit, while substantial, was only really related to the implementation of the NMPDU best practice statements. Otherwise EBPI was seen as the responsibility of the Trust clinical governance team.

### **Case B, in sum**

There were various definitions and types of evidence in Case B reflecting a spectrum from national evidence-based products to nurses' beliefs that ward routines were EBP. While there was an awareness of national evidence-based products, much of their effort, to date, had been on developing their own nursing guidance documents, although widely disseminated, these had not been as successful as hoped. There was considerable confusion about the inclusion of grades of evidence in these, which had impacted on their use. Further impediments to EBPI related to evidence quality, beliefs about relevance, lack of understanding about how to use products and a lack of consensus about EBPI roles. They had made some decisions and progress about EBPI strategies, such as local development, but this had not secured local use. As an alternative approach, they were adopting the NMPDU statements, but nurses did not have a clear understanding about how these should or could be used in practice and no information had been provided to guide them. Once again, the complexity and numerous factors involved in tackling EBPI had not really been grasped.

### **CASE C:**

#### **Types of evidence: National guidelines and standards**

SIGN guidelines were mentioned by NMs and practice development nurses as types of evidence in use, but both felt that these were more medically focused and less relevant to nursing. They were unable to give any examples of specific guidelines in use. One CNS was aware of SIGN guidelines and British Diabetic Association guidelines that were relevant to her area of practice, but again felt that these were used more by medical than nursing staff. There were also difficulties relating to the perceived relevance of national products in the local setting:

*'We've looked at evidence from elsewhere, but we don't want to use it because guidelines and SIGN and even other [health board area named] guidelines are not necessarily suitable as they just don't fit with what's happening here'. (NM)*

National standards, those provided by the CSBS, were also used as an evidence-base for practice. Although seen as more medically focused, some aspects are generic and

some, particularly in specific aspects of cancer care relate to CNSs. One NM described the standards as:

*'...more common sense than evidence, for example the audit data required by the Renal Association' .(NM)*

### **NMPDU best practice statements**

Although a launch had been held to promote the NMPDU best practice statements when they had first been disseminated to Trusts (in this case to the Director of Nursing) these had not been disseminated within the Trust and were therefore not in use, even by the two nurses from the Trust who had been part of the national development groups. Several staff expressed concerns about the quality of the statements, as a result of the development process:

*'I'm very sceptical about them. I would say that they are just personal opinions dressed up as best practice. They're not any more valuable than a nurse's own opinion, which to me, defeats the purpose of having them. Personally, I wouldn't send them out to the wards' . (NM)*

The best practice statements were not thought to reflect national views on best practice, despite the composition of the development groups. These had representatives, not from every Trust in Scotland, but from most regions, including those that were very remote and rural. These concerns were not the only reasons given as justification for their lack of use in the Trust, which was widely acknowledged to be due to:

*'A catastrophic failure of dissemination after the launch. We'd no plans to implement them and it is an opportunity so missed that I don't think we can make up for it now' . (Practice development nurse)*

### **Locally developed products**

Locally developed policies, procedures, protocols and guidelines were available on the Trust intranet. While it was possible to view these, it was not possible to determine the types of evidence on which they were based. Many were outdated, some by as much

as 10 years. These were only given as examples of evidence by one of the principal nurses and she had no knowledge of the way in which they had been developed or were updated. Observation of the nursing procedures and protocols available on the intranet showed that they did not follow a standard format and there was considerable duplication of these, presumably a legacy of the Trust mergers. One NM noted that even two neighbouring medical wards might be using different procedures as much of the rationale for their use was related to personal preference:

*'The problem here is the size of the directorates. How do you get everyone doing the same thing? We have a [health board area named] wide wound care formulary, but I know that nurses order things that are outwith it and even next door wards work differently from each other. They don't really bother with the formulary because they think it's about cost and not best practice'. (NM)*

Duplication of a new guideline was demonstrated during an interview with a CNS who had worked with two colleagues and a pharmaceutical company to recommend and attempt to standardise wound care across the Trust. In attempting to demonstrate to the researcher, the ease of access to the guideline on the intranet, another wound care guideline, also recently developed appeared instead. She was surprised and angry as she did not know the author of this alternative guideline and she did not agree with its content.

One NM felt that in many instances, what she described as 'external evidence' was not the basis for care, but while the aim may be to standardise an approach, giving the example of bowel preparation prior to surgery, locally developed protocols were governed by consultants' preferences. An agreement would be reached between all the consultants involved and then this would be written into a protocol format for nurses to follow without '*any evidence being involved*'. (NM)

The *Marsden manual* had been the main source of EBP for nurses in the surgical directorate, but these were not available throughout the Trust and their availability in this one directorate had persisted beyond the merger. Although the manual was mentioned by the Director of Nursing as a type of evidence, the NM in the surgical

directorate, not a nurse, was unable to provide any detail about the use of the manual as she was unaware of it.

Finally, three other evidence types were mentioned by staff as the basis for practice.

*'Nurses would be most likely to use clinically based evidence as we have very few with the skills to really read or appraise other evidence'.(NM)*

*'Evidence is just keeping up with the times and you just use whatever you need to do that'. (CNS)*

*'I'm sorry to say that the evidence most likely to be used here is not based on anything other than personal preference and anecdotal evidence'. (NM)*

Clinical or personal experience was mentioned by many staff as the most used type of evidence. Clinical educators actively sought to give nurses confidence in their practice to see it as a source of evidence. The expertise of CNSs was also seen as a source of this type of evidence, although access to them or it was not straightforward due to their lack of connectedness to the nursing hierarchy and their isolated way of working.

## **Initiatives and approaches to evidence use**

### ***National standards and guidelines***

Within the Trust national guidelines were reported to be in use. However, the ways in which they were used, either wholly adopted, adapted or if parts of guidelines were integrated into local evidence products was not clear since the staff interviewed were neither using them nor had been involved in the process of developing local products with them as an evidence base. The patient discharge SIGN guideline, one of the CSBS standards, was not in use at the time of the CSBS clinical governance visit and a local protocol for discharge was presented instead. The protocol was described as being based on the core dataset of the SIGN guideline, which suggests adoption of this aspect of it, but the protocol was not in use and therefore the standard was not met. Disease specific SIGN and other national guidelines were in use according to the CSBS reviews. Recommendations from several of the cancer guidelines had been

adapted and amalgamated into a policy for pain control for patients with cancer. Many other recommendations, for example the management of acute myocardial infarction, were not related to nursing.

The evidence-based CSBS standards had been adopted as the basis for care in the Trust, but the process differed between the two main hospitals in the Trust. One had adopted the standards in a 'wholesale manner', as described by the CSBS, whereas in the other hospital, the standards had not been seen as evidence in themselves and further evidence had been sought to try to achieve these by, for example, the local development of policies, protocols and procedures. This had led to the Trust failing to achieve some standards overall, because the evidence base for these was not clear. This decision had also led to a failure to achieve standards that were both high priority and high profile, in the case of those relating to health care associated infection. Although local guidance was presented to the CSBS for inclusion in the review, it did not address the standards and lacked an evidence base. Key policies were missing, for example, the nursing management of urinary catheters. These should have been based on readily available national guidelines and were also addressed in nursing best practice statements. While the CSBS recognised that these standards were largely the responsibility of the Trust infection control team, many of these and the policies relating to them involved nurses and the provision of nursing care.

#### ***Local development of guidelines, protocols, procedures and products***

Three CNSs had obtained funding from a pharmaceutical company to develop a wound care guideline for the Trust. One CNS had worked on this project alone for a year, with her colleagues, based in other hospitals, covering her caseload to enable her to focus on the guideline development. She explained that the aim was to standardise the wound care products used across the Trust as a means of contributing to financial savings. The three nurses had started by agreeing which products they felt were most appropriate and this had been supported by the pharmaceutical company, which raises concerns about the independent nature of the evidence-base. The completed guideline contained references to support the products advocated, but much of it was related to the pharmaceutical company involved. Very few other nursing guidelines appeared to have been developed in the Trust. One CNS had developed a patient information leaflet relating to diabetes and tattoos. She explained that this was a subject of interest

to her and in gathering information for the leaflet, she had visited every tattoo parlour in Scotland to ascertain their practice in relation to tattooing patients with diabetes. This information was formed into the patient leaflet highlighting the need for hygiene and safety for patients having tattoos. This product was obviously highly specialised and did not have utility beyond her own patient group.

The CSBS reports show that the local development of protocols and procedures was undertaken in addition to nationally available evidence-based products. Whether this duplication resulted from a lack of confidence in the national products or a lack of knowledge of them is not known. This suggests that national products were not being adapted or incorporated into local products but that other sources of evidence were used instead. The evidence-base of the local products was not evident to the CSBS reviewers and they expressed concern about this. In addition, there were specific concerns about the discrepancy between the data (such as protocols, procedures or policies) provided for the self-assessment aspect of the review process and those presented at the review visit as available for staff to follow. One explanation for this situation was the number of different protocols (for example) that were available, as duplicates still existed from before the merger, with each hospital still having their own.

*'We need to try and move [hospital named] out of the dark ages and into a corporate way of working. We have a lot of the guidelines, but from what I see, everyone is just doing their own thing'. (NM)*

In an attempt to standardise care across the Trust, one CNS had used evidence from nursing assessment tools and her own expertise to produce a protocol for the use of pressure relieving mattresses. The NMPDU best practice statement relating to the management of pressure area care was not included as evidence. The protocol was aimed at standardising and rationalising the use of these expensive mattresses (hired from an outside company when required) and ensuring the best use of scarce resources within the Trust.

One NM described the process involved in selecting evidence for some local guideline development:

*'We would look at the evidence, SIGN guidelines and [Trust named] procedures and so on, but mostly they aren't a good fit with what we are doing, so basically we ignore them and write our own. That way we can show our practice, rather than things that aren't relevant from elsewhere'.*

Locally developed core nursing standards were presented to the CSBS as being evidence-based and were related to the provision of patient information. Apart from the Director of Nursing, none of the staff interviewed mentioned these and they were not found on a search of the Trust intranet. It is therefore not possible to determine their evidence-base or the ways in which evidence was used to develop these or their use in day to day practice.

In a summary report to the Trust, the CSBS remark that while there is a lot of work being undertaken to develop local products, it lacked coherence and prioritisation. It suggests that a more systematic approach needed to be taken to ensure the prioritisation of important work takes precedence and to prevent duplication across the Trust of national and local products. This was borne out by some staff who suggested that nurses were 'going it alone' and others who demonstrated that their priorities were their own specific areas of interest, such as the diabetic nurse specialist who had developed the tattoo information leaflet, rather than consider national priorities. Bringing these together was not straightforward:

*'We have major problems here integrating work across sites. Everyone has their own way of doing things and their own 'evidence' [makes quotation mark signs in the air] that they think is important'. (NM)*

### ***Dissemination***

The dissemination of SIGN guidelines was undertaken by the clinical governance team and did not involve nurses. Some CNSs received copies of specific guidelines relating to their area of practice directly from SIGN if they had attended the national launches or had connections with staff on the guideline development groups. The NMPDU best practice statements had not been disseminated and the Director of

Nursing accepted responsibility for this. Locally developed Trust policies, procedures and protocols were disseminated via the Trust intranet, but NMs acknowledged that access to a computer for the length of time necessary to find and read these was a problem for most nurses. One NM (based in one of the smaller hospitals in the Trust) had bid for money from sources outwith the Trust to buy computers to address this problem and had been successful in obtaining an additional PC for nurses' use.

The CSBS had concerns about the dissemination of key evidence-based products arising from two aspects of the process. Some evidence-based products provided for the self assessment part of the review were not accessible to staff either via the intranet or as hard copies when the CSBS visited clinical areas. In addition many staff were unaware of the existence of key evidence-based products, such as pain management policies. The CSBS reports all reflect the continuing independent nature of each hospital and the lack of dissemination across directorates that spanned more than one hospital and across the entire Trust. Continuing to work independently of each other was seen as a hindrance to clinical governance.

### ***Monitoring and audit***

The only audit activity mentioned by staff, with one exception, was in relation to national audits, required for the CSBS, or other national projects, such as the Scottish Hip Fracture audit. These were undertaken by staff from the clinical governance team. The one exception was the CNS noted above to have developed the pressure mattress assessment protocol. When she was interviewed, six months after the Trust wide dissemination of the protocol, she had just completed gathering the first audit data relating to the use and prompt return of the mattress (as they were hired on a daily basis, their prompt return ensured minimum costs were incurred). She had prepared a simple audit tool which nurses ordering or returning the mattresses had to complete. She had not had the opportunity to analyse the data, but was confident that from informal monitoring of the use of the protocol by visiting the wards or talking to nurses, that it was helpful, was being used appropriately in that patients who needed the mattresses were getting them and that it had saved money.

Informal monitoring was undertaken by one NM, who reviewed the costs of continence products across similar wards. She was of the belief that all wards should

be using the same amount of products and those who were spending greater amounts were in her words “*not doing it properly*”. They were not using any of the national guidance available relating to this clinical issue and the NM assumed that greater use of products was not a sign of better care, but was wasteful of scarce resources. National guidance suggests that wards should not put ‘maximum use’ allowances on continence products, but recommends that products should be changed as often as necessary (NMPDU, 2002). Therefore the wards using more products might be costing more, but may well be providing care according to national nursing best practice. Monitoring without an evidence-based standard against which to judge care as in this instance had the potential to further alienate nurses against EBP, if it was presented only as a means of limiting costs rather than focusing on patient benefit.

The CSBS noted that the clinical improvement teams were responsible for audit. However although these teams had been in place at the time of the CSBS visits in early 2002, when this research was undertaken 18 months later, the teams were described by all staff as new and not yet functioning. Despite this discrepancy staff did report that the teams would be responsible for audit, once they were fully functioning.

### ***Clinical improvement teams***

These directorate-based teams were formed as a means of taking a multi-disciplinary approach to clinical improvement, including EBP. None of the staff nominated by the Director of Nursing as having a role in EBP was involved in a clinical improvement team and they were seen by nurses as being medically focused. As noted above there was some discrepancy about how new the teams were and the extent of their work but they were intended to develop EBP although the details of the process were not known by staff interviewed. However one principal nurse was uncertain about the reliance on the teams to get evidence into practice and she thought that shared governance held more promise for success. Her faith in it, she admitted, was based on her belief that it would empower nurses as she had seen the Director of Nursing use it successfully in another Trust. Regarding the clinical improvement teams she was less hopeful:

*‘They lack focus and co-ordination, from what I see and their work is pretty sporadic and frankly all over the place. They do some audit for the CSBS, but then nothing happens. We don’t hear about how we’ve done.*

*The doctors are only really interested in developing guidelines, not implementing. Developing - that's where the glory is'. (Principal nurse)*

The CSBS were informed that the clinical improvement teams would consider local and national priorities and SIGN guidelines and would determine areas for audit.

### ***Shared Governance forum***

Shared governance had been introduced to the Trust in 2001 by the Director of Nursing who had seen it work successfully in another hospital. The forum consisted of three councils, one for clinical effectiveness, one for research and development and one for quality. Nurses were nominated by their charge nurse or NM to participate in the councils, working on specific projects relating to the overarching theme of each council. Other than the research and development council, which had been led and largely supported by one practice development nurse with a research and development remit, the councils had not worked well nor produced the changes to care which the Director of Nursing had anticipated. Both the Director of Nursing and the practice development nurse with the greatest involvement in the forum recognised that there had been problems with nurses having the interest or skills to be involved in the councils, difficulties in being able to attend meetings due to lack of staff cover at ward level and significant problems with nurses from different hospitals (previously separate Trusts) working together, even with a common goal:

*'I'd seen it work so well at [former Trust named] but it was one, much smaller, hospital I suppose. Here it's been an uphill struggle to get people interested, rows about what evidence is and then trying to keep them interested and involved. There's still a legacy from before the merger and people only want to work with people from their own hospital who 'believe' in the same evidence and so on'. (Director of Nursing)*

None of the staff interviewed could provide examples of work undertaken by the councils in relation to clinical effectiveness or quality. Shared governance as a means of progressing EBP within the Trust had fallen into abeyance and had been superseded by the directorate based clinical improvement teams described above.

### *Designated EBP roles*

There were no nurses in Case C who had a designated EBP role. The practice development nurses were seen by other staff as being the most likely to be involved in EBP, but the re-organisation of the practice development unit had brought changes to their remit and they no longer saw this as part of their role.

The two clinical educator posts were again viewed by others as being significant in EBP, but the postholders recognised a change in focus from their previous role (the posts had ended and then were re-introduced with a new remit) which had involved EBP, whereas their new remit was to support student nurses and newly qualified staff nurses, particularly around the development of clinical skills. In addition, there were only two clinical educators in one directorate and they were not shared across the Trust.

CNSs were also regarded as staff with involvement in EBP. Their expertise and close links to medical staff were viewed as important in getting evidence-based information. However, while it does seem as if they were able to use evidence in their own practice, within their own caseload, wider dissemination depended on their particular remit. The wound care guideline and pressure mattress protocol had been disseminated throughout the Trust and had utility throughout the Trust, whereas the tattoo patient information leaflet was very specialised and focused on a very small number of patients. The CNS who had developed this remarked that she could see scope for improvements for the care of in-patient diabetics, but that lack of time to spend on the wards prohibited her from being able to share her expertise in this way.

Several NMs saw the responsibility for EBP as resting with individual nurses, but were unable to say if this was explicit in their contracts. Charge nurses were not seen as having a responsibility to ensure that their staff were using EBP and one NM remarked that charge nurses were overwhelmed just keeping the ward going on a day to day basis due to the pressure of staff shortages and financial constraints and that expecting them to take on EBP was an additional pressure.

### **Case C, in sum**

Although staff in Case C had some knowledge of SIGN guidelines, very few were aware of their use within the Trust. The CSBS noted considerable variation in their use between hospitals in Case C. There was no widespread use of the nursing aspects of SIGN guidelines.

NMPDU best practice statements, although 'launched' in the Trust had not been disseminated and very few staff were aware of them. Staff were generally sceptical of national products, being certain that they would not work in their Trust or hospital context. There was also some concern as to the rigour and representitiveness of the development process of these. It was not clear whether these views were *post hoc* justification for non-use or considered decisions for not adopting them as a basis for practice.

Personal and clinical experience were seen by staff as the most valuable and most used types of evidence, but there was also a recognition that personal preference was also important. The difficulties of incorporating these as EBP, due to the number of different views of evidence, were acknowledged.

The lack of any staff with designated EBPI roles had led to a situation where CNSs were the only nurses involved in EBPI in any significant way. Shared governance had been disappointing in its ability to progress EBPI and the clinical improvement teams were as yet unproven in this regard. To some extent, these circumstances reflected the complexity of EBPI and aspects of content and context in the Trust. While these were not solely related to content, they did have an impact on it.

### **CASE D:**

#### **Types of evidence: National guidelines and standards**

The types of evidence in use in Case D were more limited than in the other cases. SIGN guidelines and other specialist national guidelines, such as that for osteoporosis management produced by the Royal College of Obstetricians and Gynaecologists or standards from the Renal Association were in use. However these examples were

given by CNSs and other SIGN guidelines that might be more generic were not mentioned by any other staff interviewed.

The CSBS standards were being used, according to the CSBS reports, but they were only mentioned by one member of staff at interview.

### **NMPDU best practice statements**

The NMPDU guidelines had been 'launched' in the Trust at the time of their national launch, but were not being used. They were only raised in interview by one of the assistant directors of nursing, who had arranged the launch. Other staff were not aware of them. One of the nurses from Case D had taken the lead role in developing one of these national statements and had been involved in promoting them nationally. Despite this, they did not have a prominent role within the Trust.

### **Local development of guidelines, procedures, protocols and products**

Local development of guidelines, procedures, protocols and policies was the main focus within the case. Nurses had been involved in developing a guideline about the use of mercury free thermometers. The need for this had arisen after a risk assessment exercise by the clinical governance team. However after a year's work and before the guideline was complete, they discovered that the medical physics department had also adopted this task and had developed a complete guidance document which was ratified by the clinical governance director for use throughout the Trust.

Nurses had also developed a guideline for the use of aromatherapy for patients having cancer treatment at the hospital. The guideline content used was mainly practitioner experience and patient preference. The process took two years and once complete went to the director of clinical governance to be ratified. This did not happen due to his concerns over the lack of scientific evidence and the risk to patient safety without it. The nurses were extremely disappointed since they were aware that there was very little 'scientific evidence' relating to the use of aromatherapy, but as the following quote illustrates they felt that other types of evidence should have been considered also:

*'We knew there wasn't a lot of scientific evidence for aromatherapy, but some of us knew a lot about it from outside of work and lots of the patients wanted it but those didn't count and we were over-ruled. It was a waste of two years work and a huge disappointment'. (CNS)*

### **Expert opinion and experience as evidence**

Expert opinion and experience were also used as types of evidence. One CNS explained that she arranged regular visits to the regional cancer centre where many of her patients received treatment, so she could learn from the experience of the medical and nursing staff who worked there. This, in turn, augmented her own knowledge and experience that she subsequently used in several aspects of her work. She explained that many of the treatments were experimental, that is, they were being undertaken as part of clinical trials for chemotherapy and she saw these as expert opinion rather than randomised controlled trial evidence, since the trials were still ongoing. These still influenced the treatments offered to her patients (by medical staff) and administered by her:

*'I was in [regional treatment centre named] updating my chemotherapy training and they were doing different things for small cell lung cancer than we were - different drugs and so on. I discussed it with my consultant and our oncologist and now our practice has changed'. (CNS)*

### **Journal articles as evidence**

Nursing journal articles were used as the basis for many of the locally developed evidence products, in combination with experience and expert opinion. The exact nature of these articles was not known, that is, whether they were robust research that had been subject to double blind peer review prior to publication, or if they were articles that related more to the provision of information on, for example, anatomy and physiology.

### **Initiatives and approaches to evidence use**

#### ***National guidelines and standards***

SIGN guidelines relevant to their particular specialty were used by CNSs and were adopted fully, without local adaptation. One CNS had been involved in the

development of one of the respiratory guidelines and she felt that her practice already reflected the majority of the guideline recommendations by the time it was published.

*'I feel as far as our practice is concerned, that we already work within the guideline. The new asthma one has just come out, but I don't think there's much we need to change to be honest'. (CNS)*

Other CNSs were working to other national guidelines, again, without adaptation, but fully adopting all the recommendations relevant to nursing and using them in their work. This had been hindered in one instance where the Menopause CNS had tried to implement a recommendation from the national osteoporosis guideline relating to identifying women at risk of osteoporosis. It was recommended that women presenting to Accident and Emergency departments with certain fractures, should be referred to the CNS responsible for screening for osteoporosis, as a means of facilitating access to treatment and preventing further fractures. The CNS developed a small referral form, with a minimum amount of information to complete and asked the Accident and Emergency charge nurse to explain the form to his staff and asked that at the end of each week, they send the completed forms on to her via the internal mail system. However the charge nurse flatly refused as he did not consider osteoporosis to be an acute condition and felt that his staff were already overwhelmed with administrative tasks. The CNS developed a further referral form, with only the name of the patient and the date seen in hospital and made another approach, explaining that it would be less work, as she would collect the forms weekly from the department and emphasising that this was a means of following a national guideline which could prevent patients suffering life threatening fractures (such as fractured femur) in the future. The charge nurse still refused as he did not see the relevance of osteoporosis treatment in an acute setting and the situation reached an impasse. The CNS was very disappointed as she considered this to be a relatively simple, but effective way of identifying 'at risk' women, but could not see how the situation could be resolved. So, while there was a willingness by some staff to use national guidelines in their own practice, there were also barriers to their use when this involved engaging other practitioners in the process. Problems of this nature, that is, that were related to the content of the guideline and perceived relevance were also noted by another CNS:

*'Rolling things out across the hospital is more difficult because staff in other areas, for example, A and E, don't see it as being relevant to them, because it's about asthma. But for goodness sake, acute asthmatics come in to A and E all the time, so why wouldn't it be relevant there - not the whole guideline, but the bit about management of acute asthma, but they just don't want to know'. (CNS)*

The SIGN guideline for patient discharge information was in use and since it required the collection, audit and production (for CSBS review) of specific data, this must have been adopted into use, rather than adapting or selecting recommendations, but it was not mentioned by staff at interview.

The CSBS reviews related to the use of national guidelines noted that nurse led clinical pathways had been developed using SIGN guidelines, which suggests adaptation of recommendations, but these were not seen by the review team, were not subject specific and were not mentioned by any of the staff interviewed for this study.

National Renal Association standards had been wholly adopted and were being met and exceeded. The CSBS standards which were based on these in part, were also the basis for care in the renal unit and the NM/CNS had driven the use of these. The nature of the standards ensures that there is not scope to adapt them, they must be adopted and achieved, since they are standards rather than recommendations.

### ***Locally developed evidence products***

This was the main focus of the approach to EBP within Case D. Much of the work was described as *'starting from scratch'* (Assistant director of nursing) to develop products that would reflect local practice as using national products *'wouldn't work here'* (Assistant director of nursing). The aromatherapy guideline and the guidance for use of mercury free thermometers were both examples of locally developed guidelines.

Nursing procedures, policies and protocols that had been developed locally were available in two large folders, with each ward and clinical area having their own copies. Many were quite outdated, according to the completion date included on each, some by as many as twenty years. Some procedures were promoting outmoded

practice that has since been found to be unsafe. Although each procedure contained a review date, usually two years after the completion date, the majority of these had not been updated. The evidence for all these products was described as being from nursing journals and any queries about them were referred to medical staff for clarification. These procedure manuals were being added to the new Trust intranet site at the time the Case was visited which suggests that these were still seen as an important basis for care. Despite this not all staff felt that they were helpful or necessary:

*'I wouldn't say that it was relevant to me at all, in fact I can't think of anyone who would use it[the procedure manual]'. (CNS)*

A locally developed protocol handbook had been developed for use in palliative care according to the CSBS data. However it was not produced as evidence for the CSBS assessment visit and was not evident in the ward areas. None of the staff interviewed for this study mentioned this and therefore the mode of development or evidence base is not known.

The CSBS also noted that there were no locally agreed standards for cancer nursing, as required by the national standards and SIGN guidelines, although one CNS interviewed by the CSBS explained that they were using the SIGN guideline recommendations as the basis for care. In addition, a local guideline for pain management in cancer was being used for all cancer patients, which was based on the SIGN guidelines for various cancers. This reflected adoption of some aspects of the guidelines and adaptation into a local guideline. The SIGN cancer guidelines were not being used in their entirety as other CSBS standards, based on symptom management for patients with cancer, were not met.

A locally developed protocol for management of pain in gynaecological cancer (separate from that described above) had been developed, with contributions from the CNSs, but the evidence base for this was not clear. It was not mentioned by any staff interviewed. Although not seen by the CSBS, several staff interviewed by the CSBS discussed the protocol as an educational tool and it was updated on a six monthly basis prior to the changeover of junior medical staff which suggests that it may have had a more medical than nursing focus.

One other aspect of local development of products was described by the Chairperson of the shared governance forum. Nurses working in the endoscopy unit were concerned by the number of variations in practice of the different medical staff using the unit. The main difficulty arose from the use of anaesthetic throat sprays and the related patient information that nurses were required to provide prior to discharging patients. They were concerned about the risk of providing erroneous information, as each doctor had different preferences, although they all used the same throat spray.

*'We did a lot of searches on the internet and in nursing magazines and we wrote to the pharmaceutical companies and spoke to the doctors about why they did what they did. In the end we didn't get any scientific evidence but we managed to draw up a guideline which everyone is pleased with and all the nurses are much happier working to the same protocol'. (CNS, chair of shared governance forum)*

As a result and after a search for what was described as scientific evidence (none found), they managed to come to a local agreement among the doctors about a standard approach, based on the throat spray product information. This was then written into a protocol format that the nurses found very useful and which had also led to the production of a patient information leaflet. The above quotation reflects some of the ambiguity around different evidence formats such as guidelines and protocols, the terms often being used interchangeably.

A patient information pack, based on evidence from the Renal Association had been developed by the nurses in the renal unit and was commended by the CSBS.

### ***Dissemination***

Dissemination did not appear to be a significant activity within Case D. The 'close knit' nature of the hospital was mentioned by many staff and as a result verbal communication was seen as the most used method of spreading information. The success of this as a strategy for promoting EBP was less certain since products such as the NMPDU best practice statements had not been disseminated and were not known about. The charge nurse and CNSs interviewed remarked that they relied on their own initiative to find out about new evidence, or their own links to national networks, to

keep them up to date. However attempts to involve nurses in dissemination 'events' had been variable:

*'We had a launch for the best practice statements, with a drug company lunch and everything. [Director of Nursing named] even came and opened it to show his support. We held it at lunch time and loads of folk came. People were keen because most of them knew that [nurse named] had been seconded to the development of the oxygen one. It was really good. But then a wee while ago we tried something different, when I was in the practice development post, I advertised a 'research in practice' day to hear about what nurses were doing and to share best practice and I only got two people signing up so it didn't go ahead'. (Assistant director of nursing)*

The CSBS note that there were problems with communication and dissemination in Case D, noting that there needed to be a concerted effort to share information and best practice across wards.

### ***Monitoring and audit***

Audits of practice were undertaken either by the clinical governance team and were almost all medically focused or by CNSs auditing their own work, or the NM/CNS organising and driving audit of individual aspects of practice in his unit. While some of the nursing audits were undertaken to highlight areas for improving practice, most were carried out to meet national standards, such as those for the CSBS reviews.

Audits for the CSBS were variable; some, such as those undertaken in the renal unit were detailed and exceeded the standards and information required. Others were described as vague, unfocused or of poor quality and some, meant to provide evidence of the implementation of a guideline, did not do so. Outwith the renal unit, the audits provided were individual, single audits and did not complete the audit cycle.

### ***Shared governance***

A shared governance forum had been introduced in 1999 as a means of empowering nurses to change practice. It consisted of three councils: clinical practice, professional development and research. Although originally aimed at nurses and staff from the professions allied to medicine, it was viewed within the Trust as only for nurses and no other staff had ever attended. Nurses were nominated by their charge nurse or NM or could volunteer to be involved and were involved in one of the three councils, with a chairperson (a CNS) who oversaw the work of the whole forum. Any nurse could suggest a topic for consideration and the councils made a decision on the priority and relevance of the topic. After initial enthusiasm and the development of one guideline (aromatherapy, described above) and one guidance document (the use of mercury free thermometers, in conjunction with medical physics) and one protocol for the standardisation of anaesthetic throat sprays, interest dwindled. The disappointment of not seeing the aromatherapy guideline ratified had had a detrimental affect on the forum. In addition, many nurses found it difficult to leave the ward to attend meetings, either because of shortage of staff or the perception of colleagues that it was a waste of time. The CNS who had been the chairperson was unable to stand down from this position after her two year 'term of office' as there was no willing successor. She also explained that due to the nature of her nursing post, she had no-one to cover her workload while she was involved in shared governance work and often completed this in her own time.

At the time the Trust was visited for this study, the shared governance forum was in abeyance, having been inactive for almost two years. No other initiative was thought by staff to hold more promise for involving nurses in EBP.

### ***Designated EBP roles***

No nurses in Case D had designated EBP roles. The absence of a practice development unit meant that it was not even a part of a practice development nurse remit. Prior to the unification of the Trust in 2003, two practice development posts, one for nursing and one for midwifery, existed. The nursing remit had been incorporated into one of the assistant director of nursing posts, but was much more strategic than operational or practice based. The midwifery post had remained and was seen by the post-holder as a vital role.

Two nurses were mentioned as having the most significant involvement in EBP. The first, was the CNS who had become the chair of the shared governance council. Although it was clear that she had had a significant role in this regard, the forum was inactive and so although she liaised with the clinical governance director when asked to do so, she no longer saw herself as having active involvement in EBP, except in her own practice.

The second, a development nurse, who had worked in the Trust for her entire career and continued to work past retirement age, had sole responsibility for developing, writing and updating all the nursing policies, protocols and procedures contained in the nursing procedure manual. This onerous task was undertaken in only six hours per week. She had no knowledge of national EBP products such as SIGN guidelines or NMPDU best practice statements and explained that she was unable to search, access, appraise or grade evidence, but received support from library staff with these tasks. Her main sources of evidence were nursing journals and the opinion of medical staff. She explained that she kept all the nursing articles, should she be ever be required to provide evidence for her work. She worked in isolation and had no connection to the shared governance forum and no access to wards, without the invitation of charge nurses. The assistant director of nursing explained that her former role as a clinical teacher and her formidable personality meant that staff were not comfortable having her on the wards:

*'She's very good at what she does, but none of the charge nurses would invite her in, it's a bit like the wolf and the three little pigs! They knew her as a clinical teacher and they'd be afraid that she would pick them up on things. I must admit that even I'm slightly afraid of her and I'm her boss now, but she wouldn't see it like that and she's told me where she thinks I'm going wrong more than once'.*

This situation reflects the complexity of EBPI, in that role, knowledge and skills are not the only factors that can impact on the process.

While none of the staff interviewed mentioned the responsibility of individual nurses in relation to EBP, the charge nurse felt that she lacked the time to keep up to date

herself and recognised that the skills needed to appraise evidence and adapt it for use were not straightforward and, she felt, would be beyond most nurses. The CNSs and the NM/CNS were all involved in adopting, adapting and using evidence in their work. They were not linked to the wider nursing structure so any generic aspects of this were not shared outwith their own area of practice, although some were shared outwith the hospital through national networks and presentations.

#### **Case D, in sum**

Review of all the data relating to content and the aspects of process involved in describing the ways in which evidence was used focused on combined aspects of EBPI. The work related to EBP in the renal unit was not only commended by the CSBS but had received national and international note. In particular, the NM/CNS was the driver and supporter of much of the audit work undertaken by the nurses who were encouraged to go beyond the minimum standards required. The patient information pack developed in the unit was also noted to be of a high standard.

The lack of a practice development unit or staff with dedicated EBP roles has left the Trust in the position of having relied almost totally on a single strategy for progressing EBP in nursing (the shared governance forum) that had been limited in its effectiveness and was now not functioning at all. The isolation and limited skills of the development nurse meant that there was little connection between her work and other related initiatives such as clinical governance staff or CNSs – the nurses most involved with EBP, but with a limited reach due to their isolation from the wider nursing structure. The efforts of two CNSs to adopt national guidelines into their own and influence wider nursing practice had been impeded by other nurses. There did not appear to be any structure that would have enabled them to address this with more senior staff or NMs. This illustrates that the desire to use EBP or progress EBPI is not always enough to ensure success, other factors, structural or personal can also be impediments.

The content aspects of EBPI in Case D were more piecemeal than in A or B and in some ways reflected those in Case C, but it was contextually very different. However, staff faced many of the same problems in relation to evidence content and use, which suggests that context, while significant, is only one factor that impacts on EBPI. A more detailed cross-case analysis follows.

## **CROSS-CASE COMPARISON OF CONTENT**

Across the cases there were more aspects of similarity than difference regarding notions and understanding of evidence and to a lesser extent the ways in which evidence was used. Table 5.1 overleaf shows the main points relating to specific and more generic aspects of content and which highlights those similarities and differences. These are now discussed more fully.

### **National guidelines, standards and NMPDU best practice statements**

Although some staff in all cases were aware of national evidence-based products, the extent to which these were widely known about did vary. Although SIGN guidelines were mentioned by staff in each of the cases, they were often perceived as being more medically orientated and therefore not relevant to nursing. CNSs across all the cases were the nurses likely to be using at least some recommendations from SIGN guidelines in their own practice and some, for example, one cancer CNS in Case A had incorporated the recommendations from several SIGN guidelines into a locally developed guideline. Many nursing staff were not aware of (or if they were, they did not mention when interviewed) the use of SIGN guidelines as the basis for CSBS standards and the use of SIGN guidelines as requirements of the CSBS standards. While some of these were more focused on medical care and outcomes, such as waiting times for oncology surgery or specific bowel preparation prior to surgery (CSBS Breast, Ovarian and Colorectal cancer reports), others were more generic in nature. For example, the standards relating to patient discharge information and communication skills training were both relevant and involved aspects of nursing practice, but staff did not mention these at interview in any of the cases. In fact, the CSBS standards were only raised by one member of staff (the NM/CNS in Case D), at any level within any of the organisations represented in the research. However, the CSBS reports themselves and in particular, the generic Clinical Governance reports, all highlight the considerable difficulties that Trusts had in meeting the standards because of pressures of time to prepare for reviews and monitoring visits. As a result of these difficulties NHSQIS has altered the way in which reviews are carried out.

**Table 5.1: Summary of evidence content across cases**

	<b>Case A</b>	<b>Case B</b>	<b>Case C</b>	<b>Case D</b>
<b>Use of national guidelines, best practice statements and standards</b>	<p>CSBS standards in use as basis for practice and audit SIGN guidelines in use for CSBS monitoring.</p> <p>Some use by CNSs in own area</p> <p>Best practice statements in use by practice development unit</p>	<p>As Case A except nursing staff not aware of any use of SIGN guidelines as seen as medically orientated.</p> <p>Best practice statements widely circulated and use expected by Director of Nursing</p>	<p>As Case A except SIGN guidelines seen as medically rather than nursing orientated.</p> <p>CNSs using those relating to their area of practice.</p> <p>Best practice statements not in use</p>	<p>As Case A except additional use of disease specific national guidelines by CNSs.</p> <p>Best practice statements not in use as never disseminated</p>
<b>Local development of evidence products</b>	<p>Some CNSs developing own guidelines. Use limited to their own area of practice.</p> <p>Some nursing procedures developed by medical staff</p>	<p>Some CNSs developing tools to support practice, but not widely used.</p> <p>Teaching packs developed for student nurses.</p> <p>Several nursing guidelines developed by one PDN, but no local ownership.</p>	<p>Locally developed procedures, policies and protocols available but use varied.</p> <p>Medical staff preference used as evidence to develop specific nursing protocols</p>	<p>Some local guideline development, but quite limited.</p> <p>Separate development of nursing procedures, policies and protocols.</p> <p>Medical staff preference used as evidence</p>
<b>Use of other products as the basis for practice</b>	<p>Marsden manuals available in all clinical areas</p>	<p>Patient stories used as evidence.</p> <p>Journal articles used as evidence</p>	<p>Marsden manuals available in some clinical areas but not all</p>	<p>Journal articles used as evidence.</p> <p>Personal experience/learning seen as evidence</p>

**Table 5.1 continued**

**Initiatives and approaches to evidence use**

	<b>Case A</b>	<b>Case B</b>	<b>Case C</b>	<b>Case D</b>
	Adoption and adaptation of national guidelines in line with CSBS standards. Audit for CSBS and limited additional nursing audits based on evidence. Evidence use in education. Exclusion of evidence to 'fit practice'.	Adoption of national guidelines in lines with CSBS standards and used as basis for audit. Exclusion of evidence to 'fit practice'.	Adoption and adaptation of national guidelines in line with CSBS standards Shared governance form formerly in place. Directorate based teams developing practice. Exclusion of evidence to 'fit practice'.	Adoption and adaptation of national guidelines for CSBS monitoring and used for audit. Some audit taking place, by NM/CNS. Shared governance forum in abeyance.
<b>Communication</b>	Clear lines of communication regarding most aspects of EBP. Practice Development Unit had role in disseminating EBP information CNSs not tied into nursing structure	Lines of communication regarding EBP not always clear. Written communication re: EBP from DNS to Charge Nurses. Practice Development Unit not connected to wider EBP communication. CNSs not tied into nursing structure	Lack of clarity about lines of communication re: EBP Changes to Practice Development Unit remit potentially detrimental to dissemination of EBP CNSs working in isolation from nursing structure	Differing views on lines of communication for EBP. CNSs working in isolation from nursing structure

**Table 5.1: Summary of evidence content across cases**

	<b>Case A</b>	<b>Case B</b>	<b>Case C</b>	<b>Case D</b>
<b>Use of national guidelines, best practice statements and standards</b>	<p><b>Case A</b></p> <p>CSBS standards in use as basis for practice and audit SIGN guidelines in use for CSBS monitoring.</p> <p>Some use by CNSs in own area</p> <p>Best practice statements in use by practice development unit</p>	<p><b>Case B</b></p> <p>As Case A except nursing staff not aware of any use of SIGN guidelines as seen as medically orientated.</p> <p>Best practice statements widely circulated and use expected by Director of Nursing</p>	<p><b>Case C</b></p> <p>As Case A except SIGN guidelines seen as medically rather than nursing orientated.</p> <p>CNSs using those relating to their area of practice.</p> <p>Best practice statements not in use</p>	<p><b>Case D</b></p> <p>As Case A except additional use of disease specific national guidelines by CNSs.</p> <p>Best practice statements not in use as never disseminated</p>
<b>Local development of evidence products</b>	<p>Some CNSs developing own guidelines. Use limited to their own area of practice.</p> <p>Some nursing procedures developed by medical staff</p>	<p>Some CNSs developing tools to support practice, but not widely used.</p> <p>Teaching packs developed for student nurses.</p> <p>Several nursing guidelines developed by one PDN, but no local ownership.</p>	<p>Locally developed procedures, policies and protocols available but use varied.</p> <p>Medical staff preference used as evidence to develop specific nursing protocols</p>	<p>Some local guideline development, but quite limited.</p> <p>Separate development of nursing procedures, policies and protocols.</p> <p>Medical staff preference used as evidence</p>
<b>Use of other products as the basis for practice</b>	<p>Marsden manuals available in all clinical areas</p>	<p>Patient stories used as evidence.</p> <p>Journal articles used as evidence</p>	<p>Marsden manuals available in some clinical areas but not all</p>	<p>Journal articles used as evidence.</p> <p>Personal experience/learning seen as evidence</p>

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<b>Use of other products as the basis for practice</b>	<p>Marsden manuals available in all clinical areas</p>	<p>Patient stories used as evidence.</p> <p>Journal articles used as evidence</p>	<p>Marsden manuals available in some clinical areas but not all</p>	<p>Journal articles used as evidence.</p> <p>Personal experience/learning seen as evidence</p>

It may be that these were not raised as evidence by nurses or NMs because they are not aware that they were evidence-based or do not view them as evidence, seeing them instead as aspects of routine monitoring rather than elements of EBPI with scope to improve practice. However, it may be that they are viewed by even senior NMs as more medically focused and therefore were not relevant to nurses. The elements in most CSBS reports that mention nursing directly are related to CNS input and as all the CNSs in the cases were not managed by NMs, this could account for their lack of engagement with these aspects of the CSBS standards.

Other national guidelines, such as those produced by specific medical bodies, for example, the British Society of Gastroenterologists, were being used by CNSs in their own practice, but were not influencing wider practice, for example:

*'I follow the BDA [British Diabetic Association] guidelines in what I tell patients and things, but I know that doesn't happen on the ward because patients tell you that they've been told something completely different. It's confusing for them, but if they're my patients, I tell them to listen to me'. (CNS, Case C)*

The CNS felt that the care given on the ward was poor but remarked that she did not have time, or a remit, to become more involved to try to, for example, standardise patient information.

The NMPDU best practice statements had only been widely disseminated in Case B, although some charge nurses in Case A were also aware of them. In Case B this had been driven by the Director of Nursing although communication regarding their subsequent use had not been clear, in that charge nurses were not sure what was expected of them in relation to use of the statements. Similarly, in Case A, charge nurses were not sure exactly what to do with the statements, except to put them in a folder and remarked on the lack of information about their use. The Director of Nursing in Case B stated her expectations subsequently, although did not give any information as to how implementation of these should take place. Not all the statements disseminated were relevant to every clinical area, but there was a documented expectation that they should be in use. This left charge nurses with a

dilemma, how to demonstrate that they were being used prior to monitoring visits from the Director of Nursing? As a result both charge nurses interviewed had treated all the statements in the same manner, displaying them in a prominent place on the ward, but taking no other action. Although two of the statements were less relevant to the nurses in their wards, three were more generic in nature and one was specifically related to the clinical speciality represented by one charge nurse interviewed. When asked about the use of this best practice statement at interview, she replied:

*'The thing is they are more community focused, I think, like the oxygen one. Just because there is one about continence, it isn't really all that relevant here, maybe if you were working in the community, it would be more for you'. (Charge nurse, urology ward).*

It is difficult to see how a statement specifically aimed at promoting continence and providing better continence care for patients in all settings (and with specific statements to that end) could be perceived as not relevant in a urological setting. As justification for non-use it could not really be supported, but it may reflect a more specific problem of lack of knowledge and skills to undertake EBPI. The charge nurse, by deciding the statements were not relevant to her ward had circumvented evidence into practice issues. The decision making process in this instance may not even have been a conscious one.

The practice development unit in Case A was using some of the statements as a basis for education, particularly in relation to continence care, but those relating to nutrition had also been included as part of education for health care assistants. In both Case A and B, individual practice development nurses had been given the specific task of implementing the statements, but this was not without difficulty in either case.

In Cases C and D, both had held high profile 'launches' of the statements, as both had had CNSs involved in the development of these national products. Despite this dissemination had not taken place in either case and nurses were not aware of them, nor using them in Case C or D. No mention was made of specific plans to remedy the situation in either case.

### **Local development of products**

There was some development of evidence-based products at a local level within each of the cases. The staff most likely to be involved with this were CNSs and this was borne out in interviews and from the CSBS reports. A former practice development nurse in Case B had had an almost exclusive role to develop local nursing guidelines as this was thought, by the Director of Nursing, to be the most effective way of ensuring local 'ownership' of these and therefore seeing them used in practice. While these guidelines were numerous and varied, the extent to which they had ever been used in practice was questioned by all staff in the Trust. Likewise, in Case D, one nurse had, for many years, sole responsibility to develop and update nursing guidance. Other staff interviewed, while aware of her role, did not use the procedures, policies or protocols, although they did know where these could be accessed:

*'I couldn't tell you when I last looked in the procedure manual or anything. You just sort of learn as you go along and from watching other people in the early days, but as you get more experienced you don't need things like that, your own experience is what you rely on really. But if I had to, for a student or something, I could probably lay my hands on it'.*

(Charge nurse, Case D)

So local development did not guarantee local ownership or local use of evidence-based products although there was a widespread belief across the cases that it would. Rejection of national products, often on the basis that they were not relevant or did not reflect current local practice, was entangled with the notion that involving nurses in the local development of EBP products would empower them to be more involved in changing practice. Again, this was not borne out in the study, with the exception of CNSs.

In all cases, nurses reported the influence of medical staff on the local development of evidence-based products. In Case B, this was only in relation to a consultant approaching a charge nurse to become involved in developing a guideline, but in Cases A, C and D the preference of medical staff had become the basis on which protocols for nursing care were based. In Case D this had been driven by nurses who were frustrated and confused by the number of different approaches taken by medical

staff to the same procedure and they were concerned, from a patient safety aspect, that this increased the chances of a mistake in providing care. This concern led to the development of a protocol to which all the medical staff agreed and that nurses would follow.

In all three cases nurses were concerned that medical staff were making decisions about nursing care, but more so, that the basis for the protocols were medical opinion and preference, rather than any other evidence. This was in stark contrast to their views on the types of evidence that they thought were important in nursing, where personal experience (their own expert opinion) was highly valued, but the expert opinion contained in, for example, the NMPDU best practice statements, was not always considered valuable:

*'For so many of these statements, they've gone for expert opinion and that isn't any better than the expert opinion that I have or my nurses have. These might be national documents, but how representative are they of national expert opinion? I don't think there's such a thing. That's why they don't really work for me'. (NM, Case C)*

The extent to which each locally developed product was evidence-based varied. It was possible to view examples of these in each case but the evidence-base was not always clear. Case B had taken the most care to show references and grade evidence, including expert opinion, on their own guidelines, but the Director of Nursing saw this as a hindrance, rather than a means of showing the evidence base for particular guidance:

*'From what I've heard, the problem is that nurses look at them [the guidelines] and see that the evidence is down at D and decide that their opinion is just as valid as any other nurse expert, so they don't use them'.*

She admitted that this was disappointing but also acknowledged that there was a paucity of higher grades of evidence for many of the guideline subjects that they had tackled. In addition a lack of knowledge (and she included herself in this) about

research, research rigour and what would 'count' as robust evidence hindered their use.

Apart from Case B, none of the locally developed products in the other cases provided information about, or referenced, the sources of evidence used. As a result it was difficult to properly conclude the extent to which they were evidence-based rather than, for example, being based on local custom and practice. Some were clearly not evidence-based, for example, the procedure in Case D for the use of steam inhalators which have not been used in clinical practice for over 20 years due to safety concerns. Likewise, one of the clinical educators in Case A relied on information from medical equipment and pharmaceutical companies as evidence and did not feel that there could be any conflict of interest or potential bias in this type of information. While the study did not set out to appraise or judge evidence-based products, it was not possible to consider content without drawing conclusions as to the variations in the quality and types of evidence used in these locally developed products.

### **Use of other products as a basis for practice**

In Cases A and C, practice development nurses mentioned that *Marsden manuals* were available in each clinical area, but they were not certain that these were in regular use. There were also concerns in both cases that these were not always the same editions and that some may have been considerably out of date. No other staff mentioned these as being used or as a basis for EBP. Only the 2006 editions of the manuals are acknowledged by the authors to be explicitly evidence-based, with references to specific guidelines. Previous editions were based on expert opinion or custom and practice and would not necessarily be superior to those developed locally.

One NM, in Case B, was the only member of staff interviewed who raised the use of patient stories as evidence, as described fully in the earlier section relating to the Case. This seemed to stem from her experience as a charge nurse undertaking a leadership course and was specific to that particular course. As this had not been adopted widely within her own Trust, or by any of the other Trusts, this would account for her view being the only one relating to this type of evidence. However, other nurses, particularly CNSs, did see patient views and patient choice as evidence, which would not be dissimilar to patient stories. However, the ability to use them in a formal way, such as in a guideline, had been unsuccessful as they were not considered to be robust

enough evidence. This situation reflected the tension that existed in trying to balance a lack of high graded evidence with a greater amount of evidence of lower grades and still manage to produce a robust and widely acceptable and accepted guideline or evidence-based product.

Journal articles were seen as evidence in both B and D. Those referred to in Case B were mainly articles relating to anatomy and physiology and opinion or news items from popular nursing journals rather than research. The charge nurse who saw these as an important basis for practice also felt that it was important that these articles should be from UK journals as the evidence was more relevant. It does not appear from the cases that journal articles were more widely used than in these instances.

The other type of evidence the nurses in all cases were using was personal experience. This was gained through practice and through attendance at conferences, or as explained by one CNS in Case D, through personal contacts:

*'If I'm stuck with something or want to try something new, like I'd heard at a conference or national meeting, I would contact one of the other respiratory nurses in [city named] because they tend to have the personal experience of using different treatments, just because they're a bigger centre than us'.*

She explained that this kind of contact and sharing of practice experience was possible because the respiratory nurses knew each other through meeting at national events and through a local network meeting. These opportunities not only made making contact easier, but provided some sense of rigour about who might have the most experience or greatest knowledge about a particular clinical problem. The relative geographical isolation and size of Case D meant that nurses had to be more proactive in seeking opportunities to keep in contact with experts in other areas. Although Case A shared some of the same problems of isolation and geographical spread as Case D, the CNSs seemed to be more self sufficient in terms of writing their own guidelines and in undertaking similar activities. Although not geographically particularly close, many patients from the Case D catchment area went to a larger national centre for treatment, particularly for cancer treatment. This meant that patients were often started on

treatment regimes in another hospital and nurses, particularly the CNSs, were expected to be knowledgeable about these when patients attended for follow-up treatment in Case D. However, in Case A, patients were treated, not necessarily locally, but in the Trust District General hospital, rather than being sent to more distant regional or national centres. As a result, the CNSs would be more likely to be familiar with treatment regimes and plans which could account for the difference between the cases.

While only the CNSs in Case D raised this kind of personal experience (which could also be classified as expert opinion) as the basis for practice, CNSs in other cases may also have been part of local or national networks which were used in this way. However, due to their management by medical staff, many of the CNSs interviewed, in all sites, relied upon the experience and opinion of medical staff in directing their care.

Although few examples were provided, across the cases nurses listed personal experience as an important basis for practice and one of the concerns about EBP was that it did not take adequate account of this. Research (about which many were dubious) was seen as being given an inappropriately greater weight than experience and this typified the scepticism that many nurses expressed towards EBP overall.

### **Initiatives and approaches to evidence use**

In all cases, although it was not always clear from interview data, there was adoption and adaptation of SIGN guidelines evident from the CSBS reports. The involvement of nurses in this appears to have been minimal, with the exception of CNSs. The CSBS standards were also in use for audit purposes, but again the nursing involvement in this was negligible and these audits were only undertaken for national monitoring and inspection, they were not spontaneous or used independently to improve wider practice. In Case A alone, some informal nursing audit based on national standards or locally developed protocols was undertaken by practice development staff and one NM. However in Case D, in one clinical area, led by a NM/CNS, audit was seen as an integral part of everyday practice and each member of staff was responsible for a specific aspect of practice and the audit of that same aspect. Their work was underpinned and to some degree led by national standards for care and the NM/CNS at least saw these as crucial to showing continual quality of care. His belief in this was

such that as a staff team they had undertaken audits in addition to those required for CSBS monitoring in an effort to further improve on specific aspects of care. The extent to which the audit cycle was completed, by re-audit was not clear from interviews, but the CSBS remarked on the quality of audit overall.

In Cases A, B and C, practice development nurses spoke of a more questionable approach to evidence use when developing local products. Having gathered evidence, if it was thought to be too far removed from current practice, it would be excluded or adapted to close the gap between current and evidence-based practice. While adaptation of evidence is recognised as an important step towards EBPI, the exclusion of evidence or the adaptation of it to better reflect current practice seemed at odds with the principles of EBP which aim to change practice to reflect evidence rather than change evidence to reflect practice. The nurses explained that this was a means of ensuring that nurses would engage with EBPI rather than see it as totally unachievable if the gap between evidence and practice was too great.

In Case A, initiatives involving the education of health care assistants had incorporated some of the NMPDU best practice statements, as noted above. While practice development nurses in Case C were also involved in providing education and were going to be even more involved in this aspect of their role after the changes to the remit of their unit, they were not able to give examples of evidence used in educational initiatives. The focus of their work was changing to cater for the increasing need for practitioners to update and maintain clinical skills. While much of this work was more practical in nature, such as moving and handling updates or maintenance of resuscitation, than the education undertaken in Case A, it may also have been evidence based, but this was not made clear by the staff involved.

In Cases C and D shared governance forums had been developed as a means of progressing and involving nurses in EBPI. However, these had had limited success in both cases, with both in abeyance at the time the Trusts were visited for this study. In Case C a different approach had been taken to develop EBP that involved all staff, not only nurses, and these directorate based teams were seen as superseding the shared governance forum. The size of the Trust, the complexities and number of specialities in each Directorate as well as the medically led nature of these teams were all concerns

of the staff interviewed in Case C. There was a fear that nursing practice would be overlooked, although there was also an acknowledgement that the efforts of nurses to 'go it alone' through shared governance had also been a disappointment.

### **Other aspects of content**

The following four themes reflect the complexity of EBPI in the Trusts and the interaction between aspects of context, content and process. As each principally concerns the 'what' of change in Pettigrew's framework (1985a; 1988a), they have been included as aspects of content, but it is important to acknowledge that some do cross the boundaries between content and process or content and context.

### ***Communication***

Within each of the cases there were difficulties relating to content and process aspects of EBP and communication to a greater or lesser extent. Case A had the most clear and robust organisational structures in place to tackle EBP, which certainly seemed to facilitate communication, however it was not without its difficulties:

*'I turn up at meetings and one of the charge nurses will be talking about something new that is going on and I'll think, "I've never heard about that - why haven't I been told about that" (NM).*

Much of the communication in all of the cases was not verbal, but written. This then depended on the information arriving at the correct destination and being seen by the intended recipient and then, if appropriate, acted upon. This process was often fraught with difficulties as this example from Case D illustrates:

*'I gave this staff nurse something about shared governance and I said to her "Are you interested?" She said she was so I gave her something to read and said "You read it and give me comments". I'm not asking the ward sister, I'm asking the staff nurse - and what happened? I came back about three weeks later and said "You haven't responded to that". She said that she had left it for Sister. And the same thing happened again three weeks after that.'* (Assistant director of nursing)

Much of the communication around EBPI was built on assumptions, for example, although it seems as if the NM quoted above had made herself clear, the staff nurse assumed that communication in relation to shared governance must be meant for the charge nurse. In Case A where the practice development unit led the EBP agenda for nursing, there were also several clinical educators in post who all appeared to have different roles when raised at interview. While they were clear about their own remit, other staff were not, particularly in relation to EBP. While one of the charge nurses was aware of the clinical educators as they occasionally worked on his ward, he could not be specific about their role:

*'He sees the students and that and I assume that he would do evidence-based practice and things like that.'* (Charge nurse)

Explicit communication about the clinical educator role and EBPI had never taken place and the charge nurse was not certain about what the role involved in its widest sense, or in relation to EBPI.

Communication to avoid duplication of effort was also not clear. In Case D, two years into a project by medical physics staff, the nurses decided that they would also consider the use of digital thermometers and started the work, only to realise one year later that the work had already been done. A similar problem had occurred in Case C, where four nurses (three CNSs and one unknown other nurse) had independently developed two wound care guidelines. One had been disseminated as hard copies to the wards, the other was available on the Trust intranet, and their content differed significantly.

Communication to avoid effort in the first place was also a problem, in terms of the channels for checking out the viability of any guideline or other type of EBP. In Case A, a group of CNSs had spent over two years developing a guideline for the use of aromatherapy with cancer patients. Having completed the guideline it went to the Chair of the clinical governance team for validation and the guideline was rejected:

*'He told me that there wasn't enough evidence. There was plenty of evidence, lots of patients saying how much they had benefited from it, but*

*not the kind of evidence they want so that was two years work down the drain. I won't be doing it again, I can tell you'. (NM/CNS)*

A similar situation had occurred in Case D with evidence-based guidelines developed through the shared governance council failing validation by the clinical governance team and therefore could not be used in practice.

Communication around EBP was often implicit and this led to confusion and to a lack of clarity about roles and remits. Most often this related to others assuming who had the responsibility for EBP, which in all cases meant that things did not get done. Staff were not always clear about whether they were 'allowed' to develop practice or who they would approach to find out. The two CNSs in Case D who had been unable to make progress with adopting SIGN guidelines into practice as the result of the intransigence of the Accident and Emergency charge nurse, lacked communication channels to address the problem and lacked clarity about who had the ultimate authority in the circumstances.

The sense that permission to undertake EBP activities was necessary was seen in all cases, but it was not always clear to staff firstly if this was necessary, or if it was, from whom it should be sought. Some charge nurses were given ambiguous messages by NMs when it was clear that they were expected to be responsible for all aspects of ward management, but this did not include making evidence-based changes to care, as in Case C:

*'I wouldn't want them to be going ahead with any changes without discussing it with me first and getting permission' (NM).*

Practice development nurses reported that nurses in Case C felt that this was not always appropriate as their managers had no nursing background and therefore did not understand what nurses were trying to do. In Case A, NMs acknowledged that they liked to know about changes on the wards and staff said that they would most likely let them know out of courtesy, but that it was not a prerequisite step to introducing change. More senior nurses, such as the CNSs, were not managed by NMs and

therefore never approached them to discuss clinical care. This was evident in all cases.

While NMs liked to know what was going on within their area of care, staff also liked to be kept up to date. While some internal communication from senior levels within Cases A and C was undertaken electronically, this was not always readily accessed by staff who had limited time to read newsletters and related information at work and had limited access to a computer in the workplace since this was often being used for patient related matters. Staff in Case D in one specialist unit felt particularly aggrieved as they had received national and international commendation for their work, but this had not been acknowledged within the Trust or communicated to them, either by the Chief Executive or the Director of Nursing. The staff were particularly proud of these examples of EBP and felt that they were not valued by senior staff as a result. This had led to particularly low morale in the unit.

### ***Understanding and undertaking EBP***

In each of the cases it was clear that there was a lack of understanding about the complexity of all aspects of EBPI. As noted earlier in this chapter, there were differing views on the nature and types of evidence and a shared understanding of evidence or EBPI was not seen in any of the cases. There seemed to be little understanding about the need for clear lines of communication and connectedness within the organisations. Staff often had the ability to describe the nursing structure and the wider organisational hierarchy and related structures, such as clinical governance teams, but were not aware of how these linked up, if indeed they did, and how these related to EBPI. Staff in Case A seemed the most clear about this, as the practice development unit played a pivotal and central role in co-ordinating the nursing aspects of EBP and linked into the other related structures such as clinical governance and audit teams.

With the exception of the nurses who held joint roles as NM/CNSs in Case A, none of the other staff interviewed acknowledged at the beginning of the research interview that they were directly involved in EBP. It was almost always attributed to another member of staff and often they were unclear as to whose responsibility it was. This often changed over the course of the interview. For example, in response to the

opening question in the interview, one NM said: *'My only influence on evidence based practice is through the charge nurses, beyond that I have none'*. By the end of the interview she felt differently about it *'I suppose my whole role is related to evidence-based practice, it is integrated into everything and underpins everything I do.'* It was almost as if they had never had the opportunity to consider it before and having been given that, realised that it was more significant than they had previously thought.

Since knowledge of EBP seemed to be focused mainly on the products, staff were not able to discuss implementation processes, but instead often presented espoused theories of implementation. There was a sense in all the cases that staff did know what should happen, but were not putting it into practice and that they did not recognise just how difficult the process was. This was borne out by the CSBS visits where the information provided by the Trusts about implementation did not match actual practice during visits. The focus in all cases had been on evidence product development, rather than on implementation, perhaps as one NM in Case C acknowledged, because that was seen by staff as attracting *'the glory'*. However, it may also reflect their lack of understanding of the need for active management of the EBPI process, rather than relying on the existence of products to ensure their use in practice.

### ***Authority and autonomy***

Authority and autonomy were recurring themes through interviews and data analysis. As a result, it appears again in chapter six in relation to process aspects of EBPI, whereas here, the focus is only on the content aspect of authority and autonomy.

In the section above on communication, it was clear that messages relating to EBP were not always clear. Some staff at ward level were unsure as to whether they were allowed to make changes to practice on their wards without the permission of management, whereas others would be prepared to go ahead regardless. There was also a lack of clarity about what changes could be made (that is, the content of change) without specific permission. While some NMs wanted to know beforehand about any changes that might be made, others were very much of the opinion that charge nurses should be taking the initiative and as long as they discussed it with the

NM more as a courtesy, that was acceptable. However this was not always clear to staff:

*'I was once given a real telling off after I rearranged the ward equipment store, so I wouldn't be about to do anything without being told to by my manager first'. (Charge nurse)*

In Case C one manager was very clear that she would not be happy for staff to make any changes without discussing them first. As she did not have a nursing background, she clarified that this was not due to her opinion on the benefits to patients, but to ensure that there would not be cost implications that it would be important for her to consider.

All charge nurses spoke of the increasing levels of responsibility and the expansion of their role and this was acknowledged by several NMs across all cases. The delegation of management duties and the need to cover NM roles outwith office hours in hospitals gave a confusing message to charge nurses. On the one hand these were nurses who were in charge of overall patient care, and in Cases A, B and D, also responsible for ward budgets (budgetary control had been with charge nurses in case C but had been withdrawn). Out of hours, these nurses had a NM role for emergencies, press contact and arrangement of staff cover. However, they were not clear about the extent to which they could introduce evidence-based or other changes on their wards that would improve patient care. In Case A the NMs were keen to see charge nurses become more autonomous:

*'I feel that at last the charge nurses are becoming charge nurses and actually take charge of all aspects of the ward. They don't need to ask, they can just go ahead and then let me know what's happening, so I can organise cover for the ward'. (NM)*

The authority to make changes on a larger scale often rested with doctors as was the situation with the aromatherapy guideline in Case A and a similar situation in Case D. These were both felt by nurses to be very unfair and due to a lack of acknowledgement that different types of evidence were important to different staff.

They were unable to challenge this authority and in both situations this had led to a loss of morale and goodwill, since much of the work on these guidelines had been undertaken outwith working hours.

In terms of needing authority to implement national guidelines or best practice statements, staff in all cases felt that this would probably come from clinical governance teams, but no-one in any of the cases had sought to do so. In Case B, the Director of Nursing had sent a letter out to charge nurses to inform them that she would be visiting wards to ensure that NMPDU best practice statements were being used. The charge nurses interviewed assumed from this that this was not only permission to use them but also a clear statement that they should be using them. Prior to receipt of this letter this had not been understood. Once again, communication relating to EBP was not explicit.

It was clear in all cases that the most autonomous staff in relation to EBP were the CNSs. This would be appropriate in terms of their role and responsibilities, but many were on equivalent grades to charge nurses, who, it seemed, were less able to act autonomously with regard to changing patient care. In all sites the CNSs were not exclusively managed within the nurse management structure and this may be the factor which gave them greater autonomy although the professional aspects of their role were overseen by NMs. This situation gave them either real or perceived greater freedom to work autonomously or less concern about monitoring or consequences by or from NMs.

### **EBPI roles and responsibilities**

While many staff did not recognise their own role in EBP, they were able to name individuals within the Trust who were responsible for EBP. Apart from Case A, where individuals within the practice development unit all had EBP related roles, in each of the other cases individuals had the sole responsibility for EBP, or this might be shared with a very few others across the Trust. In Case B, as noted above, one practice development nurse had previously had the task of leading the development of all the evidence-based nursing statements and was also charged with developing and co-ordinating the audit of these. All staff interviewed named this individual as the

person who 'did' EBP, but when she had resigned from her post, work on these stopped and the practice development unit underwent a radical restructuring.

In Case C the Director of Nursing recognised that the success of the research council of the shared governance forum was entirely due to the enthusiasm and ability of one practice development nurse and she had played a significant role in sustaining this, while the other parts of the council had dwindled. This was solely concerned with undertaking research and not with the development or implementation of EBP.

The reliance on individuals meant that the success of their role depended to some extent on their knowledge and ability to undertake EBPI and the limits of what one individual could achieve in the wider organisation. This was clearly a problem in all cases, whether due to the size of the Trust (i.e. the number of different hospitals) or the geographical spread of a smaller number of smaller hospitals. However even in Case B which was the most geographically compact Trust, there were problems related to the nature of access to wards on separate sites and the barriers created by job titles:

*'The problem is that as soon as they go up to practice development they just lose all sight of what it was like being on the wards. [Nurse named] was a really competent staff nurse and a lovely girl, but now she comes back here and talks about evidence this and that and it's all language I can't understand'.* (Charge nurse)

The individual mentioned in this quote acknowledged that although she had the sole responsibility to implement the NMPDU best practice statements, she did not have automatic access to wards and could only go onto them at the invitation of the charge nurse. Clearly relying on individuals to take forward EBP was not without its problems.

## **CONCLUDING REMARKS**

Analysis of the content aspect of the Pettigrew framework (1985a, 1988a) has shown that there were a number of definitions of evidence and beliefs about types of evidence

in each case. These were similar across cases, with some types of evidence predominating in one case more than another. Viewing content in its fullest sense and giving consideration to the types of changes that might occur as the result of EBPI, was more difficult. It was not possible to ascertain satisfactorily in any of the cases whether evidence had only been used instrumentally or whether conceptual or symbolic (persuasive) use had also taken place to change practice. However the NM/CNS in Case D was able to explain the nature of activities related to EBPI, such as audit and monitoring strategies for nursing care in relation to national guidelines and standards. Case A had strategies for using national evidence products and there was also some local development being undertaken. Local development had been a greater part of the EBPI strategy in Case B, but while many nursing guidance documents had been developed and disseminated, they did not appear to be in use in practice. The adoption of shared governance in Cases C and D as a means of progressing EBPI, had limited success in both. In all cases there were individual staff with designated roles for EBPI. However the extent of their remit was not reflected in the number of hours they had to devote to this, their access to clinical areas or because some were only recently appointed, the progress of EBPI as a result of their roles.

Review and analysis of evidence content has shown that there are challenges relating to definitions, local ownership and the use of national products, and the quality of evidence used as the basis for practice. National standards seen by the CSBS as underpinning practice are less of a focus for nursing than medical practice and are therefore not seen by nurses as an element of evidence content. Likewise, there are problems of perception associated with national guidelines, including those specifically developed to address nursing practice. Some arise from lack of knowledge of the guidelines and possible concerns about the EBPI process, others relate to more entrenched, and therefore more difficult to tackle, beliefs and attitudes.

Generic issues relating to communication about EBPI, understanding and undertaking EBPI, designated roles and authority and autonomy were all hindrances to implementation. In each case there were problems with some aspects of these and none of the cases had managed entirely to overcome them. Ascribing specific EBPI roles to individual nurses was largely seen as the means by which EBP changes would happen, but it did not take account of the complexity of the process and the inhibitors,

such as lack of access to wards. While there was evidence of EBP content in each case, issues around understanding and undertaking EBPI and having the authority and autonomy to do so were significant impediments.

NMs had variable, but in all cases, limited involvement with the content aspects of EBPI. This was also reflected in the overlap of aspects of content and process presented. A more detailed analysis of the roles of NMs in EBPI processes follows in chapter six.

**CHAPTER SIX**  
**RESULTS (3): PROCESS**

***The EBPI process and the role of the nurse manager***

**INTRODUCTION**

This chapter presents the data related to the process aspects of the Pettigrew framework (1985a; 1988a). Since the boundary between content and process is somewhat indistinct, to avoid repetition, this chapter is arranged thematically, rather than on a case by case basis. The themes were derived from data analysis in conjunction with the EBPI literature. Starting with generic themes relating to EBPI it then focuses in on the role on the NM in the process. While the themes are presented individually it is important to recognise that there are often elements of overlap between them and they should not be viewed as discrete entities, rather as parts of a ‘whole’ approach to the EBPI process. This interplay of the context, content and process factors in relation to the NM forms a final section in the chapter. A brief summary of similarities and differences across the cases is provided in Table 6.1 overleaf.

**Table 6.1: Summary of process factors across Cases**

	<b>Case A</b>	<b>Case B</b>	<b>Case C</b>	<b>Case D</b>
<b>Generic implementation processes</b>	<p>Top down process via PDU, which had central role.</p> <p>EBPI through education from PDU*</p> <p>PDN* supporting specific EBPI initiatives</p> <p>Bottom up processes via CNS or NM/CNS</p>	<p>Top down process through dissemination and instruction to use best practice statements from Director of Nursing to charge nurses.</p> <p>PDN previously leading local product development</p> <p>PDN appointed to lead Trust wide implementation of best practice statements</p> <p>No bottom up initiatives</p>	<p>Top down processes: none evident.</p> <p>Bottom up: former shared governance forum.</p> <p>Directorate based clinical improvement teams, but limited nursing input.</p> <p>CNS EBPI in own areas.</p>	<p>Top down processes: none evident.</p> <p>Bottom up: shared governance forum, but no longer active.</p> <p>Nurse with development role, but no evidence of EBPI of products.</p> <p>CNS and NM/CNS successful in own areas of practice</p>
<b>Director of Nursing role in EBPI</b>	<p>Disseminating some national products to charge nurses.</p> <p>Aware of their areas of interest and expertise.</p>	<p>Disseminating, as above.</p> <p>Creating EBPI roles, but lack of support for staff once in post.</p>	<p>DNS not involved in EBPI.</p> <p>Verbally supportive but not actively involved.</p>	<p>DNS not involved and while reported to be supportive or EBPI, no evidence of active support.</p>

**Table 6.1 continued**

	<b>Case A</b>	<b>Case B</b>	<b>Case C</b>	<b>Case D</b>
<b>NM role in EBPI</b>	Some NMs verbally supportive, but not actively involved in EBPI. One NM had informal audit involvement	NMs new in post, not able to concentrate on EBPI, despite own experience in previous posts. Verbally supportive of EBPI	NMs not involved in EBPI. One NM had set an EBPI goal for charge nurses, but this was never met and no action was taken by NM. PDU had had EBPI remit removed  Many NMs lacked knowledge of EBPI	Senior NMs supportive, but not actively involved in EBPI. Other NMs new in post and not yet involved.  Re-organisation of NM roles and remit, so impact on ability to support or lead EBPI unknown
<b>Additional factors related to EBPI</b>	Reliance on individuals to lead and ensure EBPI. Overloading of staff with EBPI roles	Reliance on individuals to lead and ensure EBPI. Overloading staff with EBPI roles	No clear strategy for EBPI in nursing	No PDU, no PDNs.  No clear strategy for EBPI in nursing

\* For economy of space the abbreviations PDN (practice development nurse) and PDU (practice development unit) have been used in this table.



## GENERIC EBPI PROCESSES

The definition of implementation provided in chapter one is repeated here both for emphasis and to facilitate consideration of the EBPI processes explored and analysed in this chapter, and as a means of characterising the complexities of implementation and the likelihood of the need for multifaceted processes to progress it:

*'Implementation occurs when changes, based on the results of evidence, are made in practice. These activities not only rely on the availability of relevant knowledge, but more crucially on the critical evaluation of that knowledge. Implementation is fraught with difficulties. It not only requires a means to translate knowledge from a variety of sources into the language and action of practice, but also the opportunity to elicit sustained change. Successful implementation depends on many factors. Some relate to characteristics of individual knowledge, ability and motivation, and others to wider politico-economic and organisational issues'. (Mulhall & Le May, 1999)*

The aim of this section is to highlight the variability in the EBPI processes within and across the cases, such as the extent to which they were top-down or bottom-up processes and to emphasise important or unusual aspects of process from the cases. Many of these were raised in chapter five, but to minimise repetition, this section only reflects on the essence of the EBPI processes from these.

Top-down initiatives were the dominant mode in both Case A and B and in both, these were focused around the practice development units. In A, these had a more central role, being a well-staffed and well-established unit co-ordinating some local adaptation of national evidence products, education and EBPI, with very minimal involvement in informal audit of practice. One practice development nurse had roles for implementing the NMPDU best practice statements and integrated care pathways. Both of these EBPI roles had been recently added to the remit of an existing member of staff and she was concerned about her ability to achieve any success through her lack of knowledge of the processes and time limitations in which to achieve these.

In Case B, the practice development unit was seen as having a role in supporting EBPI, but not being involved in it. It had recently undergone restructuring and so was not yet fully functioning. Despite this, one practice development nurse had been employed in a newly created post, specifically to implement the NMPDU best practice statements. Again, as in Case A, she had concerns about her own knowledge and experience in relation to the enormity and complexity of the task.

In Case B, an initiative to create local guidelines for nurses that was designed to be bottom-up but led by a practice development nurse, became almost entirely top-down. This had an impact on the extent to which these guidelines had been adopted in practice. The way in which evidence was used in the development process in Case B was also seen in Cases A, B and C.

### **Approaches to evidence use and limited interlocking of EBPI**

Approaches to the use of evidence (which have several requirements as outlined in the implementation definition) varied between cases, but one questionable process was in use in these cases. As mentioned briefly in chapter five, in each case study, staff gave examples of ignoring evidence or excluding evidence as it was too far removed from current practice in their areas. For example one NM in Case C explained:

*'The reason they started from scratch with evidence was because they had looked at evidence from elsewhere, SIGN etc., but they didn't want to use any of it. National guidelines and the NMPDU or even other [Trust named] guidelines aren't suitable because they don't reflect our practice here, so we ignored that and found our own evidence instead'.*

This approach was not reflected by the CNSs who were the nurses most involved in evidence use creating products specific to their area of practice. The use of these in practice of these was generally not widespread, but limited to the area where the CNS worked and involved changes to care for different numbers of patients, depending on the reach of that specific specialty. For example, the diabetes CNS in Case C who developed a patient information leaflet for patients having tattoos, had only a small number of patients for whom this was relevant. However in Case A, the oncology nurse specialist had a role with a much larger caseload and remit, although this

remained within one unit. Finally, again, in Case C, the tissue viability CNS who had developed an evidence-based protocol for the appropriate use of pressure relieving mattresses and then implemented it across the hospital in which she was based, had in effect, changed practice for an entire hospital. In addition, there was scope, if not plans, for this to be implemented throughout the entire Trust.

There were several examples across the Trusts of the problems resulting from a lack of connection between EBPI initiatives. Data from the CSBS reviews also highlighted the need for better communication around clinical governance activities, such as the development of protocols, policies and procedures, to ensure that duplication was minimised and that dissemination was effective.

Within all of the cases there were difficulties resulting from the isolated nature of the CNS role. While they were often using evidence in their own practice and developing products that might be beneficial beyond their own practice, there were limited opportunities for this to take place. In Case A, one CNS recounted her own experience of the problems with lack of connection with wider structures and the efforts to maintain involvement:

*'We developed a chemotherapy manual and guidelines for the administration of chemotherapy and also policies and protocols, in a comprehensive way and it was distributed to all the relevant areas. We invited and kept management and nurse and senior management informed of that and when it was done we were advised that any policies and procedures, before they could be implemented, had to go before the Drugs and Therapeutics committee. We had already sent these things round widely, Trust wide and to the health board and we had no response at all, so I think it was a bit off for them to ask us to go to the ADTC [Area Drugs and Therapeutics Committee]. But we did and that was two years ago and we still haven't had anything back. And to top it all, I've now been asked if I'd write a Trust policy on chemotherapy, because it's needed for some clinical governance or clinical standards report or something'. (NM/CNS)*

Again, CSBS reviews provided data that showed that clinical governance teams were producing evidence-based products and undertaking audit. The extent to which these were shared across each individual Trust varied but there were few, if any, links between these teams and nursing structures. Some data from the CSBS visits highlighted protocols developed by nurses, but which were not known about by the staff interviewed for this study. Likewise, staff had developed protocols, policies and procedures for use in their own area of practice that were not known about in other wards. This problem was also noted by the CSBS.

Overall the picture that emerges in the cases is one of piecemeal and isolated EBPI activities. Case A, through the co-ordinating role of the practice development unit, appeared to have managed to minimise the problems resulting from this, but even here, there was a clinical educator working in complete isolation from others with the same job title and in isolation from the practice development unit.

In each of the cases, there was much greater emphasis on development strategies and dissemination efforts than on EBPI plans. In Case B, this had involved a combination of both, with a focus on developing nursing guidance documents and on disseminating the NMPDU best practice statements. However, no information had been provided with either as to how these might be or should be used. A similar situation had occurred in Case A where one of the charge nurses noted:

*'We've got them here [Best Practice Statements] but I certainly haven't studied them. They get sent out to us, but there's no information about what to do with them. What you could do with when you get the folder sent out to you is something to tell you what to act on because, to be honest, you don't have either a) the knowledge or b) the time to sit down with these and say 'right here they are, we'll get them implemented right away!''*

Some staff suggested that the EBPI process was just a matter of staff reading information and then using it in their practice. A clinical educator in Case A and a charge nurse in Case D shared this view, the latter making a point of leaving journal

articles lying around the nurses station so staff could read them and then use them in practice.

Since knowledge of EBP seemed to be focussed mainly on product development, staff were not able to discuss EBPI processes, but instead often presented espoused theories of EBPI. For example, the Director of Nursing in Case B believed that nurses had evidence-based products at their disposal, both locally and nationally developed, and therefore they should be using them in practice. The only hindrance she saw, was the lack of a 'research culture' in the Trust. Similarly, one of the NMs in Case C, had provided internet access for nurses so they could more readily access national evidence-based products and believed that nurses would use them because they had a professional responsibility to do so. These views reflected an incomplete understanding of the complexity of implementation and the numerous factors that impact on its success.

There was a sense in all cases that staff did know what should happen, but it was not being put into practice and that they did not recognise just how difficult the process was. This was borne out from data from the CSBS reviews where information provided by the Trusts to illustrate evidence use in practice did not match the actual practice seen during visits.

In all of the cases, there was little acknowledgement of the complexities of EBPI. Many interviewees spoke about the development of EBP products, but had no knowledge of how these would become part of everyday nursing practice. This may reflect the focus within the Trusts which was largely on local development, rather than on the use of national products, adapted for use in the local context. However, there was a belief that the difficulty with many national products was securing local 'buy in' and the focus on developing their own products was a means of addressing this.

While it is important to recognise that national products are unlikely to be a perfect 'fit' with local practice, one of the aspects of the EBPI process involves reviewing current and/or local practice in light of the evidence and identifying areas where practice needs to change to reflect evidence. It is also important to acknowledge that some adaptation of, for example, national guidelines, is necessary to enable local

EBPI. However ignoring or excluding evidence on the grounds that it is too distant from practice undermines the principles of EBP, if evidence is changed to reflect practice rather than the converse process. Although not explicitly stated by any interviewees, it may be that the challenges of trying to change practice to reflect evidence are so great that it was easier to concentrate on local product development that made the gap between evidence and practice seem smaller or to ignore specific evidence to lessen the challenges of EBPI.

Where staff, such as the NM/CNS, did have more of an understanding of EBPI, there was still a reliance on a very linear and step-by-step approach to changing practice. This relied, to some extent, on engaging staff in discussions about proposed changes to practice, presentation of the evidence and then depended upon staff being 'told' what changes to make. While this may have been effective, as in the renal unit in Case D, it did limit the involvement of nurses in the process and relied on a localised top-down approach, rather than the bottom-up process that the assistant director of nursing thought was occurring.

In all of the cases, specific individuals had a role in developing evidence-based products. The extent to which this was the main process used for EBPI in the Trusts varied. It had been the main focus of EBPI in Cases B and D, although D also had a shared governance forum. The development nurse in D had limited skills for this role, in that she was unable to search for, access or appraise evidence and did not understand the nature of evidence hierarchies. In A and B individuals had also been given the remit of implementing the NMPDU best practice statements.

While it was important to recognise that these individuals had a part to play in EBPI in each Trust, there were also difficulties associated with this approach. When individuals resigned, as happened in Case B, this left a gap that was not readily filled as no other staff were thought to have the same expertise and this led to a restructuring of the whole practice development unit. Likewise, the products developed by this nurse had not been used in practice as they were seen as 'hers' by nurses and practice development nurse colleagues. This level of local ownership and reliance on individuals had not been facilitative of EBPI in this Case and suggests that local

development does not ensure local use and that other factors need to be given consideration for EBPI.

Relying on individuals to progress EBPI not only depended on their skills, but also on the ability to undertake the work in the time available. Even those with a specific EBPI role, such as the practice development nurses in Cases A and B had EBPI tasks that required more than the time allocated to them. This ‘overloading’ of capable staff had the potential to crush their confidence and limit their success in the EBPI process. There was a widespread lack of understanding of both the complexity of the EBPI process and the time necessary to plan changes to practice, undertake them and sustain them, let alone undertake audit to determine the success of any change to practice. Staff in every case spoke of having to do EBP related work in their own time and this had a detrimental impact on morale when it became a regular occurrence. This also led to EBP being viewed as an ‘added extra’ rather than an essential part of everyday practice.

Communication around EBPI, whether as a means of explaining Trust wide strategies, explicating dissemination and EBPI plans or clarifying roles, was not always clear as explored in chapter five and problems arose due to the lack of a clear understanding about roles and responsibilities for EBPI or related activities.

*‘It’s terribly frustrating when you’re trying to share information about EBP, or anything really, but you can see what needs to be done. I’ve told the charge nurses about things and it just stops there. I know you can’t tell everybody everything, but trying to find the best mechanism...I’m not sure we’ve got it right yet’.* (Assistant director of nursing)

Communication around EBP was often implicit and this led to confusion and a lack of clarity about roles and remits. Most often this related to others assuming who had the responsibility for EBP, which in all cases meant that things did not get done. Staff were not always clear about whether they were ‘allowed’ to develop practice, or who they would approach to find out.

While communication concerning EBP lacked clarity, methods chosen to progress evidence use lacked efficacy. There was a reliance by NMs on methods to promote evidence use which have been shown in the literature to be ineffective, in particular exhortation, noticeboards and 'evidence folders'. In Case B the Director of Nursing had told charge nurses that they should all be using the NMPDU best practice statements and this was followed up by a letter to inform them that she would be visiting the wards to ensure that these were being used. The mechanism by which she would do so was not made clear to staff. One charge nurse responded to this by pinning the statements up in a prominent area in the ward. She explained that beyond doing this, she had no idea how else to use them, but felt that at least that way the Director of Nursing would see them. This need to demonstrate EBPI efforts was shared by a charge nurse in Case A:

*'People here just want to be spoonfed, so I just take the approach of telling them what I want them to do and I've spoken to [NM named] and have said that I'm not really happy doing that, but she said it was fine with her. I mean there are other charge nurses here who are even less confident than me and she [NM] is sending them to me so I can help them! When it comes to EBP and I'm being honest, I'm just as clueless as them'.*

The charge nurse had responded by putting the best practice statements into a folder and leaving them on a prominent shelf in the duty room. He felt that if any NMs or the Director of Nursing did come on to the ward, at least they would be obvious.

One of the charge nurses in Case D, adopted a similar method, to that used by senior NMs in her Trust:

*'They send stuff round, with no information about what you're meant to do with it. I leave it around with a tick list, so I know if people have read it. I do the same thing with EBP. I leave interesting articles lying around in the office and that way people can use it in practice'. (Charge nurse).*

The belief that evidence would make the leap from articles in the office to changes in patient care, seemed to describe a process of osmosis, rather than active management to effect practice change.

The use of folders to house EBP information and of noticeboards to display evidence-based products on the wards was widespread and only one NM in any of the cases recognised that this was an ineffective way of getting evidence used in practice:

*'We need to get it through to them that evidence needs to get out of the folder or off the shelves to make a difference at the bedside.'* (NM)

This NM was not typical in that in a previous post in another Trust, as a NM she had been responsible for the development of EBP products and for leading the Trust wide implementation of these.

This approach was contrasted in Case A where staff from the practice development unit and some NMs would occasionally undertake what they described as an informal 'walk round audit' when some new guidelines or best practice statements became available, to determine how much of a gap there was between what they were seeing as current practice and what was recommended in the statements as EBP. This gap would be addressed in various ways, mainly by providing education and clinical skills updates, by embedding the evidence into the educational materials and by incorporating the evidence into locally developed guidelines and protocols. Beyond the informal audit, the NMs had no further involvement. The success of this as an EBPI strategy was not known. While NMs described what they were doing to oversee current practice and the steps they would take to remedy any gaps between this and current evidence, no further audits had been undertaken, or had been planned to identify if the changes had indeed brought practice in line with evidence.

Despite the role of the NM as a delegator of EBPI to other staff, there was still a belief expressed by NMs in all cases, that the development of evidence-based 'products', such as nursing guidelines, procedures or protocols was a significant way of getting evidence into practice. This would explain the considerable focus in each case, on development rather than EBPI processes. There was a lack of understanding

that getting evidence into practice was an active process that required to be managed and that the existence of products alone would not make changes to practice.

This focus on the development of evidence-based products was seen as the principal means in all sites of getting evidence into practice. While there was some understanding of the need for dissemination, the extent to which this occurred varied. This was seen by NMs as part of their role and contribution to EBPI. However their description of the entire process was often an aborted one and stopped short of EBPI. While some NMs in some cases had some concept of the need for an active process to get the evidence used in practice, on the whole NMs did not have an understanding of the complexity of EBPI or of the effort required to bring about changes to practice. This was borne out by their delegation of the task to individuals, to undertake EBPI for the entire Trusts, or by their exhortation to 'use' evidence, with no information as to how to approach making changes to practice or explanations of the different ways in which evidence could be used.

Despite their incomplete understanding of the process and the effort involved to implement evidence into practice, NMs, and in particular, Directors of Nursing, had a role in validating the development process by 'signing off' locally developed evidence-based products as of good quality and ready for use in practice. This validation process was viewed by NMs as the marker of a quality product. The criteria by which the products were judged were not clear, but seemed to rely upon the credentials of the staff who had been involved in their development more than any other factor. While these nurses' knowledge of the subject area and clinical expertise is not in question, the processes by which they gathered and appraised evidence seemed to be less clear. In Case D, all of the nursing protocols, procedures and guidelines were updated and 'made' evidence-based by one development nurse who could not undertake literature searches or reviews or appraise evidence. She explained that if she was unsure, she would check with doctors. Despite this, the NMs were happy with this as the means by which evidence products were developed and the Director of Nursing 'signed off' the products once they were complete. Likewise, the Director of Nursing in Case B admitted that she had neither knowledge nor interest in research and therefore her ability to appraise the quality of an evidence-based product before 'signing it off' is questionable. The ability of staff to undertake critical

appraisal of evidence was questioned by one senior practice development nurse (and former NM) in Case A. In admitting that her own skills were poor, due to lack of use, she also had concerns as to the ability of most nurses to undertake accurate critical appraisal of evidence and therefore this had an impact on the quality of any products being developed. She recognised that while many staff were nominated by NMs to be involved in the process, most often because of their clinical expertise, this alone did not guarantee the ability to accurately appraise evidence, nor did a nursing grade or role, such as CNS. This did not seem to have been recognised in other cases and does highlight concerns as to the quality of locally developed evidence-based products.

### **Two model approaches to EBPI**

While many of the points raised in the previous section suggest that EBPI was limited and largely ineffective, two approaches, discussed in chapter two, were identified as underpinning and explaining the EBPI processes in use in the cases: these were the ‘research-based practitioner’ and ‘the embedded evidence’ models (Walter, *et al.*, 2004). The models are used here as analytical tools to demonstrate the EBPI processes and explain them more fully.

While many of the messages relating to EBP and EBPI were not clear, there were wider assumptions about the processes by which evidence would come to be used in practice. In general, these were a combination of two approaches, the ‘research-based practitioner’ and the ‘embedded research model’ (Walter, *et al.*, 2004). The research-based practitioner is assumed to be autonomous, empowered and capable of taking evidence, and through an active process of implementation, using research in practice. The CNSs in all cases were research/evidence-based practitioners, using evidence in their own practice and also having some involvement in developing evidence-based products for their own (and sometimes wider) areas of practice. The CSBS reviews note the involvement of CNSs in these aspects of developing practice. These processes were a combination of top-down and bottom-up developments, but were only used in discrete areas of practice, not beyond the reach of the CNSs’ areas of expertise.

There was a widespread belief among NMs and practice development nurses that individual nurses were research/evidence-based practitioners, in terms of having the responsibility to use evidence in their own practice. However, there were also

concerns expressed in all the cases that nurses did not have the skills or confidence to make this a reality.

The embedded research model was most evident in Case A, where practice development staff were using (embedding) evidence in teaching materials and nursing protocols. The aim was to teach EBP without staff realising that this was the case, lest they chose to ignore it. While EBP was also reported to be used for teaching clinical skills updates in Cases B and C, in contrast to Case A, the approach was not covert.

Despite the numerous models, strategies and examples of successful EBPI projects available to guide and support EBPI, as discussed in chapter two, these were the only two models identified as being used by participants in this study. However, their use was not conscious, in that the staff using them did not identify the approaches used as being linked to or based on these models. The research-based practitioner model had been broadened to include other types of evidence, not only research, but the skills and attributes of the research-based practitioner were also those of the evidence-based practitioner.

The embedding of evidence into teaching was a conscious decision, although not an explicit process. This approach had been taken to teach health care assistants and it is recognised that this model has been used, in the main, in organisations with unskilled staff. However, it could also have been used for the provision of education or the development of teaching materials for other grades of staff. It may have been used in this way in the cases, but staff were not able to provide other examples of the process. It clearly provides scope for greater implicit EBPI.

Having presented the generic aspects of EBPI in the cases and considered some of the implications of these in relation to using evidence in practice, the following section focuses in greater detail on the specifics of NM roles in EBPI.

## **THE ROLE OF THE NURSE MANAGER IN EBPI**

### **The Director of Nursing - a leadership role**

This section moves on to consider the specific influence and roles of NMs in EBPI. It begins by considering the involvement of the Directors of Nursing in EBPI in each of the cases and then focuses on the specific role of the NM in EBPI.

Although the nursing hierarchy varied across cases, and was particularly affected by the size of the Trust, this did not seem to explain the relative 'distance' of the Director of Nursing from the clinical area. Charge nurses in Case A described how the Director of Nursing knew them personally and ensured that evidence-based information would be sent directly from him to charge nurses on occasions. While the Director of Nursing did not visit their clinical areas, nurses felt that he knew them and at the very least, knew what area of nursing they were involved in. This familiarity was starkly different in Case C where ward nurses were not able to explain the whereabouts of the office of the Director of Nursing, even when it was in a corridor adjacent to their ward. The Director of Nursing in Case B attended meetings with senior nursing staff, including practice development nurses, but they felt abandoned by her after they had been given tasks to work on. In Case D one assistant director of nursing admitted that the Director was not a visible presence around the Trust and this was confirmed by clinical staff. Nurses took this as evidence of his lack of interest in them and their work, including EBP. The extent to which the Director of Nursing had an interest in EBP appears to have had an impact on the extent to which the nurses themselves had become involved in the process. While it might be unrealistic to expect Directors of Nursing to have had an active, involved role in EBPI, only the Director of Nursing in Case B had any level of face-to-face involvement with nurses and was attempting to drive EBPI forward. While her approach to this did not convey an understanding of the complexities of EBPI (sending out NMPDU best practice statements and letters stating that she would be checking on their use), it did show that she was trying to disseminate best practice and encourage its application in clinical areas. While nurses in Case B, were at times frustrated by the initial enthusiasm for EBP and what they considered to be, the subsequent withdrawal of the same by the Director of Nursing, they did acknowledge that she did take an interest in EBP, which they saw as being important:

*'She's always full of ideas and wants things done her way and to be honest, they're not always do-able in a practical sense. When things don't work out, like [nurse named]'s guidelines that she developed, then [Director of Nursing named] cools off a bit. We're left to pick up the pieces, but I suppose you could say, better that than if she took no interest at all'. (Practice development nurse)*

Being visible and being involved, to any extent, were not only preferable, but necessary aspects of the leadership of the Director of Nursing. Cases A and B had also seemed to have been able to give a sense of importance to the EBPI process that was not present in Case C and D. The sense of importance given to it by the Directors of Nursing in these cases reflect or may have promoted this. Some specific aspects of the role of the Director of Nursing in EBPI are explored within the wider consideration of the role of the NM under the appropriate themes in the following section.

Having considered some of the wider aspects of the process of EBPI in the cases and looked briefly at the leadership of the Director of Nursing, the NM now becomes the main focus of the analysis. The roles that NMs had in the EBPI process were broadly divided into direct roles, in which they were actually engaged in aspects of process, and indirect, where they were not fully engaged in the EBPI process.

### **The role of the contemporary nurse manager**

While the context within which the NMs were working was fully described in chapter four there are some structural elements relating to process that it is not possible to separate from context. Indeed this overlap and complex interplay between the three elements of Pettigrew's framework (1985a; 1988a) has been previously recognised and is seen as an integral part of understanding the change process. The following aspects relate to the broader role of the NM, but cannot be separated from the overall impact that these have on either the ability of the NM to engage with EBP or their desire to do so.

NMs in all cases spoke of the huge remit of the contemporary NM. This was also recognised by other staff, and it was presented as both a reason and an excuse for lack of involvement in EBP and other clinical issues:

*'I think that part of the problem with nursing management is its sheer breadth. They can't get involved in the nitty gritty because of all the other things that they are doing'. (CNS)*

*'I think that one of the problems we have now is that nurse managers have got further and further away from the patients. We've had managers for nursing who didn't have any clinical background, who unlike the medical managers had lots of clinical but no nursing focus. I think as a profession we need to look at why we've taken our managers away from the essence of the profession.'* (CNS)

*'I think the biggest barrier for any nurse manager, certainly in this Trust and I would think in any Trust, is that the role of the nurse manager has developed to such a point where it is just overloaded.'* (Practice development nurse)

*'My role is just too big, massive really, you can only touch on areas and you are not actually being successful in any.'* (NM)

These quotations, from staff in different cases, aptly illustrate one significant aspect of the overall problems that NMs had in engaging more actively with EBPI. The changes to the role after its re-introduction meant that it was a role with a huge remit, covering vast clinical areas and often geographical ones also. This had led to a distance developing between NMs and their staff.

The role of the contemporary NM in all aspects of their work was therefore hindered by the sheer size of their remit and this had an impact on the way in which they saw themselves (and the way they were viewed by their staff) as being involved in, or being able to be involved in, EBP.

*'I don't have the capacity to be looking at development in structural or formal ways in terms of making sure that it is EBP.'* (NM)

### **NM roles and linkages**

The roles and linkages of the NM, while described in active terms, were in reality, passive roles, limited by understanding, the nursing hierarchy and the capacity of individuals to become involved in aspects of nursing which they saw as being related to practice and therefore not their remit. The development of the role of the NM had expanded to such a point that few NMs were able to be more involved than through nominating staff, attending meetings and occasionally sharing information relating to EBP. Beyond this, their role was minimal.

The role of the NMs to disseminate information relating to EBP was recognised by them and staff in Cases A and B. However in C, dissemination seemed to be largely absent and had been the role of the practice development unit, prior to restructuring. The Director of Nursing in Case C also admitted that she had failed in her responsibility to disseminate national evidence-based products. In Case D, although the NMs saw themselves as having an important role in dissemination, the extent to which this was successful was in question:

*'I wouldn't say their communication and dissemination is especially good. I find that I always have to go and find out things for myself'.*

(Development nurse)

This reflects the differing views of the roles of the NMs in relation to EBPI as seen by them and by their staff. There was often a discrepancy between the two.

### **NM direct involvement in EBPI?**

Most NMs did not see themselves as having a direct role in EBPI. While some were ambiguous about their involvement, starting by reporting that they were not involved, but then moderating this to suggest that their whole role involved EBPI, as suggested by one NM in Case A, most were clear that it was not part of their role. They were able to name other staff or staff roles that were involved more fully in the process. One NM in Case A recognised that she and her colleagues had some flexibility in their roles and the way these had developed, enabling them to become more involved in areas that reflected their interests and skills. This had resulted in her becoming involved in the 'walk round audit' with her colleague in the practice development unit

(formerly they were both NMs together). She was interested in the work of the practice development unit and able to be involved in this limited and informal way. Another NM, at a different hospital in Case A, also explained that she had some flexibility to develop her role to reflect her own interests and skills. This had taken the form of involvement in the political aspects of health care, arranging for local and national politicians to visit the hospital and showing them the work carried out there. This involvement may have reflected concerns about potential hospital closure that were ongoing in 2003. Her other interest was in practice and she was the only NM interviewed in the entire study who maintained direct clinical involvement, working one shift each week in her area of clinical expertise. Despite this, she did not see this as involving EBPI; her rationale for maintaining this clinical input was that she enjoyed it and she hoped that her staff would see her as approachable, if she worked alongside them each week.

One of the NMs in Case B had been involved in writing nursing guidelines, protocols and procedures in a different Trust and a previous post. While she was quite new to the post in Case B, she was hopeful that she might be able to be involved or share some of her expertise related to this experience, but thought it unlikely due to the demands of her own workload. So although she was interested and willing to become more involved in EBPI, the opportunities were limited by the demands of her NM role:

*'I would say that it is not possible for any nurse manager to have a direct role in practice - whether that's implementing evidence or something similar. It's just not possible to take on something like that, even if, like me, you have some interest and experience in it, but as it is, we've got too much else to do and I'm working a 60 or 70 hour week just trying to keep on top of it all'. (NM)*

These examples illustrate that the involvement of NMs in EBPI was to some extent dependent on their interest, but also on their workload. The NM with the clinical input was managing a small hospital, with a role that was quite distinct from the rest of her colleagues in Case A and was not typical of any other NM interviewed for this study. This suggests that while opportunities existed, they were not always recognised as being opportunities for EBPI, or acted upon in the belief that it was not their remit.

Opportunity alone is not the only significant factor in determining NM involvement in EBPI.

In addition to the structural elements of the organisation which related to EBP, NMs in some Cases, in particular A and B, appeared to have a degree of input into the development of their own roles and responsibilities when the post of NM was re-introduced after the mergers. While EBP was relatively new at that time, the ability to develop their role to best reflect their own interests and abilities had continued. This was particularly noticeable in Case A where the NMs all had very different roles. One NM here commented: *'All nurse manager roles are different due to organisational requirements.'* (NM), but discussion with managers at interview highlighted that their roles also seemed to reflect their own interests and abilities. Some of the NMs described themselves as having virtually no role in relation to EBP:

*'I would just refer them on to HQ, so I would say that while on the whole I am supportive of EBP, I can't possibly do everything.'* (NM)

Others saw it as an integral part of their work, even though they might not have a direct role in developing or implementing evidence, it was seen as underpinning practice as they were managing clinical areas. They were not able to be explicit about the ways in which their role actually contributed to underpinning practice in relation to EBP. In Cases A and B, NMs had some scope to take on areas of work which interested them, or which reflected their abilities or previous experience.

The lack of NM posts in Case C was seen as significant in terms of EBPI and the ways in which NMs might be able to influence it:

*'My concern is with the clinical nurse manager posts gone, we don't have the drivers for EBP in nursing that we should.'* (Director of Nursing)

However in other cases with NMs with a nursing background EBPI had not necessarily progressed in such a way as to reflect the difference that the role might make.

### **NMs indirect facilitation of EBPI**

The previous section highlighted the very limited direct roles that NMs believed that they had in relation to EBPI. These were often less ‘hands on’ than they considered them to be and their staff did not always view them as direct roles. This section goes on to consider the other aspects of the NM role in relation to EBPI, which they considered to be less direct in nature.

The role of the NM in managing different aspects of EBP was diverse both within and across cases as described in the earlier sections. Despite this, there were common themes that arose in interviews relating to their role. NMs felt that they had a role, albeit, not a direct one and NMs’ indirect roles in managing EBPI are now explored. Data analysis has revealed that there was not a coherent, systematic engagement of NMs in the EBPI process and to a considerable extent this study was trying to identify processes and linkages that did not exist. This was not a straightforward task as NMs described their role in EBPI in active terms. In fact, what they described was a more passive role, one of facilitating and empowering nurses, particularly charge nurses, who were seen as having the greatest responsibility for progressing practice. This was recognised by some nurses:

*‘She sees the benefits of enabling us, where she doesn’t have to do all the work, and also it empowers us to take things on.’ (CN)*

The extent to which these were empowering and enabling actions on the part of the NM was not clear, as they did not appear to involve anything more than asking or telling nurses what they would be expected to take on. On occasions, communication was not even this explicit, with situations where NMs were not aware of initiatives undertaken by charge nurses and charge nurses were unaware of NMs expectations. NMs were aware that some charge nurses were struggling with the basics of their role, let alone tackling EBP:

*'There are problems with charge nurses not performing very well. There is a lack of skills higher up to help them manage their ward well. If someone is failing, as happened here, they just moved her because the ward was so dysfunctional. EBP is a long way away from the everyday realities of practice'. (NM)*

This seemed to be borne out by a charge nurse in the same Trust:

*'I've kind of learned as I've gone along, with off duty and things like that. I'd never done off duty before and PDPs [personal development plans], these are all the important things and there's nobody to help you with this, you're just left to get on with it.'* (Charge nurse).

She went on to explain that she really knew nothing of EBP; although they had received copies of the NMPDU best practice statements, she had ignored them because they were all community based (which is not the case, and one statement in particular, related to her specific area of practice). Although explaining that she had no knowledge of EBP, she did describe her upcoming involvement with developing a new guideline:

*'One of the consultants thinks we should have a guideline on bladder irrigation. What you have to do is write it out step by step and then get research to back it up. Before that though, you have to get a form, fill it out and send it off for permission, but I don't know who to.'* (Charge nurse)

So in terms of providing an empowering experience and one that enabled staff to develop their skills, it seems as if this was not always the case. NMs in all Trusts spoke of the problems related to under-functioning charge nurses and yet they were content to delegate EBPI to them despite this.

NMs in Cases A and B spoke about providing support for staff undertaking EBP, although the nature of this varied. Some NMs spoke of doing this by 'overseeing' their area but could not be more specific as to what this actually involved, whereas

others spoke specifically about providing support. One NM in case A described her role in relation to EBP as:

*‘...a role of leadership and support as well as management with a valuable clinical component.’ (NM).*

Despite being very clear about the supportive element of her role, she could not provide examples of the nature of this and as quoted above (p213), she described her responsibility in relation to EBP as *‘...referring on to HQ’*. (NM). For several of the NMs interviewed there seemed to be a lack of clarity about exactly what their role did involve and the use of vague terms such as empowering and enabling, allowed them to feel that they were doing something, although it might not be tangible.

The NMs with the greatest direct involvement in EBPI were those in the joint NM/CNS posts. Without exception, all NM/CNSs were undertaking aspects of EBPI in their everyday work and supporting their staff to do so also. This joint role is explored more fully towards the end of the chapter.

### ***Linking, nominating and delegating activities***

Despite the lack of a direct role within EBPI, NMs were often the formal link between management and practice, by dint of their position in the nursing hierarchy. This involved activities specifically related to EBPI, such as attending shared governance meetings or through informal links with practice development staff. These linking activities were seen by NMs in Cases A, B and D as part of their role in relation to EBP. Some NMs in Case C could describe the organisational structures in relation to EBP but were not involved in them. In Cases A and B the NMs also had some links to the practice development unit. These links were informal, mainly consisting of information exchange, rather than any active involvement. However, without these, as in Case C, information relating to EBPI throughout the Trust was often lacking.

The process of getting evidence into practice is dynamic, active and iterative and this was reflected in the ways in which some of the NMs described their role in the various processes. Although some saw themselves as having a more active role than others and

some saw themselves as having no role at all, all played some part in nominating and delegating staff to be more actively involved in EBPI:

*'It's really about seeing how much of the workload can go down to the G grades, because the G grades are really, in my view, totally responsible for the development of the service and the development of all our staff and that is evidence into practice after all'. (NM)*

Although the NM quoted above was in Case C, NMs in the other cases were also of the belief that the responsibility for EBPI lay firmly with the charge nurse (or G grade) or with individual nurses themselves. Therefore EBPI was seen as a practice responsibility and was delegated, although not explicitly to ward nurses. NMs believed that charge nurses in particular knew that it was their responsibility. Delegation was often a combination of assumptions and implicit communication, with no means of monitoring the effectiveness of this as a strategy for progressing EBPI.

NMs felt that they knew the skills and abilities of their staff well and this was considered a strength when it came to nominating them for the task of (almost exclusively) participating in the local development of EBP products. One of the difficulties arising from this method of staff selection was the extent to which NMs really did know their staff and their skills, abilities and workload. One practice development nurse in Case A working in a relatively new part-time post to address clinical skills for nursing and medical staff, described how she felt overwhelmed by the amount of work she had to achieve in this aspect of her work alone. She had then been nominated by her NM for an additional role, to implement the NMPDU best practice statements throughout the Trust as well as develop integrated care pathways for specific clinical areas. Her concerns related not only to the amount of work that it was possible to achieve in a part-time post, but also to her lack of knowledge and experience of both the best practice statements and integrated care pathways:

*'I'm a bit overwhelmed with the number of different things that I have to do and I'm still learning an awful lot. I only work 25 hours a week, so it's a big undertaking and I haven't actually worked in an area where they use either [the best practice statements or the integrated care*

*pathways] so it's quite difficult to know how I could support them, when I haven't actually worked them myself, or done anything like this before really'.(Practice development nurse)*

This was not a problem that was exclusive to Case A, as a similar situation had occurred in Case B, with the Director of Nursing deciding that staff should be 'nominated' or have work delegated to them, as appropriate to their skills and abilities:

*'The reason I took this job was because it had a very clearly defined role for teaching and education. That's what I'm good at and that's what I'm interested in, that's why I took the job. I had the job description in front of me when [Director of Nursing named] starts throwing 'projects' at me. When I came at first I was quite shocked by it because she had me dealing with patient complaints, resolving staffing issues and I was thinking 'why am I doing this - that's not my job'. But she puts it to you, that she knows you are capable and it's about developing me as well, so you just have to get involved in all sorts really'. (Practice development nurse)*

Another practice development nurse in Case B had been given the sole responsibility for undertaking EBPI of the NMPDU best practice statements throughout the entire Trust. These examples suggest that NMs either over estimate the ability of their staff, in terms of what is reasonably achievable in a given number of hours, or that they have a poor understanding of the complexity of the EBPI process and the difficulties these staff will need to overcome to achieve this. Some roles were seen as fluid and 'developing' despite detailed contracts of employment with very specific roles, which led to anxiety for the nurses about their ability to achieve as they were unsure exactly what was expected of them. These additions were often suggested as projects by NMs, which made staff think that they would be small and time limited, but the opposite was more often the reality:

*'I've been given professional development and research and development for nursing as my projects. But when you actually look at it, they're big*

*areas of work really, not so much small projects'. (Practice development nurse).*

These problems were not exclusive to practice development nurses. Both the newly appointed assistant directors of nursing in Case D realised that they had not so much had work delegated to them, but that the Director of Nursing had looked at the overall workload which had to be covered and shared it out between them. They had been able to 'volunteer' for the pieces of work that interested them most, or where they thought their skills and abilities lay. However, both recognised that they had ended up with responsibilities for which they had no interest and no previous experience, but the Director of Nursing had assured them that these were personal and professional development opportunities.

Other aspects of delegation suggested that NMs were not entirely sure of the circumstances of day-to-day nursing. One suggested that the nurses most likely (and that she relied upon) to make evidence-based changes to practice, were student nurses and newly qualified staff nurses:

*'[Nurse manager named] said to me we should be relying more on the students and new staff nurses for EBP, because that's all they get at college. What they don't appreciate is that they've got their hands full just getting to grips with being on the wards, never mind EBP. In my experience it's the older staff nurses who are doing degrees or post-reg courses that bring in the new ideas, not the newly qualified ones. It's pretty unlikely that anyone would listen to them anyway and when you're new you don't want to be making enemies of the other staff by saying that things need changed'. (Clinical educator)*

Charge nurses felt that newly qualified nurses were the least likely staff to be able to introduce change in the ward environment, where they were more focussed on 'fitting in' than changing practice. The medical directorate in Case C had re-introduced the clinical educator posts to support newly qualified nurses, recognising that it was a particularly difficult role. The main focus of the clinical educator support was in helping the new staff gain clinical skills. It seems unlikely that newly qualified nurses

would feel confident to tackle EBPI under these circumstances but NMs seemed unaware of this.

It was clear from chapter four that the contexts of each of the cases had both similarities and differences. However in Cases A, B and D the NMs were involved in various nursing and wider organisational structures with specific EBPI responsibilities. The extent to which this took place did vary across the Cases, with most involvement being seen in Case A and the least in C, but NMs in A, B and D described this involvement as part of their role in relation to EBP. Some NMs in Case C (those with a nursing background) could describe organisational structures relating to EBP, but were not involved in them. It is important to highlight that at the beginning of several of the interviews with NMs, they did not acknowledge that they had a role relating to EBP, but this perception changed over the course of the interview and the data presented is based on the information gained during the interviews as a whole rather than on their first impression. Their roles seemed to be similar in Cases A, B and D with NMs describing their involvement in structures such as attendance at clinical effectiveness meetings and shared governance meetings. They did not necessarily have an active contribution to these meetings, describing their involvement as gathering information relating to organisational goals or progress and nominating staff to participate in groups relating to evidence development. The NMs interviewed saw this as an important role because of their place within the nursing hierarchy and the wider organisation. NMs in Case C were not involved in the same way, with practice development staff having previously undertaken this role and since the advent of the clinical improvement teams, things had not changed.

Despite this, the extent to which information was disseminated or passed on to nursing staff varied considerably within and across cases, with nurses being unable to describe in interviews, any of the information passed on to them by their NMs in this way. However, the NMs considered that their strength in this aspect of their role was that they knew the skills and abilities of their staff and could nominate nurses who would be able to take on the task of (almost exclusively) participating in the local development of evidence-based products. As discussed in the previous chapter, this took place in different arenas, whether under the guise of shared governance forums

(Cases C and D) or by an individual nurse (for example, Case B) or through the practice development unit (Case A).

A practice development nurse in Case B, spoke of the evolving nature of her (and her colleagues) role(s). Additional responsibilities were given at the behest of the Director of Nursing, depending on what she felt was required at any given time. The nurse felt that they had all been given impossible tasks, such as to develop local guidelines (one nurse) or to provide education for all the Trust staff (one nurse). As these tasks were above and beyond those listed in their employment contracts, the staff often had only vague information and little detail as to the nature of the task, which made them even more anxious that they would not be able to achieve what was expected of them. They were not able to describe these expectations in anything other than vague terms:

*'We all have fairly broad remits, wide ranging, I suppose. Things like professional development, research, education, EBP, clinical skills...that way we can be given other jobs and told that it's part of our job'.*  
(Practice development nurse)

Another practice development nurse in Case B also described the feelings of abandonment having been assigned these roles, as there was no further support or direction provided. One nurse did admit that this had been exacerbated by the lack of NMs, due to long term vacancies at that time and justified the actions of the Director of Nursing by saying that it was a means of encouraging their personal and professional growth. However she did admit that both she and her colleagues found this an extremely stressful and a less than productive way of working.

To suggest that these goals are challenging is not to suggest that there is any lack of willingness to tackle them on the nurses' part. These difficulties arose throughout the interviews suggesting that these were not isolated problems in one Trust, or the result of one particular administration or individual.

So while NMs may have been involved in meetings about EBP, these were almost exclusively related to nursing. Apart from the practice development nurses in Case A (some previously NMs), none of the NMs interviewed described their involvement in

wider organisational structures, such as clinical governance structures, that would have tied nursing into these. The role of the NM as a channel of communication was limited to nursing and did not include first hand knowledge of the whole organisation approach to EBP, or indeed even the nursing approach, when this was raised at interview:

*'Strategy or approach for getting evidence into practice? I couldn't say, I mean, I just don't think we have such a thing, at least if we do, I've never heard of it'. (NM)*

It was clear that in Cases A, C and D, had this been the case, then duplication of, and unnecessary, effort could have been avoided in the first place in relation to the development of EBP products. In addition to lack of local knowledge about EBPI, a lack of knowledge of national EBP products also meant that NMs were nominating staff to undertake development of evidence-based products, without realising that similar national products already existed, as one nurse described:

*'We worked on that for about a year and then found we were trying to do what other people had done years before, so we'd reinvented the wheel really and then they still asked us to write it all up. A complete waste of everybody's time.'* (Charge nurse).

As representatives on the nursing structures the NMs placed considerable emphasis on these as the means by which they were both involved in EBPI and relied on their role to inform nurses about EBP. It was not clear quite how the NMs thought that attending meetings contributed to EBPI. The focus of most of these meetings was around the development of locally evidence-based products and occasionally their dissemination, once complete. EBPI was assumed by the existence of products and subsequent dissemination.

In Cases A and B, NMs also had some links to the practice development unit. These were most formal in Case A and less so in B, but the practice development staff and NMs did have some contact through some EBP related meetings, such as clinical effectiveness meetings. In Case C managers had no direct links with the practice

development unit and the clinical educators in post in the clinical areas managed by the NMs, were not linked to the practice development unit either. In Case D no practice development unit existed. Since much of the work related to EBP fell to staff in practice development units in A and B, it seemed important that there should at least be some links with nursing management. These links were informal, and as outlined above, largely consisted of information exchange, rather than NMs taking an active role in EBPI. However, without these, as in Case C, information relating to EBPI throughout the Trust, from the staff interviewed, was lacking. Although the re-organisation of the practice development unit had seen the redeployment of EBPI to the clinical improvement teams, NMs were not aware of the process by which this would take place, nor of the staff involved in the teams, other than that they were medically led.

In addition to delegation, the strategy of nominating nurses to be involved with EBP or to take on EBPI as their sole role, was seen by all NMs in all cases as their remit. The difficulty with this lay in the enormity of the task and the lack of understanding of this by Directors of Nursing and other NMs. This meant that in cases A and B one individual had been given the role of implementing all of the NMPDU best practice statements across the Trust, as explained in the above section. This seemed to reflect the view that individual staff were the process by which evidence would be implemented and showed a lack of understanding of several key aspects of the process by which changes would be made in practice. The key aspects included; the need for 'buy in' from other staff, the problems that resulted if staff left their post (as happened in Case B and EBP product development ground to a halt), the problems of developing ownership of EBP and the need for an understanding of it for all levels of staff, but particularly for ward staff who were going to be required to make changes to practice.

Nominating staff to take part in evidence development groups was part of the NMs role in all the cases, but the focus of these was very much on the development of local nursing evidence-based guidelines or protocols and not on EBPI. Apart from the practice development staff in Case A, who had previously been NMs, none of the other NMs interviewed were able to provide any information relating to the EBPI of these products. In fact there was a very strong sense that the existence of the products

themselves would ensure that they were used in practice, without any additional effort on the part of the staff involved.

Nominating individuals as a strategy was unsuccessful, regardless of the ability of the individual, but as a result of work overload, the vast nature of the task, within and across Trusts and the gap between the evidence and current practice. As a strategy, nominating did not take account of educational needs, ward staffing ratios and other contextual factors, such as other organisational changes or goals, which could impact on the success of EBPI initiatives. Simply nominating staff to 'do' EBPI did not acknowledge the complexity of the process and the impact of contextual and content factors.

While the NMs described active roles in relation to linkages, disseminating information and nominating staff for EBP work, these were in fact, largely passive roles. The extent to which the linkages were effective for progressing EBPI, is not clear, but dissemination and nomination were other aspects of their role which were incomplete. In particular, nomination of staff was a troublesome factor, not for the NMs, but for the staff nominated and the extent to which NMs really did know their staff, in terms of workload, previous experience and ability, is questionable. NMs clearly thought these were important aspects of their role in the overall EBPI effort and seemed unaware that so many of their staff felt that they were falling short of achieving this.

### ***Monitoring evidence use***

NMs were to some extent aware of their own short-comings when it came to their involvement in EBPI. Perhaps as a means of justifying this the NMs were all quite clear that in terms of using EBP, nurses should already be doing this themselves, without needing to be asked to do so by management. Despite the fact that it is a part of the nurses Code of Professional Conduct (NMC, 2004), the nurses interviewed were not aware of this and neither NMs nor nursing staff of any grade were able to state definitively if involvement in EBP was part of their contract of employment. In all the cases there was ambiguity about this, with NMs being certain that it was stated, although maybe not explicitly, while nurses were just as certain that it was not stated. One charge nurse interviewed went to the trouble of unearthing an old 'E grade' nurse

contract, to see if this was the case. The wording was not explicit, other than relating to the need to 'keep up-to-date', but the contract pre-dated the advent of EBP. Many staff pointed out that they had been in post for many years prior to the concept of EBP therefore it would not be included in their contract. Without clarity about this, it was difficult for NMs to take issue with staff who were not committed to EBP development projects, dissemination or EBPI and the best that they could hope for in terms of delivering something to highlight the importance of EBP was a letter from the Director of Nursing to state that EBP was to be used in clinical areas (Case B). None of the NMs interviewed saw themselves as having a monitoring role in terms of nurses meeting their contractual obligations in relation to EBP, as all personal development appraisals and planning were undertaken by charge nurses. However in Case C, in one unit, the NM had introduced a system to help charge nurses achieve four goals annually and these were reviewed as part of an annual appraisal. One of these goals was to introduce EBP to one aspect of practice. The NM admitted that none of the charge nurses had ever achieved this, although they did achieve their other goals, relating to the administrative, personnel and personal development aspects of the charge nurse role. No sanctions were introduced and no other action taken by the manager as a result of failure to achieve this goal. The role of the NM in monitoring the achievement of EBP seemed to be non-existent.

Clinical supervision, which would have provided opportunities to discuss EBPI, was only mentioned by one nurse, a practice development nurse in Case B. His role was to develop clinical supervision across the Trust. It did not appear to be in place in any of the other cases and in Case B was going to be delegated to charge nurses to undertake for their staff and would take the form of peer supervision for charge nurses. This suggests that it would not have the scope to act as a means of NMs introducing ideas about EBPI or monitoring its progress.

### ***Support and commitment***

Some of the nurses quoted above felt very let down by NMs in terms of the support that was available to them once they had taken on the additional tasks which had been delegated to them or for which they had been nominated. The notion of support was a strong theme in interviews, raised by all grades of staff and by those different roles. The Director of Nursing in Case B felt that providing support was the most significant

aspect of the NM role in relation to EBP. However, being committed to EBPI and being supportive of it as a concept, did not necessarily translate into tangible support for their staff involved in the process. The lack of visible support or experience of the support of the NM was at odds with what the managers thought they were providing. In all cases, nurses felt that they did not get the support or commitment from their NMs that they needed in relation to EBP:

*'The DNS is supportive in theory about ideas I've had and is not totally unknowledgeable about the service, but as to what he actually does to support EBP in my area, my mind draws a blank'. (CNS)*

This opinion of the involvement and support of the Director of Nursing in Case D was also acknowledged by one of the senior NMs:

*'The DNS has a wee bit of a low profile. Of course evidence-based practice is important to him, but members of nursing staff are maybe not always aware of that'. (Assistant director of nursing)*

It was not clear how the Director of Nursing thought staff would become aware of this. He was the only one from the four cases who declined to be interviewed saying (through his personal assistant) that it was not a priority for him at that time. The Director of Nursing in Case B highlighted the supportive role of NMs in EBP:

*'The nurse manager would have a supportive role but would not be directly involved in EBP, neither would practice development staff. They would not be directly involved in implementing, but would have more of a supportive role'.*

In stark contrast to this, the practice development midwife and former manager (the only member of staff in Case D in a practice development role) saw the explicit provision of support to ward staff as an important part of her role:

*'I supported staff to take time out from the ward to read, surf the internet for information, look at their own CPD [continuing professional*

*development]. I see it as part and parcel of EBP and day to day practice and that's an acceptable thing to do. Staff need tangible support from their managers to allow them to go and do that and if it wasn't happening, then I would tackle it'.*

It may be that the workload in midwifery is more variable or that there are more staff which would provide more flexibility to have time for the kind of activities mentioned. However, probably of more significance, was the belief of the manager and the expression of support of this to her staff in practical ways. Making EBP seem like part and parcel of day-to-day practice was a significant and potentially influential EBPI role.

Staff in all cases felt that they did not have tangible support from their NMs and in some instances felt quite abandoned by their managers when left to deal with EBP related work:

*'Support and commitment from my manager? Well, it's pretty much stand alone so I'd say I have very little input from my manager, in fact, none'.*

(Charge nurse)

Despite all the theoretical support provided by NMs and other staff, nurses did not seem to be aware of this and did not seem to have experienced it. Either they had not been told what the nature of this support would be in practical terms, for example, to provide time away from the clinical area to work on EBP projects or plan EBPI, or they had tried to make use of this kind of support and had found it lacking. In Cases C and D, the shared governance forums had waned, largely due to difficulties for nurses in attending. Getting time away from clinical areas was problematic, either because there was no staff cover available, the ward was already short staffed or because of the stigma and guilt that nurses felt leaving the ward to participate in an activity that their colleagues did not consider to be important:

*'Getting off the ward was always a problem. There are chronic staffing problems here anyway and nobody would be allowed to get bank staff for something like EBP. Nurses don't want to leave the ward when everyone*

*thinks they're just going to be skiving [slacking off] for an hour or two'.  
(Practice development nurse)*

*'Nurses can't get off the wards, there's no cover and people make jokes about how we spend our time drinking tea and chatting. They don't take it seriously, so folk don't like to leave the ward when people are talking behind their backs. It's no easier for me, I might not have a ward to leave, but I still have a caseload and I end up seeing patients and then having to take my paperwork home to get it finished'. (CNS, chair of shared governance forum)*

Nurses in both cases (C and D respectively) felt that NMs should have been more supportive in helping to provide staff cover to allow them the time off the ward that was necessary. In Cases A and B, the development of EBP relied less upon small groups and the staff involved in this tended to be more senior, for example, CNSs or practice development nurses and therefore they relied less on the NM in this regard. NMs were not always seen as the source of support when problems arose, such as the difficulties experienced by two CNSs in Case D when trying to engage accident and emergency nurses in EBPI. Neither had approached a NM about this situation, most likely a reflection on their independence from the nursing hierarchy, however:

*'It wouldn't have occurred to me to go to her, she wouldn't know anything about it and I doubt if she'd be much help anyway'. (CNS)*

*'Nurse managers are really up against it when it comes to support. We didn't have them, then they brought the nurse manager back in. Taking them away was a loss for nursing because I think nurse managers were very much for the development of nursing and they did a lot to champion it, but that just got lost. A lot of their work then got put down to the charge nurses, most of it was over their heads. Even though we've got the nurse managers back now, we've still got the medical mantra. My medical manager is clear that all he wants is someone who is hard working. There's nothing about leadership for nursing. The medical managers are really focused on resources and the directorate nurse*

*managers are bound by that. They don't have time or energy to give to supporting nurses. The pressure is on them all the time to come in under budget – not to get EBP up and running. It's not down to any individual, it's structural and tied up with the medical culture that dominates here. I think we need to be asking ourselves why we have taken our nurse managers away from the essence of the profession and what the consequences of that will be'. (NM/CNS)*

This is a recognition that NMs were limited to some extent in what they could offer as a result of structural limitations and cultural expectations of their posts. The tensions between nursing and medicine that impeded their ability to offer practical support were also acknowledged.

Staff in Case A felt more supported by staff in practice development roles, many of whom had previously held NM posts, but recognised that the main support in relation to EBP and their NMs came in the form of dissemination of information. Two instances recounted by nurses in Case A relating to EBP and management support began with nurses asking for support to develop practice in line with evidence-based protocols which were being opposed by medical staff. In neither instance was the NM able to affect any change to the decision. In one situation the medical staff felt that there was not enough robust evidence to support the introduction of the practice and in the other they felt that nurses were not qualified to administer the specific drugs outlined in the protocol. NMs had not been able to argue against either of these and this had left nursing staff feeling that NMs were as powerless as they were themselves and adamant that they would not look to them for help with anything in the future.

Not only did staff feel unsupported by NMs when it came to EBP, but in general, they felt that managers kept a low profile and were therefore not the most likely people that nurses would turn to if help with EBP was required. Across the cases there were common themes relating to support and commitment from NMs:

*'I'd say we are pretty much left to ourselves. I can't think, off the top of my head, of a situation when I've had their [NMs] support.'* (CN)

*'We don't see much of her [nurse manager] at all.'* (CN)

*'I never see her, I doubt if she would have any idea what I do.'* (CNS)

*'They don't come on the wards at all, they're just not visible. Their argument is that people would be suspicious of them if they turned up, but I think it would be good and folk would soon get used to it.'* (CN)

So while NMs were content in their role to be providing support for EBP and in being committed to it, this was not recognised by other staff, particularly those working in the clinical area.

*'I think the DNS has a significant role in EBP, but I think that the role is not actually recognised. He is really pushing shared governance. People will probably tell you differently because they might not ever see him, but he is hugely supportive of it.'* (Assistant director of nursing)

This quote highlights the mismatch between what NMs felt that they were providing for staff and what staff felt they were getting in terms of support and commitment for EBP from their managers. Staff felt that they needed some kind of *demonstration* of support and commitment, which would be evident by the physical presence of NMs and the provision of tangible, meaningful, practical help, such as time away from the clinical area to undertake EBP work. This did not seem to be happening in any of the cases.

Several NMs in Case A described their role in relation to EBPI as one which '*...which is more about being rather than doing*'. (NM) This sense that their contribution did not involve an active role links with the view that staff had, that NMs were not visible in clinical areas and that delegation of EBP tasks or being nominated to participate in EBP activities by managers did not constitute support or commitment.

So although the NMs felt that they were aware of the issues around EBPI and were, in theory, supportive of nurses and committed to them in progressing EBP, nurses were not experiencing this as their reality.

### *Autonomy and authority*

As noted in chapter five, aspects of autonomy and authority were relevant to both content and process issues. Those presented here related to the latter.

Linked to the felt need for greater support and commitment of NMs to EBPI, were the issues of authority and autonomy and the extent to which nurses were able (that is, possessed the skills) or were allowed to make changes to practice to reflect evidence.

There was considerable variation across the cases in relation to the extent to which nurses had the authority and autonomy to be involved in EBP without the express permission of their NMs. The increasing delegation of management duties to charge nurses apparently gave some NMs the opinion that charge nurses would understand that they were responsible for initiating EBPI. However, this did not seem to be clearly understood by charge nurses and they saw themselves as needing permission from their NMs to undertake any kind of change in the clinical area, both organisational and in clinical practice. Some nurses in Case A seemed to have more confidence in taking things forward themselves and discussing plans with NMs more as a courtesy than as a prerequisite to beginning a project of any nature. The exception to this was if their plans were going to incur significant costs, in which case they would approach their NMs at an earlier stage. However most of the plans that they discussed at interview were more related to organisational changes, rather than the introduction of EBP. NMs were clear that their role was to make the charge nurses more autonomous and they were trying to encourage them to be so, by giving them responsibility for the ward budget:

*'We are trying to make them into charge nurses, give them the freedom to work, make decisions, create a different kind of culture where people are encouraged to use skills and to think differently. I think that is the key thing.'* (NM)

In Cases B and D, although the NMs made it clear during interviews that they would be happy for nurses to take the initiative with EBP, without approaching them first, this was not happening and the only nurses involved in EBP had been nominated by

NMs to do so. In Case D, one of the charge nurses felt that it would be pointless to discuss any plans for clinical practice with her NM as she saw her as being out of touch with practice and ineffectual, preferring to speak directly to one of the assistant directors of nursing instead. It was not clear whether she felt that they were more in touch with clinical practice, had greater influence, or just that she knew them better. She did clarify this statement by saying that she had never introduced any kind of EBP or changes to practice in her ward, so it was more theoretical than an actual occurrence.

It became clear that while NMs believed that nurses did have the authority and autonomy by dint of their role and professional status to undertake EBPI, this was not without difficulties. Nurses were not aware of this authority and where some had taken the initiative to try to progress practice, this had not been successful as the result of medical barriers. Problems with the overall abilities and skills of charge nurses compounded the problems as some had to focus on the basic aspects of ward management and were not able to consider developing practice. The nurses who did possess the necessary authority and autonomy were CNSs and these nurses were managing to undertake EBPI in their discrete areas of practice. The most autonomous staff were those holding joint posts of NM/CNS. Managing their own clinical area, managing staff and holding their own caseload, they had been able to make significant changes to practice, without any of the difficulties relating to medical and nursing relations since most worked closely with medical colleagues and were often managed by them.

Once again this was a NM role that would have benefited from clearer communication from the NM to the charge nurse and staff nurses. The lack of clarity about the need for permission to be involved in EBPI seemed to be hindering progress. Again, while the NMs saw their role as encouraging charge nurses to 'be charge nurses' and thought of this as being empowering and giving them the authority to undertake EBPI, it was often a more passive role, with its action not recognised by nurses.

Overall, there was considerable ambiguity about authority and autonomy, which resulted from these factors not being clearly articulated to nurses in relation to EBP.

There was a mismatch between empowering and giving authority for EBPI, which conversely were not seen by NMs as necessary because the need to use evidence in practice was contained in the nurses' code of professional conduct. The lack of clear communication about aspects of authority and autonomy was further complicated by medical staff involvement in decisions about nursing practice.

### ***Potential power brokers***

NMs had a potential role that was not recognised by them. There were several instances where nurses had lacked the confidence or authority to make changes to practice or introduce new practices. The situation had arisen twice in Case D, where two individual CNSs had tried to implement evidence-based referral routes via the accident and emergency department. These attempts had been unsuccessful due to the intransigence of the nurse in charge of the clinical area and could have seen a NM intervene to provide support for the CNSs, or at least get fuller information about the reasons for not adopting the new referral route. While the CNSs did not have NMs, the charge nurse did and the problem could have been addressed with his NM.

In two Cases, A and D, guidelines that had taken two years to complete were vetoed by the director of clinical governance. In both instances this was reported to be due to lack of evidence. However, in both instances, nurses had gathered considerable amounts of evidence, just not the types of evidence thought to be preferred by doctors. Again, rather than reject these guidelines outright, there may have been scope to review the evidence and consider whether anything could be salvaged from the huge amount of work undertaken to produce the guidelines. NMs were not involved in either situation, but may have been able to discuss the situation with clinical governance staff on a more equal footing. However, their own lack of skills relating to critical appraisal and evidence grading (acknowledged by several NMs across all the cases) would have impeded this solution.

Two instances in Case A had involved NMs when charge nurses looked for support to develop protocols in line with evidence. These were being opposed by medical staff and NMs were unable to effect any change in their decision. In one instance, the medical staff had felt that there was not enough robust evidence to support the introduction of the practice and in the other, they felt that the nurses were not qualified

to administer the drugs outlined in the protocol. NMs had been unable to counter any of these claims and had left the nurses feeling that NMs were as powerless as they were themselves and adamant that they would not look to them for help with anything in the future.

The following quotation illustrates the problems between the professions and the limited ability of the NM to intervene:

*'I'd arranged to use the education room to talk to all the students about EBP. Not about implementing it, you understand, just about the reasons for it and how it should direct practice. I had the room booked from 1.30pm but the doctors were in there having their packed lunches. I waited and then finally went in at 1.45pm, explaining that I had the room booked for a teaching session. I was met with a barrage of abuse. Basically they were claiming that I had interrupted their break and that under New Deal they were entitled to uninterrupted meal breaks. They said they were going to report me to my manager. It doesn't make for good working relationships, nurses have been stretched to the limit because of New Deal and the doctors know that. Some have just been rubbing our faces in it. I beat them to it and went straight over my manager's head and spoke to the principal nurse since I thought it was that important. She was sympathetic but said there was nothing she could do but I could, I could, talk to the consultant if I wanted to, but her suggestion was to just let it ride'. (Clinical educator)*

The Director of Nursing in Case C had tried to use her influence on the Trust board to re-introduce the NM role across the Trust. However, she was not an equal member of the board and was only present at meetings in an advisory capacity. In this instance they had chosen not to take her advice and she saw this as resulting from doctors who did not understand what was best for nursing.

So while the role of the NM as a power broker might have potential, it did not guarantee success and the final decision about nursing care often rested with medical staff.

## **CNSs AND NMs AND A JOINT ROLE FOR EBPI**

Throughout the research fieldwork, the nurses who had the most authority and autonomy to make changes to practice and those most involved in EBP were the CNSs. Although the professional aspects of their role were overseen by NMs, CNSs were not managed within the nursing hierarchies of their Trusts, with most having a medical manager instead. In all cases the CNSs were making significant progress in both developing EBP and in implementing it into their practice. Many had been involved in developing national and local evidence-based guidelines and then went on to implement these within their own area of practice, by using them in their own practice or through the development of evidence-based products that were used more widely. Not only did these nurses have greater autonomy and the respect and authority from their managers to do this, they also had up-to-date and credible clinical knowledge and expertise. However, sadly, many of these initiatives were not widely shared as they did involve fairly discrete, specialist areas of care and in some instances, such as the information leaflet for tattoo parlours, care that would only have an impact on a very small number of patients and which could not be considered a priority. As they were managed by doctors, their expertise was not fully linked into nursing and much of this was lost to the wider nursing community as a result. This problem was recognised by several NMs across the cases. There was no desire expressed by CNSs to become more closely linked to wider nursing structures. Their current arrangements provided a considerable amount of clinical freedom and there was a concern that this would not be sustained if they were managed by NMs.

It was never the intention of this research to measure success in terms of EBPI and the focus has been on identifying processes and progress. However, even without comparing the cases to one another, some successes were evident and are highlighted. In particular, the work of the renal unit in Case D was notable and was viewed by the CSBS as going beyond the minimum requirements for the CSBS clinical governance and Renal Association standards. The team, led by the NM/CNS, had pioneered an approach to tackling EBPI and audit which divided the workload fairly, so each nurse had worked on an area of special interest to them and undertook audits for those aspects of care. Implementing national standards and guidelines was still a top-down process, with adoption, rather than adaptation of these and while each nurse had an area of special interest, this was not necessarily of their own choosing. To a

considerable extent, the NM/CNS recognised that work was allocated to staff, rather than volunteered for (particularly in the early days of developing practice) and his authority and overseeing role kept staff involved. As the benefits of changes to practice became evident and audits showed sustained change, staff became more willingly engaged. Their confidence in their own abilities to tackle EBPI improved. Once they had received positive feedback from the CSBS and national conferences, this further increased interest and enthusiasm to the point that the NM/CNS was able to make suggestions and allow staff to take responsibility for progressing practice themselves.

As mentioned in chapter five, they had developed their own protocols for practice in the absence of national products, relying on research and best practice (expert opinion) to determine the evidence-base for practice. This overall approach had been the subject of several publications (although not in nursing journals) and had been presented at national and international conferences, winning them commendation for their work.

Their success had not been recognised within their Trust. No mention of it had been made by any of the NMs or by the Director of Nursing. This in combination with an ongoing dispute relating to change to working hours to accommodate more time for EBPI, had left staff with little appetite to continue to improve or even maintain standards and with morale very low within the unit.

These successes were isolated within their own Trusts. There was clearly scope for Trusts to learn from these successes and use similar approaches in other areas to improve care as one use of EBP.

While many of these successes were the result of work by CNSs, one role did emerge in Cases A and D that combined both management and practice. In both cases there were nurses who held joint roles as CNS and NM. These were in more specialised areas of care, such as renal services, cancer services or intensive care nursing. In all three areas they were able to provide examples of evidence-based practice that they had implemented and in the intensive care unit, they had also changed their shift system to allow them to have a journal club, to encourage all staff to be more involved in reading, discussing and sharing evidence. While these nurses were clearly

successful in their posts, the autonomy and authority that these nurses had was not entirely straightforward. At the time Case D was visited there was a significant dispute with the Director of Nursing over changes to working practices proposed by the NM/CNS. The Director of Nursing would not agree to this, despite the fact that the NM/CNS was not asking for extra staff, an increase to his budget or any other changes with financial implications. So autonomy and authority to make changes was not an entirely free hand and some of the other NMs found this difficult too, because they did not feel that they were involved in decisions, and therefore became out of touch with new changes:

*'The problem is then that I don't necessarily know everything that is going on. I would like to have some feedback and some recognition and not always have to ask for feedback about what is happening to nursing.'*

(NM)

So to a greater or lesser extent both NMs and nurses were feeling aggrieved about this situation which left neither feeling that communication was good or that support was provided when necessary. However this had not appeared to halt the EBP progress that was taking place in these discrete areas of practice.

The post holders of these joint posts were responsible for smaller numbers of staff than other NMs and also for a smaller and discrete areas of clinical care, in which they were regarded as specialists. They worked closely with medical staff and had a good working relationship with their own staff. This clinical credibility and expertise were seen by them as a crucial factor in the success of EBPI and were also recognised as being so by the other NMs in the Trust. In both cases these posts had arisen to some extent to address the problems resulting from their stable workforce. As a result of this, there were few opportunities for promotion for senior staff and in Case D there had been a conscious decision to create these posts:

*'We realised we would have to develop a nursing role for nurses with expertise and a special interest, so we could keep them'.* (NM)

The expertise of these practitioners was not in doubt, with all of them being involved in guideline development or similar initiatives at national level and all were able to give examples of EBP that they had achieved in their own areas, including undertaking audits of practice before and after the introduction of changes to practice. Despite being in two different cases, their main complaint was the same - that they lacked recognition from senior hospital managers for the success that they had had in their work:

*‘As far as I am concerned the nursing hierarchy doesn’t have any input at clinical level, they are faceless, which is one of the problems I have with them...they are very detached from what goes on and if I wanted to make any changes in the unit then I would discuss it first with the nurses and then with the consultant...’ (NM/CNS)*

#### **THE INTERPLAY OF PROCESS WITH CONTEXT AND CONTENT IN EBPI.**

The joint NM/CNS role had been effective in the two cases as a means of progressing EBPI and clearly had scope to do so in other cases, or areas of practice also. They had been able to overcome or mediate some of the inhibiting aspects of the Trust contexts or evidence content to achieve EBPI. The following section considers, in brief, the interplay of context, content and process and the role of the NM in EBPI, by providing illustrations from each case.

Review of the roles of NMs in the EBPI process has shown that their roles are often passive and characterised by minimal involvement. However, this has more often resulted from the complexity of the EBPI process and the interplay of facilitating or hindering contextual or content factors. As a means of demonstrating this, an illustration from each case is now presented, with a brief explanation linking them to the NM role, whether active or passive.

***Box 6.1: Case A: Evidence-based continence care***

Content:	Adoption of the NMPDU Continence Best Practice Statement (NMPDU, 2002) and selection of appropriate recommendations for use in educating health care assistants. Recommendations were seen as appropriate to local context. No resource issues (if anything EBPI would save money otherwise spent on incontinence products), so no wider permission needed to implement changes to practice.
Context:	Practice development unit had a central role in co-ordinating and leading EBPI for all levels of staff. Practice development nurses were highly qualified and experienced with former roles as NMs or in education and were supported by the Director of Nursing. He was supportive and encouraging of the health care assistants to publish their experience of EBPI and of improvement of care.
Process:	Recommendations from the best practice statement were embedded into education materials, but not identified as anything other than 'best practice', to increase chances of use. Recommendations were not onerous and the focus was on improving continence through better toileting care and access to facilities, both within the remit of the health care assistants. Focus was also to move away from the provision of incontinence products to one of improving and maintaining continence. While this was a change in practice, it was not viewed as anything contentious or as anything other than good practice and was seen by the health care assistants as achievable. Changing their practice also had a consequential change in the practice of the nurses, who adopted the approach of the health care assistants. Improvements to the quality of care were considered to be the most significant aspect of this EBPI initiative.

The three factors interacted to produce significant changes to patient care through the application to practice of a national evidence product. It was used appropriately, in that specific recommendations were selected for the target staff group. The staff undertaking the education had the knowledge, skills, authority and autonomy to provide the education and support the implementation of changes to practice. No recourse to NMs was needed. The Director of Nursing, although not actively involved in the process, was supportive of it and publicly acknowledged the success of the initiative. The initial EBP initiative subsequently changed the practice of other staff and patients were, quite appropriately, the ultimate beneficiaries.

**Box 6.2: Case B: Non-implementation of NMPDU statements**

- Content:** NMPDU best practice statements had been ‘adopted’ by the Director of Nursing as a basis for practice. Prior to the publication of these the Trust had opted for a process of local development of nursing guidelines, led, and largely undertaken, by one practice development nurse. The evidence content of these varied depending on the subject and the types and amount of evidence available for each. Many were based on expert opinion.
- Context:** The Director of Nursing was giving conflicting messages about EBP, such as the lack of a research culture in the Trust, her (stated) inability to read or appraise research, yet having the significant role of ‘signing off’ or verifying the evidence-based products developed in the Trust. She had adopted the NMPDU statements, by disseminating them throughout the Trust and subsequently informing every charge nurse of her expectation that these should be used in practice. To support EBPI, she had created a post for a practice development nurse to implement the NMPDU statements, but the nurse had no direct access to wards to undertake or support this. Numerous other contextual factors existed.
- Process:** Charge nurses had been told by the Director of Nursing to ensure that the statements were being used, but they had been given no guidance or support to do so. They, themselves, lacked the knowledge and skills to tackle EBPI. The practice development nurse appointed to facilitate the evidence into practice process (although she was not clear of exactly how she would/should do this) was not able to get access to wards and was unwelcome on some, so was very limited in what she could achieve. She was of the belief that it was her role to implement the statements, however the Director of Nursing stated that the role of practice development nurses was not to be directly involved in evidence application, but was a facilitative role only.

The interaction of factors in Case B shows greater involvement of the NM in attempting EBPI. However, in reality, it demonstrates a process that had not progressed further than the dissemination of products. Although the Director of Nursing had made a commitment to adopt the NMPDU best practice statements, the ways in which these might come to influence or change practice had not been made clear, either to charge nurses or to the newly appointed practice development nurse.

Conflicting statements about EBP from the Director of Nursing added to the confusion for staff about the value of EBP and the role that it could/should take in practice. This example illustrates a lack of coherence and an unconnectedness around EBPI which had hindered its progress.

### **Box 6.3: Case C: Implementation of a protocol for pressure care**

- Content:** No national products were in use to guide or inform nursing practice, except those in use by CNSs. One had undertaken the local development of a protocol, based on her own experience and product knowledge, relating to the use of pressure relieving mattresses. Her rationale was not only to make financial savings, but also to ensure that patients were being provided with the most appropriate product for their needs and that those who needed the expensive, hired in, mattresses, should get them. The protocol provided information about all of the products and their appropriate use.
- Context:** Multiple complex organisational factors were involved, with an impact on the ability of most staff, including NMs, to be involved in EBPI. Shared governance had not been successful as an approach to supporting the EBPI process. No-one had specific responsibility for leading, developing or supporting EBPI. Some CNSs were using evidence in their own practice. One CNS had implemented a hospital (but not Trust) wide initiative for pressure care.
- Process:** The protocol was disseminated in person, by the CNS to each ward. As her role as a tissue viability nurse meant that she saw patients on every ward, she had ready access to these, which facilitated dissemination. Detailed explanation of the rationale for the protocol and of the way it should be used was provided. Her contact details were given to each charge nurse to ensure that she could be reached to address any problems. Monitoring of the use of the protocol was incorporated into it, as nurses had to inform the CNS (via an answerphone, so it could be at any time) that mattresses had been hired and returned. A proforma detailing the choice of mattress and length of time in use and its success in preventing skin breakdown had to be completed by nursing staff and returned to the CNS. Although formal audit had not taken place, it was planned. The protocol had only been in use for six months, but informal monitoring showed that the costs of mattress hire had fallen and the incidence of skin breakdown and subsequent problems had not increased.

This example illustrates that the efforts, skills, knowledge and initiative of one CNS (a former NM) had led to the successful implementation of a patient care protocol. While the evidence-base might not have been as robust as that of nationally developed products, it shows that locally developed products, designed to reflect local need, can still have positive outcomes when fully implemented. Despite the unfavourable context, the CNS had used her position and confidence from her previous role to progress EBPI. While this was an isolated pursuit initially, it had been disseminated and used to change practice in one large hospital. As one of seven in the Trust, it

clearly had scope to be used more widely throughout the Trust. There was no involvement of the NM in this EBPI initiative as the CNS was not managed by a NM and saw no reason to involve any NMs in the project.

**Box 6.4: Case D: The partial implementation of SIGN guidelines**

- Content:** Two CNSs had adopted the nursing aspects of SIGN guidelines relevant to their specialties, one related to acute asthma, the other to osteoporosis prevention and treatment. Both had identified recommendations from the guidelines that were related to aspects of nursing practice, both referral routes that would identify patients requiring follow-up of further treatment from a CNS.
- Context:** Recent merger meant that managers were ‘otherwise focussed’ and did not see EBP as a priority. The Director of Nursing was thought by other NMs to have a low profile in the organisation and was not seen as leading nursing. The Trust had no specific practice development unit or nurses and relied on one nurse, working very part-time, to development nursing procedures. Shared governance had been developed as a means of involving nurses in EBP, but had limited success and had not been sustained due to waning interest and the inability of nurses to be involved, due to work pressures. CNSs were using evidence in their own areas of practice.
- Process:** While guideline recommendations were relevant to both of the CNSs patient groups, both were trying to implement these in the Accident and Emergency department (A&E). In both instances the recommendations focused on staff in A&E alerting the CNSs that patients with the specific conditions had attended the department, so they could receive appropriate follow-up. However, the charge nurse in A&E did not view either condition as ‘acute’, that is, part of the departmental remit, and would not agree to complete (or allow his staff to complete) a short referral form to each CNS. Neither would he agree to make a phone call to the CNSs, as an alternative means of referral. As a result, these recommendations of the SIGN guidelines could not be implemented.

This illustration from Case D demonstrates the need for co-operation and a shared understanding, for successful EBPI. Regardless of the robust evidence-base and a willingness on behalf of the CNSs to find alternative ways of referring patients that would not be too onerous for the A&E staff, EBPI had still not been possible. These recommendations were specific and discrete and should not have been too complicated for A&E staff to accommodate. So, while both CNSs were able to use

evidence in their own practice, they were not able to bring any influence to bear outwith this. The particular contextual conditions in this Trust, with a lack of EBP focus and the absence of a practice development unit or nurses meant that there was no other recognised support for EBPI that the CNSs could access to mediate or resolve the situation. NM support had not been sought by either CNS as it was not thought to be useful.

These four examples demonstrate the necessity of seeing EBPI as a process that was only one factor in the complexities of Trust context and evidence content. The roles of NMs in the process varied, but were significant in either the presence or absence of their involvement. It can also be seen that EBPI was taking place in the cases, where individuals had been able to tackle this themselves.

### **THE EBPI PROCESS AND THE ROLES OF THE NM: A SUMMARY**

This chapter concludes by providing a summary of the role of the NM in the process of EBPI and the strategies used by them to achieve this. While this and the previous two chapters have been presented as the separate categories of Pettigrew's (1985a; 1988) context, content and process framework, it needs to be borne in mind that these categories are fluid and it is seldom possible to consider one fully, without recourse to the others. However, the focus in this chapter has been on the process of using evidence and began by considering generic EBPI processes and the roles of the NM, in these. The roles, while often described by NMs in active terms, were in reality, more passive roles based on delegation of EBPI to others. The extent to which any individual manager was involved in EBP seemed to depend more upon their personal interests and abilities, than on the needs of the organisation or staff.

Many of the strategies used by NMs to progress EBPI were based on the belief that EBP products themselves would guarantee EBPI or that people involved in EBP product development would secure their use in practice. These did not reflect an understanding of the complexities of EBPI processes or of the factors that might hinder these in specific contexts.

In all cases, the focus was very much on the development of EBP products and this was the stage that NMs saw themselves as being most involved in by providing support. None of the NMs interviewed discussed or described specific support for EBPI. This lack of knowledge about the process and the validation of the end product by NMs who had little knowledge of the EBPI process, highlights concerns about the quality of locally developed products. It may be that the challenges of EBPI or lack of knowledge about it, shift the focus to product development, where NMs feel more confident, rather than consider changes to practices that reflect evidence but are a greater challenge.

Several NMs did not consider that they had a role in relation to EBP, but often changed this view after discussing it during interview. They saw it as a role that involved delegating duties to charge nurses and this included EBP, although this did not appear to have been made explicit to charge nurses. They described their role in very general ways such as ‘empowering’ or ‘supporting’, but these were not roles that were acknowledged by their staff, who did not experience the empowerment or support. The notions of authority and autonomy to develop EBP and implement change within the clinical area were not widely recognised, except among the staff holding joint NM/CNS roles. These nurses had been successful in combining the two roles and in implementing EBP. The lack of clarity about these issues had hindered EBPI progress.

The final section presented four illustrations of EBPI or non-implementation from the cases, to demonstrate the interplay of the context, content and process factors in understanding EBPI and the roles of NMs within this.

While the roles of the NMs and their involvement in EBPI did vary both within cases and across cases, the common themes presented suggest that it is a role that has a significant impact on the extent to which EBP is being used in practice. Whether this is dependent on the actions of the NMs or their lack of involvement in the EBPI process is explored in the following chapter. The discussion considers the data presented in this and the previous two chapters and relates it to the literature on EBPI and the role of the NM.



## CHAPTER SEVEN

### *DISCUSSION OF CASE STUDY FINDINGS*

#### *The emerging roles of nurse managers in EBPI*

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##### *INTRODUCTION*

This chapter presents a detailed discussion of the case study findings outlined in chapters four, five and six. It comprises two main sections: firstly presentation of the three key findings and then consideration is given to the study's propositions in the light of the key findings. For each of the key findings, the discussion is based on three strands: the main dimensions or features of each of the findings; links to the literature reviewed in chapter two, to determine the extent to which the findings fit with what is already known or are reflected in the literature relating to EBP and EBPI; and some explanation as to why these findings have occurred in light of the interplay of context, content and process.

##### *KEY FINDINGS*

Three key findings were revealed by the data analysis. There are:

- The complexities of EBP and EBPI
- The difference between the theoretical and actual roles of NMs in EBP and EBPI
- The potential of the NM/CNS role in EBPI

These are now considered individually with reference to the literature reviewed in chapter two.

##### *1. The complexities of EBP and EBPI*

The complexities of EBP and EBPI were often unacknowledged by NMs and other nurses. This complexity had not really been grasped in any of the cases, beyond acknowledging the difficulties inherent in getting individuals to change their practice. Although knowledge has increased since the International Council of Nurses suggested that implementation (of research, rather than evidence, but the principle applies) would be straightforward after securing the agreement of staff and provision of education (ICN, 1996a,b), it has not necessarily increased the use of research in practice. None of the Trusts were finding it straightforward. Many factors contributed

to the complexity and are discussed below. They are not presented in order of priority or importance, but more as a means of ‘telling the story’ of EBPI arising from the study’s findings.

### ***Understanding and undertaking EBPI***

The predominant view of EBPI was one of a straightforward, linear process (Kitson, *et al.*, 1998; Nutley & Davies, 2000a,b), built on the belief that nurses had a responsibility to use evidence and that they had the skills (gained as part of their pre-registration nurse education) to use it. This was demonstrated by a reliance on newly qualified nurses to lead EBPI that belies an understanding of ward dynamics and the focus of newly qualified nurses on ‘fitting in’ and learning, rather than challenging their superiors (Benner, 1984). The barriers studies, which support Benner’s findings, highlight the significance of organisational, not individual issues that impeded EBPI (Andersson, *et al.*, 2007). Caine and Kenrick (1997) consider the reliance on newly qualified nurses to be managerial complacency and a failure of managers to accept responsibility for RU/EBP.

Viewing EBPI as a straightforward process may have arisen from a lack of knowledge, but also may have reflected, on the part of NMs, a view that they wanted to portray to nurses, lest it seemed too complicated to tackle. Many of the key factors known to be necessary for EBPI, did not exist or had not been acknowledged as important in the cases. For example, there was a lack of agreement about the nature of evidence and positive advantage of EBP (Hewison, 2004) or a sense of ownership (Harvey & Kitson, 1996). There were few signs of shared goals and priorities and the benefits of EBP for patients were either not understood or not acknowledged. EBP was seen, in general in a negative light, either as resource intensive or as more work. Much of the lack of EBPI activity appeared to stem from nurse’s uncertainty about how to proceed, such as pinning up NMPDU statements so the Director of Nursing could see them, rather than an unwillingness to tackle it.

Difficulties also arose from the multiple views of evidence held in each case and no common understanding of terms existed. There was a lack of an agreed definition of evidence, either within or across cases and no common language to describe evidence or EBPI. This was noted by Le May, *et al.* (1998) in relation to research-based

practice also and the assumptions about shared understanding of these terms has been acknowledged by many authors elsewhere, for example, McCormack, (2006). Many research participants described innovations or new ways of working such as changes to shift patterns and organisational changes, for example the introduction of nurse practitioner posts as part of development of accident and emergency services, but could not relate these to an evidence-base. Others were either not confident of the concept, or had strong views on the nature of evidence which reflects other nurses' views (Upton, 1999a; McInnes, *et al.*, 2001; Driever, 2002; Sleep, *et al.*, 2002; Thurston & King, 2004). This issue is not limited to practice, with academics continuing to debate the nature and definitions of evidence (Mulhall, 1997; 1998; Mitchell, 1999; Rycroft-Malone, *et al.*, 2004b; Scott-Findlay & Pollock, 2004; Rycroft-Malone & Stetler, 2004, Rycroft-Malone, 2006). Many of the nurses and NMs interviewed felt that the main problem was not lack of consensus (Rolfe, 1999; Bradshaw, 2000), but with the nature of evidence and they felt strongly that nursing should not be forced to accept the randomised controlled trial as the benchmark for nursing, seeing it as medical imposition (Closs & Cheater, 1999). Despite the lack of support for the randomised controlled trial as a basis for nursing care, staff did acknowledge that one of the difficulties with EBP was the lack of nursing research on which to base care. Other participants described evidence as synonymous with research and although there are a number of different types of evidence now recognised, this suggests confusion or a barrier that is inhibiting EBPI (Kitson, 1997; Royle & Blyth, 1998; Estabrooks, 1998; Le May, 1999; Carnwell, 2000; Stetler, 2001; Rycroft-Malone, *et al.*, 2004a,b).

Despite the acknowledgement in the literature that multiple types and sources of evidence do exist, NMs and nurses had no shared view of these within, or across cases. Jennings and Loan (2001) suggest that nurses' superficial grasp of the concept of EBP is impeding implementation as there is incorrect use of terms and they see the need for a shared or agreed definition of evidence and a standardised framework for EBPI within nursing as both urgent and paramount. Within cases, it was difficult to determine the extent to which this shortcoming was inhibiting EBPI, but lack of agreement and a view of EBP as a medical import provides nurses with reasons for not engaging with EBP more fully. It was certainly a recurring theme in interviews and until some consensus can be reached, it seems unlikely that EBPI will progress.

An opportunity or forum to discuss evidence within cases did not really exist, although the shared governance forums in Cases C and D might have provided this for a few nurses, it could not include them all. This led to nurses and NMs using terms without recognising that others may not share their understanding or viewpoint about EBP and this was hindering EBP and evidence use.

The confusion about the concept was revealed as nurses and NMs spoke of their use of, or knowledge of use of, EBP. In describing other types of change as evidence, such as new off duty systems, the introduction of new equipment, or a service development, participants were indicating that not only did they not fully understand the concept of EBP, but that they had failed to acknowledge the most significant aspect of it – that it is a process to aid clinical decision making and improve patient care outcomes (Di Censco, *et al.*, 1998; Carnwell, 2000; Muir Gray, 2001). Upton (1999a) has suggested that nurses may be using EBP, but be unaware of it, or calling it something different. However, the opposite situation seems to have been demonstrated in the case studies, where practitioners were using EBP as a blanket term for anything new, without following the principles or process of it and without fully understanding the implications of EBP. While the difficulties of identifying EBP in the practice environment have been acknowledged (Estabrooks, 2004), the sense that there might be improved, or beneficial outcomes for patients through EBPI, did not feature in any of the interviews undertaken in this study. (Although the term ‘clinical improvement team’ was used in Case C to describe a new structure, none of the staff interviewed there referred to this aspect of EBP).

#### *Evidence-based products*

While knowledge of national evidence-based products varied, both within and across cases, the extent to which they were used by nurses in practice was minimal, even those developed specifically for nurses’ use. In the main, they were seen as medically orientated, not having any relevance to nursing. There was a lack of understanding at ward level as to how the NMPDU statements should be used and no direction given from practice development units or NMs as to the ways in which they could be used. Many of the responses given at interview suggest a disparity between perceptions of SIGN guidelines and actual knowledge of them, many nurses reporting that they hadn’t seen SIGN guidelines, but expressing the belief that they were not relevant to

nursing. These views regarding national products are widely held and are recognised as being a barrier to their use in practice (Tolson, *et al.*, 2005; Glasziou & Haynes, 2005; Ring, *et al.*, 2005; Ring, *et al.*, 2006). Even products aimed specifically at nurses were not able to overcome the problems of lack of local ownership, with two cases having failed to disseminate them. Facilitating access to these was not described by NMs as part of their role, rather it was seen as the remit of practice development staff. Access for nurses to these types of products, in the first instance, is acknowledged as an important step towards developing local ownership (Royle & Blythe, 1998; Coleman & Nicholl, 2001; Gerrish & Clayton, 2004; Ring, *et al.*, 2006). While SIGN does make guidelines available to download from the internet, time and access to these for nurses might inhibit their use. Although SIGN makes the guidelines available, the intention is not that they should be adopted in their entirety (Davenport, 2000), but that they should be used as the basis for methodical local adaptation and implementation (SIGN, 2002). The reluctance to adopt or adapt national guidelines for local use has previously been recognised, so it does not appear to be related specifically to the case studies (Von Degenberg, 2001), although there may have been aspects of the interplay of the context, content and process factors, such as EBP being a low priority or a decision to focus on locally developed products as a means of promoting local evidence use, which contributed to this.

In each of the cases, development of local products was the main focus of EBP in nursing. The exact nature of these varied and there was no standard format for guidelines, procedures, policies and protocols, even within cases. These terms seemed to be used interchangeably by staff which has been recognised in the literature as stemming from the belief that all are simply sets of instructions (Parahoo, 2006). However, they do have different formats and functions and basis in law (Yin King Lee, 2003; Hewitt-Taylor, 2003a,b) which was not acknowledged by the staff interviewed. There was a belief that not delineating between them would aid local ownership, which would in turn, facilitate the use of these products in practice. This led to considerable duplication of effort, with some Trusts working on the development of areas of practice for which national products already existed, so the local process was not aimed at plugging gaps. Duplication of effort within cases also occurred. This 'reinvention of the wheel' had been a problem for the NHS prior to the introduction of EBP (Pettigrew, *et al.*, 1992a,b) but with one of the principles of EBP

being to make the best use of scarce health care resources (Muir Gray, 2001), it does not reflect this.

In addition, the reluctance to use national products and the reliance on locally developed products has implications for practice. While nationally developed products were more robust in terms of the quality and rigour of the developmental process, they were not necessarily more likely to be used in practice as a result of these attributes. In fact, the development processes were often suspect in the eyes of practitioners, with regard to their representativeness of local or widespread opinion, and there was an inherent suspicion and dislike for products that were seen to favour higher grades of evidence. This was largely due to the belief that this approach reflected the evidence-based medicine approach to EBP, favouring randomised controlled trials and the concern that nursing practice was not easily 'measured' or evaluated in this way. Nurses' perceived lack of randomised controlled trial evidence for nursing practice was underpinned in the cases when nurses' own guideline development had been rejected by medical staff, due to lack of scientific evidence. This further polarised views about the kinds of evidence that were available for nursing and the kinds of evidence that were valued (or seen as necessary) by doctors.

The implications of this outcome for EBP in nursing appear to be twofold. Firstly, it emphasises the types of knowledge that nurses perceive to be important to them are not necessarily those that are most prominent in debates about EBP. The nurses in this study gave more value to evidence products that were locally developed as opposed to those developed nationally. However, this was not only a matter of local ownership, as many locally developed products were not in use either. Personal opinion was seen as the most used type of evidence, or experience, as it was also named. This is congruent with what is already known about the types of knowledge most used by nurses in practice (Thompson, *et al.*, 2001a), but raises concerns in relation to the way in which it is integrated with other types of evidence, as this integration did not seem to be happening in the cases. As it was seen as the most valuable types of evidence by many nurses, other types were disregarded without due consideration. This raises the question about the extent to which nursing practice has developed from the days of, not necessarily routine and ritual (Walsh & Ford, 1989) but to the development of non-standardised care that is based on individual nurses' knowledge, skill, opinion or

preference. As such, it is not too far removed from the 'new rituals for old' concerns expressed by Ford and Walsh (1994), with nurses continuing to practice much as before, but 're-branding' it as personal opinion or experiential evidence. This is not to diminish the role that these practices have in an overall evidence 'tool kit', but they need to be given their place, with due consideration, along with patient preference and values and other types of evidence. The key process that appeared to be missing in the cases, was the 'due consideration' as outright rejection of some types of evidence, was more obvious. The difficulty remains, that the types of evidence more often favoured by nurses, were those relating to their own knowledge and experience and codifying, evaluating or sharing this tacit evidence is highly complex and problematic. Scott-Findlay and Pollock (2004) have gone as far as to suggest that these should not be termed 'evidence', but rather knowledge, to differentiate between the two concepts. While these are undoubtedly important aspects of conceptual and theoretical debates about EBP, the extent to which these might be influential in changing practitioners' views to be more open to other kinds of evidence, remain unclear.

The second issue, that arises from nurses' preference for personal experience and opinion over locally developed products and over nationally developed products, is the extent to which it widens the divide between evidence-based medicine and evidence-based nursing. Nurses' concerns about the value and importance of the randomised controlled trial was mainly based on what they viewed as the (real or perceived) medical dominance of nursing practice. The inter-professional issues are deeply entrenched and pre-date EBP by many years, but contemporary health care relies much more on good working relationships between professions and these are not only necessary, but imperative, for many aspects of service delivery. While the inequality between the professions has been recognised (Mulhall & Le May, 1999), it has also been seen to be a hindering factor in progressing EBP and other service developments (Ferlie, *et al.*, 2005; Powell, 2006).

NMs seemed to be unable to mediate in these situations and the structures that might have ameliorated some of these difficulties, that is those that might have provided scope for dialogue between nurses and doctors, such as clinical governance meetings did not involve nurses. Attempts to involve other professions in 'nursing' structures,

such as the shared governance forum, in Case D, had been unsuccessful. Where multi-disciplinary strategies had been adopted, nurses were not only suspicious of these, but were uninvolved, as they were medically led and therefore had no appeal to nurses. Managerial attempts to intervene or mediate had not been tried, but other studies have shown that this is not a simple solution either, with professional groups seeing this as a threat to their professional autonomy (Dopson & Fitzgerald, 2005), that might aggravate, rather than facilitate professional relationships.

These complexities of EBP and EBPI are illustrations of the interplay of context, content and process factors. Many of the issues concerning the nature of evidence and the unwillingness of nurses to engage more fully with specific types of evidence are clearly content factors. However, they interact with and develop from or are underpinned by, aspects of attitude, organisational culture and professional group behaviour that are more contextually linked. Aspects of process, the actions, reactions or interactions of NMs (Pettigrew, *et al.*, 1992), can also be seen to be involved, although more often the *lack* of action on the part of NMs, is noted.

### ***Skills for EBPI***

Some nurses involved in product development admitted that they did not possess the knowledge and skills necessary for the task which been recognised as central to the quality of the final product (Von Degenberg, 2001). This did not seem to be a concern to NMs who nominated staff to be involved in the development process for a number of reasons, such as a nurse having an interest in a subject or needing (in the view of the NM) to be ‘stretched’, but did not include possession of the required skills. Further difficulties arose in cases where there were large number of vacancies and where charge nurses were not seen by NMs as coping with their role. The impact of context, cannot be seen as separate to the wider issues of EBP.

Given the concerns about knowledge and skills, the extent to which locally developed products could then be described as evidence-based is a concern (Royle & Blythe, 2001; Van Mullem *et al.*, 2001; Gerrish & Clayton, 2004). Whether this is a deliberate attempt to ‘dumb down’ EBP to make it more appealing to nurses that are disinclined towards the research focussed medical model, or merely a case of making the most of available skills and interest, it is difficult to say. In Case B, both the NM and nurses

remarked on the policy of the Director of Nursing not to support (by funding or providing time) nurses continuing education which could have increased both knowledge and skills for EBPI. In contrast, the nurses thought of as most likely to be interested in EBP, were those undertaking educational courses or degree modules. However it was not universally seen as relevant; in Case D, one charge nurse, who had just completed a Master's degree in nursing felt it had not increased her knowledge or interest in EBP. The 'individual determinants' of nurses involved in EBPI have been extensively studied and educational achievement is always noted as one which was thought to be significant, for example, Pepler, *et al.* (2007), but a meta analysis of these concluded that the only individual factor that was statistically significant in EBPI was attitude to research or EBP (Estabrooks, *et al.*, 2003).

Besides the production of local evidence products, there were no other specific EBPI initiatives in the cases. Although shared governance councils were in place in Cases C and D they were not functioning and their focus had been on product development, rather than EBPI. None of the staff interviewed referred to any EBPI strategies or initiatives from the literature, examples of which were provided in chapter two. It may be that the local ownership notion also impacts on adopting external approaches to EBPI. It is clearly not a straightforward issue.

### ***Types of evidence/research utilisation***

Efforts for EBP were focussed on instrumental use, with no recognition that there were other ways that it could be used to inform or influence practice (Estabrooks, 1998; Landry, *et al.*, 2001a,b; Nutley, *et al.*, 2004b; Parahoo, 2006; Nutley, *et al.*, 2007). The literature concerning RU has identified three types of RU, instrumental, conceptual and symbolic RU (Stetler, 1994; Estabrooks, 1999a,b; Walter, *et al.*, 2005). These highlight that evidence can influence the way nurses think about or reflect on practice (Closs & Cheater, 1994), be used to persuade management of the need for changes to practice (Lacey, 1994) as well as being used directly to make changes to practice. Landry, *et al.*, (2001a,b) have asserted that knowing about a piece of research or evidence is not enough to ensure that it will be used in practice and this was evident in all the cases. Many nurses knew about national guidelines, but had rationalised their decision not to consider them as a basis for practice. Many nurses knew about NMPDU best practice statements, but again had either rejected them as a basis for

practice, or lacked the knowledge to begin to tackle the adoption or adaptation processes as part of the implementation continuum (Nutley, *et al.*, 2007). The focus on instrumental use probably reflects the practical nature of nursing and the long-standing and well recognised difficulties in interesting nurses in reading research due to lack of confidence and knowledge of research (McSherry, *et al.*, 2006), which might have had conceptual or symbolic impacts.

Shared governance could be viewed as a means of attempting either conceptual or symbolic evidence use, through the notion of empowering nurses, inherent in the approach. However, there was no clear evidence in either case where this had been used, that it had revealed either symbolic or conceptual use. Involvement in the shared governance forums may have influenced the way nurses viewed evidence or have given them confidence to use evidence to lobby management for more resources, but these reflect ideals of the shared governance initiative, rather than reflecting the reality demonstrated in the data.

There were wider aspects of the Trusts that impacted on the complexities of EBPI in each of the cases, such as organisational culture and structures and these are discussed below.

### **Organisational culture**

Recognised as being a complex and contested concept, (Scott, *et al.*, 2003a,b; Mannion, *et al.*, 2005), organisational culture is nonetheless an aspect of organisational life that had to be considered. Scott-Findlay and Estabrooks (2006) have noted that within health care there is no single culture, but many that can be identified. Culture is a factor that is known to have an impact on EBPI (Ross & McLaren, 2000; Rycroft-Malone, 2004; Tod, *et al.*, 2004). It was certainly a concept which NMs and other staff raised at interview as one which had an impact on several aspects of their organisations and the extent to which evidence could be used there. The link between structures and cultures was made by staff in several cases, particularly after Trust mergers and structures did not always lend themselves to the facilitation of integration of different cultures. While no causal links can be identified between structures and ways of working (Sheaff, *et al.*, 2003), culture can impact on the development of structures (Hyde and Davies, 2004). Divisions were exacerbated

by organisational structures, such as directorate structures, and local cultures developed within these are those that remained from previous structures, prior to mergers of Trusts or directorates. The introduction of new structures, to try to change culture, such as shared governance forums had been attempted. In both Trusts where this has been introduced, it was seen as a means of empowering nurses, that is, changing the culture to one that gave nurses greater autonomy and equality of decision making. However, neither was successful in this regard and this reflects the numerous cultures that have been recognised within health care organisations, rendering attempts to change one culture, as largely ineffectual.

NMs and other nurses were very clear that EBP products '*wouldn't work here*', seemingly quite contextually and culturally aware when it came to the matter of implementing national evidence-based guidance. Paradoxically, NMs in particular, were very unaware of their own influence on the culture of organisations. Other cases saw the merger of several Trusts as problematic and hindering progress in many aspects of work, including EBP, resulting from the continued existence of different residual cultures 'left over' or imported into merged Trusts. Manifestations of culture in beliefs, attitudes and behaviour (Scott, *et al.*, 2003a,b; Davies, *et al.*, 2000) in relation to EBP cannot be ignored and have been widely acknowledged as barriers to EBP, for example, Nolan, *et al.* (1998), Sitzia (2001), Estabrooks, *et al.* (2002) and Bartholemew & Collier (2002). So while there was some acknowledgement of the impact of culture on some aspects of EBPI, these were not understood to the point that they could be overcome to facilitate EBPI. The wider impact of making decisions based on culture, such as 'it wouldn't work here' often meant that alternative solutions were attempted, such as local development of EBP products, but were not necessarily more successful in changing practice.

### ***Clinical governance and shared governance***

Although the approaches to implementation of clinical governance have varied (Lough *et al.*, 2002) there is no doubt that it has been a considerable challenge to all health care organisations and there have been other concurrent outer context changes with consequential inner context impact. The introduction of clinical governance was largely behind many of the structures in places within the cases and the CSBS

monitoring of EBPI was externally driven, but neither fully reflected EBPI in nursing practice, and which NMs were only able to describe to varying degrees. However, other than shared governance forums, which had been selected not only for their potential to progress EBPI, but because they were seen more as a means of increasing nurse empowerment, NMs had little involvement with wider clinical governance structures and were disconnected from them on the whole. NMs were not linked to the organisation wide quality improvement structures and this may provide one reason for their level of understanding of EBPI. Closer links to clinical governance may have increased knowledge and understanding of the complexities of the EBPI process.

However, there was a sense in all of the cases that clinical governance was largely the domain or responsibility of medical staff and those in clinical governance teams. The aspects of EBP that were given the most attention were those that were monitored as part of the CSBS reviews and only discrete aspects of these concerned specific nursing practice. While this aspect of organisational behaviour has been previously recognised (Sheaff, *et al.*, 2004), there were unintended and unrecognised outcomes of the overwhelming focus on meeting the medical aspects of CSBS reviews, that were to the detriment of nursing development. Likewise, the development of the clinical improvement teams in Case C, was an attempt to focus directorates on achieving national clinical governance targets and meeting locally identified needs at 'team' level. However, the notion of 'team' as a multi-disciplinary group was neither universally agreed nor serving any clear function for developing EBP or supporting EBPI in nursing. While these teams might have been seen as an attempt to develop bottom-up initiatives, similar to organisational learning ideals (Davies and Nutley, 2000; Nutley and Davies, 2001) these were not a good fit with the much more top-down clinical governance processes (Wilkinson, *et al.*, 2004) and as such were unlikely to be successful in achieving either goal.

Despite the purported independent nature of shared governance forums (Gavin & Wakefield, 1999; Burnhope & Edmonstone, 2003) this had not been the reality in either case. So despite NMs viewing and supporting these as a useful way of involving and empowering nurses to be part of EBP and of seeing them as linked to clinical governance, they had not fulfilled expectations in this regard. Importantly in the context of this thesis, the link between shared governance and clinical governance

is not seen in the literature. As a means of empowering nurses, which NMs described it as being, it had not achieved its goal. In both cases, it was used as a means of developing EBP products. Shared governance has been used as a means of empowering nurses and as an approach to developing EBP (Geoghegan & Farrington, 1995a,b; Legg, 1996; Newhouse, *et al.*, 2007; Kuokkanen, *et al.*, 2007), but its success in the UK has varied. It has been seen as a means of supporting leadership development and increasing communication for nurses (Williamson, 2005b; Scott & Caress, 2005; Gavin, *et al.*, 2005), but these have all been based on the premise underpinning the model, that the aim of shared governance is to make nurses self governing and obviate the need for managers (Hess, 2007).

In the USA its development has been driven not by what it has to offer nurses, but more by what it has to offer the organisation, and appraisal of its success often reflects the organisational goal of achieving Magnet status (a quality accreditation award) rather than those relating more specifically to nursing and EBP. In the UK the literature focuses much more on ways or models of developing shared governance than it does on considering its success as a means of empowering nurses and implementing EBP. It is clear from the literature relating to EBPI in the UK, that it is neither straightforward nor quick and it may be that in both Case C and D it was still a relatively new concept that needed further time to 'bed in' in order to produce empowered nurses capable of progressing EBPI in their respective Trusts. The shared governance forums had not become fully integrated into nursing in either case and had not (in Case C) been given any further opportunity to do so. Significant difficulties around the concept, practical difficulties for nurses' involvement, that would not be readily overcome, had placed limitations on the potential of the initiative in both cases.

### ***Practice development***

NMs and Directors of Nursing had been involved to some extent in the development and re-structuring of practice development units within the cases and these structures were seen by NMs as having a significant role in EBPI. In Case A, the unit did have a central and co-ordinating role in EBP, although the focus was largely on education and development, rather than EBPI. While Case C also had a large practice development unit, in terms of numbers of staff, its role had changed and previous

involvement in EBP activities, such as ‘launching’ the NMPDU best practice statements and supporting the shared governance forum, would not continue. Their focus on training and skills update, while still having scope for progressing EBPI through these roles, would be much more focused on the individual practitioner, than on organisational approaches to EBPI but nurses lacked the authority, autonomy and skills to enable them to progress EBPI without substantial support. This approach reflects the EBPI model identified by Walter, *et al.*, (2004), but did not take account of the conditions necessary for the evidence-based (or research-based) practitioner to be successful and while the emphasis for a corporate approach to EBPI had been removed with the re-organisation of the practice development unit, there had been no explicit communication to nurses to inform them that they would be expected to take this forward themselves.

The changes to the unit in Case B also reflected a more individual focus, with posts specifically developed for skills updating and training health care assistants. Again, there is scope for these methods to be used for EBPI. One other practice development nurse in Case B had the responsibility for implementing the NMPDU best practice statements and her colleagues saw her as the nurse who ‘*did EBP*’ (Practice development nurse). Although not without difficulties, Case A appeared to have a more coherent approach to tackling the challenges of organisational level EBPI and of increasing the skills of individual nurses. It had a combination of strategies ongoing and had developed new posts to reflect the changing EBP landscape, incorporating EBPI of specific nursing best practice statements into existing roles. This had relied upon a good relationship with the Director of Nursing who had bid for, and successfully achieved, funding from the Scottish Executive for developing practice. Education was a cornerstone of their work, linking with outside nurse education providers and developing the knowledge and skills of both qualified nurses and health care assistants. The staff in key roles in the practice development unit in Case A had all previously been NMs or held posts in nurse education, which was in contrast with the staff in the units in the other cases. The Director of Nursing in Case A saw this as significant as he felt that they were able to consider strategic as well as practice issues that were important to nursing and it was for these reasons that he had created the practice development unit during the re-organisation which saw the re-introduction of NM posts some years ago.

Formalising practice development in this way has been seen as an important step for nursing, providing more coherent and influential opportunities for nurses developing practice, than for those 'going it alone' (McCormack, *et al.*, 1999; Ward & McCormack, 2000). They have also been recognised as a trusted and used resource for EBP by nurses (Thompson, *et al.*, 2001a). While the practice development units in the cases varied, to some extent, staff in each had the greatest sense of the complexity of EBPI and the challenges inherent in this, but these were either not communicated to NMs who created new posts or practice development unit structures, roles or remits or they were not understood by these NMs. This led to situations where individual staff with already large remits, were designated EBPI responsibilities without any acknowledgement of the enormity of the role. These problems have been recognised in other specialist nursing roles, where there is a lack of clarity about remits and role boundaries (Lloyd-Jones, 2005) and the expectation that they will absorb any work that even loosely fits with their job title. These titles did not always adequately reflect the individual's role and as a result, the nurses in these posts were prone to having their remit expanded to fit, often the Director of Nursing's idea of what the title encompassed. This raises wider issues for nursing with regard to the development of specialist roles and in relation to the broad concept of practice development, which has scope to be seen as the universal panacea to nursing practice problems, without a full understanding of its aim or the ability of any one practice development nurse.

The inability of individuals to change practice without wider organisational support is well recognised in the literature (Mulhall & Le May, 1999; Redfern & Christian, 2003; Rycroft-Malone, *et al.*, 2004a,b; Ring, *et al.*, 2005). In this study there were assumptions that the title of practice development nurse itself would facilitate the EBPI process, but in Case B this title was a further barrier and access to wards to enable the nurse to undertake her EBPI work was not in place, again highlighting a complex process that was not fully understood or acknowledged. Communication relating to these and other aspects of EBPI was often implicit or built around assumptions of roles, remits and responsibilities.

### ***Communication***

Communication has been identified as being a significant factor in successful EBPI (Kitson, 1997; Ross & McLaren, 2000). Communication within the nursing hierarchy

varied considerably but was difficult in each case. This was not restricted to nursing, as the CSBS noted problems in all cases with communication throughout Trusts. Modes of communication varied, depending on the availability of, for example, email. However, there was a recognition that no communication method was without problems and that ward staff felt the lack of face to face communication with their NM. At the same time, some NMs complained about lack of information from the ward areas and clearly neither was content with the situation. Communication across clinical directorates was non-existent and although NMs might meet with those from other directorates, it was never to discuss sharing good practice or EBPI. Meetings were strategic rather than clinically orientated, highlighting the divergent aspects of the NM role (Upton, 1999a). Some of the complexities of EBPI were exacerbated by communication issues and the quality of communication between all parties has been identified as a key element of any type of organisational change (Tourish & Mulholland, 1997). Pettigrew, *et al.* (1992a,b) saw communication as a significant task in creating contexts that would be receptive to change, in this instance, that of EBPI. Communication within cases was hampered by their size and geographical spread, but also the directorate structures and the impact of mergers. Effective communication within wards, across directorates, hospitals and Trusts has been seen as important, not just for the spread of good practice, but for encouragement, highlighting problems, preventing duplication and lowering resistance to change (Greenhalgh, *et al.*, 2004). There were no clear examples of this type of effective communication at any level within cases.

Size was not the only element that hindered effective communication, as it was still problematic in the smaller, more compact Trusts. In addition, organisational structures did not exist to facilitate better communication in relation to EBPI and this compounded the difficulties associated with an incomplete understanding of EBP and EBPI processes and the lack of acknowledgement of the complexities of these.

### ***Medical impediments to EBPI in nursing***

One of the complexities of EBPI that was acknowledged by some staff related to communication and professional relationships between nursing and medical staff. In Cases A, C and D there were examples given of situations relating to EBPI that had been impeded by medical staff. One of the most frequently cited barriers to EBP in

nursing is that medical staff won't allow EBPI or changes to practice and these are well documented in the numerous 'barriers' studies, for example, Funk, *et al.*, (1991) and Bryar, *et al.*, (2003). The links between nursing structures and clinical governance structures (although these were not formalised in the cases) necessary for successful EBPI of locally developed EBP products, also carried the risk that these would not be validated. The concerns of doctors about nurses having the necessary skills or abilities to progress practice highlighted the lack of autonomy that many nurses felt and expressed during interviews. The complexities of these situations are reflected in the literature where medical dominance has been shown to inhibit nurses in general and EBP in particular (Buchan, 1994; Bradshaw, 2000) and which acknowledges that nurses remain in a subordinate position to doctors (Mulhall & Le May, 1999). For many nurses EBP is still viewed as a medical import and there are concerns that it detracts from nursing roles and values (French, 1999; Miles, *et al.*, 2004). Attempts to address these concerns within the cases by developing multi-disciplinary forums for EBPI had either been unsuccessful, as in the shared governance forum in Case D, or viewed with extreme suspicion and concern that nursing input would be tokenistic, as in the clinical improvement teams in Case C. The complexities of EBPI in relation to the influence of medical staff was recognised by some of the nurses interviewed, but not the NMs, who may have been better placed to mediate in situations that arose around difficulties with EBPI, but this had not taken place. This may be due to lack of awareness of these situations, on the part of NMs, but it may also have resulted from the greater power of doctors constraining middle (and nursing) managers (Currie, 2006). The relative isolation of senior nurse managers and Directors of Nursing within organisations has been cited as an impediment to more effective communication (West *et al.*, 1999) but successful EBPI has also been recognised as dependant on good multi-disciplinary relationships and strategies (Rycroft-Malone, *et al.*, 2004a).

However, despite these situations, it is important to recognise that some nurses, in particular the CNSs had close working relationships with medical staff and many were managed (albeit not closely in some cases) by doctors. This had not hindered their ability in EBPI and in some instances they felt it had given them greater freedom to make changes to practice than under nursing management. This may be a reflection of their clinical grading which is at the minimum equivalent to a charge nurse, but can

be the equivalent grade to NMs (ISD, 2004). This may increase the confidence of medical staff in their abilities, or it may be due to their closer working relationship, which enables the CNS to demonstrate their knowledge in specific clinical situations to their medical colleagues.

### ***The management-practice gap***

One of the factors that contributed to the complexity of EBP and EBPI, which was recognised to an extent by many staff, was the growing gap between management and practice. The research-practice gap (Pearcey, 1995; Le May, *et al.*, 1998; Buchan, 2002) and the theory-practice gap (Rolfe, 1998; Upton, 1999a) have both been recognised as having an impact on the use of research in practice. However, relatively little has been noted in relation to the management-practice gap that emerged in this study. Although the different cultures of managers and practitioners have been identified (Traynor, 1994; Cutcliffe & Bassett, 1997; Le May, *et al.*, 1998; Price, *et al.*, 2007), the extent to which structural management arrangements may contribute to this is less well recognised. In all the cases, there was evidence of increasing clinical specialisation, in the way that clinical areas and practice were organised. The differences between even adjacent units has previously been acknowledged (Perry, 2002; Thompson & Learmonth, 2002) and nurses did report that they had very little contact with other wards, even those physically adjacent or part of the same clinical specialty or directorate. This did not support the sharing of good or evidence-based practice. These clinical areas often shared a NM who did not facilitate shared communication across these areas.

As practice became more specialised, management has become more generalised and distant from practice and this was to some extent explained by the vast areas of practice covered by a single directorate. One NM described her remit as being very clinically diverse and spread across half the hospital. This situation is reflected more widely than in this study (Currie, 2006). There was a recognition by NMs that it was impossible to be clinically 'in touch' with such a number of specialties, particularly if none related to the NMs own clinical background. The demands of management meant that NMs could not keep up-to-date with practice and it was difficult to see how they could contribute to practice in a meaningful or credible way. Problems relating to the difficulties arising from the role of non-nurse managers and the

growing remit of the NM have both been previously identified (Caine & Kenrick, 1997; Jasper, 2006). These factors are seen as impediments to the role of the NM in facilitating or promoting EBP and were seen by staff in Case C, as significant.

One of the significant aspects of the study of change in organisations and of that relating to EBPI processes, is the view that change is not step-wise and linear, but a dynamic, iterative and interactive process (Nutley, *et al.*, 2007). The difficulties of representing this in anything other than a rather two dimensional way (in writing) aside, analysis of the case study data has revealed that in all cases, the EBPI processes that were evident, were not presented by interviewees as anything other than linear and step-by-step approaches. While the literature adequately reflects the complexity of the EBPI process, for example, the PARIHS model (Kitson, *et al.*, 1996; 1998; Rycroft-Malone, *et al.*, 2002; Harvey, *et al.*, 2002; McCormack, *et al.*, 2002; Kitson, *et al.*, 2008), it did not represent the reality of the processes revealed in the case studies. Nor did it reflect the potential for EBP to be integrated into wider organisational systems for nursing seen as an important and achievable aspect of quality improvement (Long, 2003). It may be that nurses and their managers have either limited knowledge of the importance of taking account of the wider factors that impact on EBPI, or have limited knowledge of the resources available that could facilitate or elucidate these processes in health services, such as Iles & Sutherland (2001), Iles & Cranfield, (2004). However, their approaches to EBP may simply reflect that they do appreciate the difficulties involved and attempt to break down the process into a series of, apparently more manageable, steps. In approaching fieldwork with an eye for dynamic change processes, these did not accurately reflect the reality of EBPI within the cases and this has to be acknowledged.

Overall many of the pre-requisites for EBPI such as, shared goals, clear roles and responsibilities, knowledge and skills and strong leadership were not in place in cases, and it did not appear to be an organisational priority that included nursing (McCormack, *et al.*, 2002,b; Tod *et al.*, 2004; MeInyk, *et al.*, 2005). This bears witness to the unacknowledged (or not explicitly acknowledged) complexities of EBP and EBPI.

## **2. The difference between theoretical and actual roles of NMs in EBP and EBPI**

In each of the cases and in the overall findings of the study, there was a marked difference between the theoretical or potential and actual roles of the NM in EBPI. As with the first key finding, this was demonstrated in a number of ways and was due to a combination of the context, content and process factors. The discussion of these follows. Once again, they are not presented in any specific order.

### ***Leadership***

As noted at the end of the previous section, one of the pre-requisites for EBPI is strong leadership and this is a theme that is frequently highlighted in the literature (Funk, *et al.*, 1995; Stetler, 1998; 2003; Titler, *et al.*, 2002; Mathena, 2002; Parfitt, 2002; Estabrooks, 2003; Caramanica & Roy, 2006; Newhouse, 2007; Sellgren, *et al.*, 2006). Indeed, Newhouse (2007: 21) has stated that '*Nursing leadership is the cornerstone of successful evidence-based practice programs within health care organizations*'.

Le May, *et al.*, (1998) noted the gap between espoused and observed activity in relation to RU attitudes and actions of NMs. This lack of consistency between what is said and what is seen by practitioners, was also regarded as detrimental to EBP by Stetler (2003). Caine and Kenrick (1997) also found that NMs were willing to encourage RU, but were actually doing little in practical terms to facilitate it. They go as far as to state that this was a '*practical failure*' (1997: 157) to use their leadership position to influence RU. In the case studies many staff believed that NMs were not involved in EBP or EBPI and their role appears to have been one that was actually more passive or indirect involving delegating or devolving the work of EBP to others. Each individual nurse was seen by NMs as having a responsibility to change their own practice and this was viewed as being overseen by charge nurses. The main roles in EBPI described by NMs were communication and dissemination. Again the extent to which these roles were undertaken did vary, within cases and across them, and both were problematic. Communicating information to nurses about EBP was not done face to face, but mainly via internal memos, newsletters, email or internal mailings of, for example, in Case A and B, copies of NMPDU best practice statements. Communication with wider Trust structures regarding EBP was the remit of Directors of Nursing, or in Case A, some senior practice development nurses. The unique

middle manager position gives them opportunities to act as a two-way conduit of information, but these were often missed opportunities. Distance from clinical care has been shown to have a detrimental impact on effective communication from managers (Tourish & Mulholland, 1997) and this may have been a factor in the cases.

The attitudes of NMs have been seen as inhibiting EBP (Caine & Kenrick, 1997) and the attitude of Directors of Nursing in each case was seen by staff as indicative of the value that they placed on them and EBP. The Director of Nursing in Case A was viewed as being interested in EBP as a result of his willingness to send on information relating to EBP to charge nurses. In Case B, the Director of Nursing, although more involved in appointing nurses to EBP related posts than in other cases openly expressed her own disinterest in research and this impacted on her credibility with staff involved in EBP. The 'low visibility' of NMs in the clinical area was also seen by nurses as symptomatic of their attitude to practice in general. Stetler (2003) exhorts NMs to demonstrate their commitment to EBP by raising their profile in clinical areas. This was identified by nurses in Cases C and D who saw the lack of visibility of NMs in wards as indicative of their lack of interest and even one of the NMs in Case D recognised that the low profile of the Director of Nursing could be perceived as such. However, this lack of visibility may have been due to the NMs concern that they were not clinically knowledgeable about all the areas for which they were responsible, in large directorates, rather than a disinterest in practice. Their workloads were considerable and this alone would have given them little opportunity to spend time on wards. The growing gap between management and practice, discussed above, also explains this situation. Being able to demonstrate the importance of EBP by taking an interest and visiting the clinical areas was seen by nurses as a necessary part of the NM role which was not fully recognised by them.

One other aspect of leadership in relation to EBP that was seen as important by nurses was the celebration of success. While it was mentioned by one practice development nurse in Case C, after one of their nurses had led the development of an NMPDU best practice statement and this had been highlighted by the Director of Nursing at the Trust 'launch' of the statements, this success had never been followed up by the dissemination or use of these in practice.

Also in Case D, was the success of the NM/CNS led renal unit that had received specific commendation from the CSBS, had published papers in international journals relating to the developments in their practice and the NM/CNS had spoken about this at both national and international conferences. None of these successes had been acknowledged by the Director of Nursing and this had left the staff with the feeling that their work wasn't important to him. Organisational hierarchies have had an impact on the extent to which even Directors of Nursing can be involved in making decisions that concern nursing (Carney, 2006) and so it may be that some Directors feel quite remote from practice as a result of this and do not see the importance of acknowledging success from nurses' viewpoint.

The need for nurse leaders to demonstrate the value of EBP by taking an interest and by celebrating (if not rewarding, as is suggested by some authors in the USA, for example, Caramanica & Roy, 2006) success was evident from the study.

In addition to leadership, there were a number of other potential NM roles in EBPI.

### ***Empowering nurses for EBPI***

One of the ways in which NMs felt that they encouraged and enabled nurses to become more involved in EBP was by nominating them for various EBP initiatives. Nominating staff to be involved in EBP suggests that it is not an activity that NMs see as being appropriate for all staff, although they did believe that the responsibility for progressing EBP lay with individuals and charge nurses. NMs in Caine and Kenrick's study (1997) saw this as a specific responsibility that they had to ensure that nurses could meet their professional obligations to the (then) UKCC. A considerable emphasis has previously been given to studying individual nurses' RU/EBP, however more recently the focus has changed from seeing it as an individual responsibility to reflect the growing awareness of the contexts and cultures in which they work (Sitzia, 2001; Rycroft-Malone, *et al.*, 2004a; Scott-Findlay & Estabrooks, 2006). This ambiguity around roles and responsibilities is known to hamper communication and EBP progress (Harvey, *et al.*, 2002; Rycroft-Malone *et al.*, 2004a). In addition to nominating staff to take on roles relating to EBP, either informally, such as in shared governance, or by promoting or appointing them to specific posts, NMs needed to have a knowledge of their skills, abilities and experience of this work. This did not

seem to be the case, with nurses being given additional tasks for which they felt ill-equipped and with no previous experience, often tasks which were difficult to achieve in the number of hours they worked. These kinds of issues were not raised by any NMs interviewed as a problem, rather, they were seen as successful ways of progressing EBP. It did not address the large percentage of the nursing workforce *not* nominated or receiving specially delegated tasks. Local guidelines were seen as the responsibility of the charge nurses, those most involved in practice, but who were actually the least connected to EBPI structures or strategies, leaving an unsatisfactory gap. Increasing delegation to charge nurses of aspects of management that were previously the responsibility of NMs had resulted in overloading and under-performing of charge nurses in some of the cases and was recognised as such by some NMs. The need for a rethink of the charge nurse role has been identified in the literature (Allen, 2001; Doherty, 2003), particularly as it is seen as one with specific influence over EBPI (Doherty, 2003). So while NMs thought that they were empowering nurses by delegating responsibility for EBPI or nominating nurses to be involved in EBPI projects, such as product development, these were not always viewed as empowering experiences or successful in their aim of increasing nurses involvement in EBPI.

### ***Creating a supportive environment***

While NMs were nominating some nurses to become more involved in EBPI activities, there was also an expectation that each nurse had a responsibility to develop their own practice. NMs felt that as a means of addressing this strategies had been adopted to help progress EBPI. These were seen as a means of providing support for nurses to help them achieve EBPI.

However, the strategies described by NMs that they used (or that were being used) in the cases to develop EBP, such as shared governance councils and reliance on individuals to develop and undertake EBPI were also problematic. The introduction of a system of shared governance had been seen as the way in which nurses would be empowered and supported to be involved in EBP and as a result EBP would be used to change practice. Nurses were nominated to be involved and NMs had no involvement, as this was their understanding of the concept. The difficulties in its implementation, and these were mirrored in the case studies, were the lack of recognition of shared governance as a whole organisation approach to management

and it was seen by many managers as ‘...a nurse thing...’ (Burnhope & Edmonstone, 2003: 150), which happened in Case D. In addition, in both cases, it was seen as an additional task (or chore, for some) and once on the shared governance councils, it was impossible to resign as no-one was willing to take over. In both cases, NMs had nominated nurses to be involved and empirical studies of shared governance have shown that encouraging nurses to volunteer for involvement was much more successful than nominating ‘conscripts’ (Burnhope & Edmonstone, 2003). These were genuine efforts of NMs to provide more support and involvement for nurses in EBPI, but they had not achieved their potential in this regard in either case.

Attempts to create a more supportive environment for nursing and a means of progressing EBPI, often focused on the creation of new posts or the extension of the remit of existing practitioners. These strategies often had unintended consequences, that have been acknowledged in other studies, for example, Lloyd-Jones (2005) and Powell (2006). With dedicated posts for practice development, nurses have the scope to see this as the responsibility of the postholders, rather than see them as a resource or support for individual nurses. This is often exacerbated by the lack of clarity about roles and the nebulous nature of concepts such as practice development. For example, the Director of Nursing in Case B saw the practice development nurses as only an indirect or supportive role in EBPI. However, she had created a post solely to implement the NMPDU best practice statements and the nurse appointed saw this as her responsibility. The wider implications of attempts to create a supportive environment had not been considered, or if they had, had not been addressed.

### ***Authority and autonomy***

With shared governance seen as one way of empowering nurses to become involved in EBP, issues of authority and autonomy came into focus. Several studies have shown that these are significant factors in facilitating or impeding EBP and nurses feel that they lack the authority and autonomy to make changes to patient care (Stetler, *et al.*, 1998; Sitzia, 2001; Stetler, 2003). In the case studies, there was ambiguous communication regarding these issues. In Case C, NMs made it clear that they did not want nurses making changes to practice without first consulting them, however, this was explained as being due to financial constraints. This reflected a belief that EBPI would incur costs and failed to acknowledge that changing to EBP

not only prevents the continuation of potentially harmful and costly care (Jester & Williams, 1999) but that management of scarce health care resources is one aspect of EBP (Closs & Cheater, 1999; Muir Gray, 2001; Craig & Pearson, 2002).

In the other sites, NMs seemed surprised when issues of authority and autonomy were raised at interview, seeing nurses as autonomous professionals, responsible for undertaking EBPI on their own initiative and without the need for management approval, but also complaining that they were not kept abreast of changes in clinical areas. The autonomous nurse has been described as the research-based practitioner (Walter, *et al.*, 2004), but requires knowledge and skills and well as authority and autonomy to make changes to practice. There was no consensus about what was expected of charge nurses, or what was 'allowed' in terms of making changes to practice. This situation was noted in Rodgers' (1994) study of RU finding that nurses felt that the power to make changes to practice lay with the NM, while NMs expected nurses to take the lead changing clinical practice.

Lack of clear communication and lack of explicit permission to make changes to practice, again are recognised in the literature as barriers to EBP (Nolan, *et al.*, 1998; Parahoo, 2000; Nilsson-Kajermo, *et al.*, 2000; Olade, 2004; Micevski, *et al.*, 2004; Hutchison & Johnston, 2004 ). Much of the communication between NMs and charge nurses about EBP was implicit, lacked clarity and was based on assumed understanding. With regard to the need for explicit authority and autonomy for nurses to undertake EBPI and a perceived lack of this, the findings from the study reflect those of the many 'barriers' studies, for example, Bryar, *et al.*, 2003.

### ***Support and commitment***

Linked in the literature to authority and autonomy to undertake EBP, are the concepts of support and commitment from NMs for nurses. Again, NMs were surprised that this was raised at interview and seemed genuinely unaware that their behaviour could influence the uptake of EBP. This echoes the finding of Caine & Kenrick (1997) who found that NMs believed that they were providing these for nurses. All NMs with a nursing background, were quick to confirm their support of and commitment to EBP. However, these claims were not recognised by staff, who felt that NMs did not demonstrate these factors by, for example, visiting the clinical area, providing advice,

‘troubleshooting’ when problems arose with EBP or through explicit EBP related communication. NMs felt that they showed their support and commitment by nominating nurses to be involved in EBP projects, by developing new posts and by supporting shared governance.

However, there was a mismatch between the two, the kind of support and commitment that nurses felt they needed was not that provided by NMs. Staff need demonstrable support and commitment and some nurses have expressed a desire for more direct leadership (Sellgren, *et al.*, 2006), and Stetler (2003:101) states candidly that it is not enough for NMs to talk about the support they give, it has to be seen by staff, as: ‘...*staff within an organization is cognizant if the talk of leadership is incongruent with the walk of leadership*’. Once again, this highlighted the marked difference between the theoretical or potential role of the NM and the actual role as found in the data. This seems to have resulted from a genuine belief of NMs that they were providing authority and autonomy, support and commitment, but this was not explicit and did not meet the felt needs of nurses. This was also reflected in studies of RU and NMs (Caine & Kenrick, 1997; Le May, *et al.*, 1998). Caine and Kenrick (1997) believed that by failing to provide explicit support for nurses, NMs were actually inhibiting RU. It may be that this situation reflects unrealistic expectations of nurses, rather than lack of provision of these factors, but may also reflect the challenges of EBPI and nurses’ belief that they are unable to tackle these without greater support.

Nurses have an explicit professional responsibility to use evidence in their practice, stated in their code of conduct (NMC, 2004) and therefore it is not unreasonable for NMs to expect this of them, although the need for wider organisational structures and support to facilitate these are vital (Royle & Blythe, 1998; Harvey, *et al.*, 2002; Rycroft-Malone, *et al.*, 2004a; Gerrish & Clayton, 2004). While EBPI concerns practice change, it is still a management concern (Dunning, *et al.*, 1998; Perry, 2002).

### ***Setting goals and monitoring EBPI***

Another aspect of the underdeveloped role of the NM in EBPI related to monitoring. The data demonstrated that the reality did not match the potential or expected NM roles outlined in the literature. Again, this was an implicit activity, not evident in the

case studies. One aspect of change management is the monitoring and evaluation of change (Pearson, 2004). While opportunities did exist to explore the progress of EBPI, these were not taken up. One NM in Case C had set her charge nurses four goals to be achieved as part of annual personal, professional development. None of the charge nurses had managed to achieve the introduction of EBP to even one aspect of practice goal, despite reaching the other three goals, relating to personal or other professional goals, such as education or skills improvement. The NM was unconcerned about this and had not attempted to discover why this had occurred. Stetler (2003) and Caine and Kenrick (1996) saw appraisals as an opportunity for NMs to encourage nurses in EBP involvement. However, in each of the cases, ward nurses had their appraisals with charge nurses, so it seems unlikely that this would occur. Charge nurses in Case B were involved in a system of peer appraisal, so the NM would not be able to use this as an opportunity to promote EBP either. Monitoring EBP was not a priority for the nurses or the NMs. The organisational structures in the cases did not lend themselves to enabling NMs to achieve this aspect of their role as identified in the literature. Examples of systems for monitoring and rewarding nurses' EBP activities are often from the USA, such as Stetler, (1998; 2003) and Iacono (2006) and do not reflect the Scottish health care context, which would explain some of the discrepancy between the potential and actual role of the NM in this instance.

However, managers are required to ensure efficient and effective care delivery (Kenrick & Luker, 1996) and monitoring this would be one way of ensuring that it was being provided. As autonomous practitioners, nurses should not require 'monitoring' in this way, but nurses did not demonstrate this degree of autonomy over practice in any of the cases, so this suggests that there is scope for closer monitoring of EBP related activities. Quite how the NM would be able to absorb this additional responsibility into an already full role, is not clear.

### ***Resourcing EBPI***

While resources for EBP were not the main focus for this research, nonetheless each case provided information that highlighted the necessity of these to facilitate EBPI and they were seen as barriers or impediments to progressing EBPI. Once again, it was an aspect of EBPI and NMs that differed between the data and the literature.

Studies of the barriers to EBPI/RU, for example, Funk, *et al.*, (1991) and Nilsson Kajermo, *et al.*, (1998) have shown that lack of resources are significant. In a UK study of barriers to RU (Closs, *et al.*, 2000), nurses ranked resources as the greatest barrier and a more recent study of the impact of contextual factors on EBPI demonstrated that resource issues were a significant impediment to the process (French, 2005). The Director of Nursing in Case A had been successful in bidding for money for specific nursing posts and this had been used to augment the remit of one practice development nurse to enable her to focus on the application to practice of the NMPDU best practice statements. Prior to this money becoming available, it had not been possible to consider this across the Trust. The Director of Nursing recognised that it took time to prepare written submissions for applications for finance and it was rarely successful, but it was considered to be important and a creative use of the funding that had been received. There was also some financial support available for nurses undertaking degree courses linked to nursing, providing they were willing to undertake projects that linked the education and practice elements of the course and thus provided some benefit to the Trust.

The most significant resource issues for all the cases, in relation to EBP, was the difficulty of providing replacement nurses while others were off the ward undertaking EBP work. The ability to ‘back fill’ posts to free up staff was an ongoing and significant difficulty and had definitely had an impact on the shared governance forums in Cases C and D as nurses could not be released from wards to attend meetings or carry out EBPI tasks. In a study of implementation of new, evidence-based services, Powell (2006) found that many of the problems were not an unwillingness on the part of clinicians to adopt the changes to practice, but, conversely, that clinicians could not persuade managers that practice was sufficiently important to displace or take priority over other goals. If NMs are not able to provide practical support for nurses attempting to undertake EBP/EBPI, this suggests that organisational priorities, rather than clinical priorities are considered to be of greater importance. There is a need to consider in some detail, the message that this gives about practice and the impact of this on patient care and how organisational goals and clinical priorities can better reflect one another.

NMs in all cases alluded to the significance of these problems in progressing EBP. There was also a belief in Case C that introducing EBP would be costly and the NM had not considered the potential for EBPI to rationalise care and provide cost savings. This illustrates that the focus was more heavily on balancing the budget than on proving best practice for patient care.

These have been recognised as being significant in many studies undertaken into the barriers to EBP and are noted specifically as being related to lack of time and money. Since it is not something that can be done without dedicated time set aside for it (Olade, 2004), lack of a budget for RU/EBP or inadequate resources (Olade, 2004; Nolan, *et al.*, 1998) also impede EBPI. However the scope for EBPI to provide cost savings by ending ineffective care while replacing it with more beneficial cost effective care (Muir Gray, 2001; Pearson & Craig, 2002) was not recognised by NMs.

While it is acknowledged that NMs do not have the sole responsibility for resourcing issues and that there are wider organisational factors involved, they do hold directorate budgets and to some degree have responsibility for staffing provision. Ward budgets were held by charge nurses in Case A, B and D and would therefore not have been the responsibility of NMs. Once again, the role of the NM in providing practical/financial support for EBPI was not fully realised in the cases, this being to some extent as a result of the local arrangements within organisations for managing budgets.

### ***Competing priorities***

This notion reflects NMs own knowledge of EBP and interest in it, which varied considerably. Some were quick to admit that they were out of touch with clinical practice and others recognised it as important, but were unable to make it a priority at that time. This finding is supported by similar results in Caine and Kenrick's (1997) study of NMs and RU and Scott's (2002) study that highlighted the incongruence of priorities of NMs given to monitoring quality and balancing budgets. Two of the senior practice development nurses in Case A (previously NMs), were embarrassed to admit that they had no critical appraisal skills and felt it unlikely that any of the NMs would either. One NM, Case B, had, in a previous post been involved with developing EBP products and acknowledged the considerable skills and time required to do so,

much of this taking place outwith working hours. With this experience, both had sympathy for nurses having to take on this as part of their role, with no additional skills or time. EBPI was not seen by nurses as part of their role, but as an additional task. This has been reflected in studies of aspects of clinical governance, such as Price, et al., (2007).

The amount of literature, and empirical studies into the educational preparation and skills of nurse for EBP reflects the difficulties inherent in the process and lack of time is undoubtedly the overriding factor which nurses feel prevents them from being able to engage with EBP. It has been highlighted as a barrier in a number of studies, for example, Bryar, et al. (2003), but notably in the STEP project (Redfern, *et al.*, 2000) a detailed examination of the factors influencing EBPI, only one of nine sites complained that lack of time was a barrier which suggests that in some cases it could be tackled. However, these are clearly not difficulties that are exclusive to these cases and are not going to be readily overcome. The ability of NMs to become more closely involved in EBPI was a combination of factors, lack of time or competing priorities and to a varying extent, a lack of EBP related skills. The competing priorities of management and practice are recognised in the literature (Stanley, 2006) and the erosion of clinical involvement of NMs has resulted from the organisational precedence given to management (Ulusoy, *et al.*, 1996). Many of these circumstances have been the result of the numerous changes to the NM role over recent years (Caine & Kenrick, 1997; Tilley & Tilley, 1999) and reflect aspects of outer context, rather than individual NM factors. NMs in each of the cases raised historical changes to the role of the NM and in some cases complete abolition and subsequent re-introduction of the posts, as still significant in the current context. Feelings still ran high in relation to this series of events, particularly in Case C, where NMs had been forced to apply and compete with non-nurse managers for what they considered to be their own posts in the mid 1990s. Pettigrew (1985a,b; 1988b) and Pettigrew *et al.* (1992a,b) acknowledge that organisational history has an important contribution to make to the ways in which change occurs within that organisation and gaining an understanding of the history of the NM posts in each case went some way to aiding understanding of their current situations. Indeed, the ‘*radical impact*’ of the continual organisational change and re-structuring of NM posts noted by Cooper (1996: 265) had a noticeable legacy in terms of competing priorities, in the case studies.

In addition, data analysis set in context both the structures and cultures of the different cases, where mergers had taken place or where large geographical areas covered by the Trust, led to the development of entirely separate working arrangements. These were recognised as a hindrance to the implementation of clinical governance by the CSBS. This had an impact on the role of the NM in Cases A and D, but not in B or C, which were relatively more ‘compact’ Trusts, although mergers had still occurred some years previously. These changes to outer context had had an impact on changes in inner context (Pettigrew *et al.*, 1992a,b) and coincided with other statutory changes in health care, such as the introduction of clinical governance in 1999. These changes, which were outlined in chapters one and four, focused on changing the culture in health care to one which recognised the responsibility for improving the quality of health care delivery (Donaldson & Muir Gray, 1998; McSherry & Pearce, 2002; McSherry, 2004). In addition, it was hoped that change would be supported by a greater emphasis on learning, both individual and organisational and this was linked to clinical governance with the belief that it would improve the quality of care (Davies & Nutley, 2000; Nutley & Davies, 2001). While these two concepts are not necessarily as closely linked as policy suggests (Wilkinson, *et al.*, 2004), the notion of organisational learning was not acknowledged by any of the participants in the research. While this is only one aspect of the many outer context issues competing for attention from health care managers, it suggests that NMs, at least, did not view it as an important part of their role as relating to EBP.

Pettigrew, *et al.*, (1992b) suggest that process factors are concerned with the actions of individuals, the reactions of individuals and the interactions between them. In this study, the inaction of NMs was more often the dominant theme, particularly in relation to support for EBPI. Some of these were seen by nurses as failings on the part of NMs, but they reflect the interplay of contextual factors, such as the specific directorate focus that does not enable sharing across boundaries, a lack of engagement with evidence and an incomplete understanding of the nature and complexity of implementation and the inaction of NMs in terms of progressing EBPI. The combination of these factors were an impediment to EBPI.

The impact of these changes is not recognised and has not been addressed in the literature in relation to NM roles and EBPI. This is a significant gap as they do explain why it was so difficult for NMs to engage more fully with EBPI. Furthermore it explains why there is such a marked difference between the espoused roles for NMs in EBPI in the literature and the reality as seen in this research.

### **3. The potential of the NM/CNS role in EBPI.**

Before considering the more detailed role of the NM/CNS in EBPI, it is important to acknowledge that some other processes, not involving NMs were taking place in the cases. Individual CNSs were involved in adopting and adapting national products for use in their own practice and occasionally for use in wider areas of their specialty or Trust and this is a role that has been recognised as significant in EBPI (Rutledge, *et al.*, 1998). The extent to which their EBPI work could be more routinely used across Trusts was hindered by the nature of their nursing posts, not part of the nursing structures in any of the cases, which is not unique and is, at least in part, due to the way in which CNS posts have developed (Castledine, 2002). The CNSs did seem to have the autonomy and authority to undertake EBPI and the personal skills, confidence, networks and expertise that are significant in the dissemination and implementation process (Milner, *et al.*, 2005). While some authors have seen the role of the CNS in EBPI as one of a ‘boundary spanner’ (Gerrish & Clayton, 2004; Milner, *et al.*, 2005; Dopson & Fitzgerald, 2005; French, 2005; Nutley, *et al.*, 2007), having the scope to link practice areas or communities, this was not evident in the study.

With the exception of one CNS in Case C, whose role as a tissue viability nurse, gave her legitimate access to all clinical areas, all other CNSs worked solely within their own area of practice and some did not even become involved in the care of inpatients related to the same specialty, as they saw their role as being tied to out-patient work. Two CNSs in Case D had made attempts to make links with another department to initiate referral routes, but both had been unsuccessful, due to the intransigence of the charge nurse involved. So their ability to be ‘boundary spanners’ even within their own organisations was very limited. It is, however, a role with considerable scope for development of this aspect of sharing practice and EBPI.

Some studies have suggested that CNSs lacked support from their managers to undertake EBPI (Rutledge, *et al.*, 1998) or lacked authority to make changes to practice, but this did not appear to be an impediment for the CNSs interviewed. While some had faced difficulties progressing locally developed guidelines, this had been due to the evidence content, rather than lack of support from NMs. It is important to recognise that none of the CNSs interviewed had NMs, all were managed by medical staff, so this may be less relevant to their situation. The greater autonomy and authority seen in this study may have been a reflection of local management arrangements, which could be different from those in the wider UK.

One NM role contrasted with the second key finding as being very successful in getting evidence into practice in the case studies, that of the NM/CNS. While hybrid roles have been noted previously in relation to management and practice, these have related to doctors and managers, rather than nurses (Dopson & Fitzgerald, 2006) and this is a new finding and contribution of this study in this regard.

While NM/CNSs were only in smaller, discrete areas of practice, the postholders had nonetheless been able to influence and support EBPI. Their success in this regard stemmed from their ability to bridge management and practice, a gap previously identified as hindering EBP and which NMs were not able to span. The NM/CNSs had clinical knowledge and credibility, possessed critical appraisal skills, were educated to a higher level than most nurses and NMs (having obtained or were working towards Master's level qualifications) and an in-depth knowledge of EBP related to their own clinical area. All those interviewed had been involved in developing national EBP products to some extent. They had good working relationships with their medical colleagues, but very little contact with NMs. These roles had developed in cases where there was a recognised need to create posts to retain experienced nurses in posts and where (due to low staff turnover) there were few opportunities for promotion. Their close working proximity to their nursing workforce meant that they were able to provide visible and tangible support and commitment to EBP, such as providing time away from the clinical area to undertake practice audits, or look for evidence for product development. These have been acknowledged as significant factors for progressing EBP.

The NM/CNS's senior staff, had the autonomy to make changes to practice and were expected to demonstrate the benefits of these through audit, patient satisfaction surveys, or patient stories. It was clear from interviews that these NM/CNSs were highly skilled, motivated and committed to improving practice, all characteristics that have been shown to be vital for the progress of EBP (Stetler, 2003). Their skills also reflect those identified in the literature as being significant in facilitating change, skills such as current knowledge, being innovative, knowledge of the organisation or local systems, communication skills and allowing others to 'learn by doing' while remaining supportive (Harvey, 1993). However, one nurse noted that the significant aspect of successful EBPI was the personalities of those involved and again, these personal attributes have been identified as important for effective facilitation of change. The ability to be flexible and use a number of approaches, identified in the literature (Harvey, *et al.*, 2002) was reflected by the NM/CNS in Case D. When first introducing change he had taken a more directive approach, delegating specific tasks and taking a localised top-down approach. This has been identified as welcome by some staff undertaking 'new' EBP projects (Sellgren, *et al.*, 2006). As staff became more interested, involved and able, and as their confidence in their own abilities grew, he stood back and took a 'hands off' approach to managing EBPI, supporting, encouraging and guiding, allowing staff to approach him with ideas and plans for change. This need for support in the initial stages of managing EBPI, when staff confidence may be low due to unfamiliarity with the process and uncertainty about adjusting to change has been identified as an important role of the NM (Newhouse, *et al.*, 2005).

Recognising the development of staff and their increased interest and abilities for EBPI, allowed the NM/CNS to withdraw from such an active role as time moved on. This stage of managing change and encouraging/enabling independence has also been recognised in the literature (Thompson, *et al.*, 2006).

Overall, the NM/CNSs were ideally placed to be 'in touch' with unit culture which has been identified as a significant factor in the ability of individuals to support or influence change (Pepler, *et al.*, 2006). In addition to being 'in touch' with the culture, they were a part of it, able to influence it in ways that made it more receptive to EBPI.

In both cases where these roles existed, they had been developed as a means of providing promotion for highly qualified and skilled nurses, in Trusts with stable workforces and otherwise little opportunity for promotion. The intention of the role as one that would support and lead EBPI was not known, but it had been successful in this regard and the postholders acted in boundary spanning roles, recognised as being important in EBPI (Nutley, *et al.*, 2007). While they did not link nurses to their NMs outwith their clinical areas, within them, they linked aspects of management and clinical practice, effectively spanning the management-practice gap identified in the first key finding as being an impediment to EBPI. The joint role was able to overcome the barriers experienced by those in single CNS roles (Profetto-McGrath, *et al.*, 2007) and those of the context and role imposed limitations of the contemporary NM. The role clearly has potential for progressing EBPI in other aspects of nursing, beyond the small units in which it was seen in this research.

## **THE STUDY PROPOSITIONS**

As noted at the beginning of the chapter, the study set out to explore and explain the roles of NMs in EBPI. The research was informed by propositions, shown in chapter two, but to what extent did these reflect the reality of the NM roles revealed by the data? A review of the extent to which the propositions emerged from the data is now provided.

### **Proposition 1**

*NMs are significant in their influence and ability to increase EBPI because they occupy a crucial middle position within health care Trusts. They are ideally placed to channel information from above and below and from this position to have an influence through attitudes and behaviours on the nurses that they manage and for other staff in the Trusts, for example, medical staff. It is acknowledged that despite their middle position, their influence on more senior members of staff may be limited.*

NMs middle position in organisations did give them the potential to be conduits of information for EBPI, but the extent of this varied both within and across Trusts. They did not have a significant positive influence on EBPI. They were either unable to

influence medical staff in relation to nursing EBPI, or were unwilling to do so. Their influence on more senior members of staff was not demonstrated.

### **Proposition 2**

*EBP is likely to have a higher profile or to have made greater progress in Trusts where NMs champion it by providing support and commitment to it in both practical and 'emotional' ways. For example, by providing or sanctioning time away from the clinical area to undertake EBPI activities, or through financial support for educational initiatives or through the provision of their own expertise. Emotional support will be demonstrated through positive attitudes and behaviours relating to EBPI.*

The impact of the NM role on progress towards achieving greater EBPI did not appear to be the only significant element. The combination of context, content and process factors could often not be disentangled to reveal the most crucial factor, but what did emerge was that visible or demonstrated support and commitment to EBPI from NMs was largely absent. They acknowledged their own lack of skills and expertise for EBPI related tasks, such as appraising evidence, or reading research.

### **Proposition 3**

*Managers are a significant influence on the culture of organisations and their attitudes and behaviours will reflect this through their approach to EBPI, such as clear devolution of authority and support of nurses' autonomy to undertake EBPI. The culture of the organisation and the part played in this might also explain the dominant 'mode' of EBPI, whether top-down or bottom-up.*

NMs were, to a great extent, unaware of the impact of their own attitudes and behaviours, in relation to EBPI. Likewise, they had not grasped the significance of a need for explicit devolution of authority and autonomy to nurses, despite the widespread belief that nurses had responsibility for EBPI in their own practice. The dominant mode of EBPI seen in the cases was top-down, which highlighted a mismatch between this and the espoused belief that nurses should be responsible for EBPI.

#### **Proposition 4**

*NMs are most likely to have come from an era in nursing when research was not so widely recognised or accepted as a basis for care. As a result, it is probable that most NMs will not possess the knowledge and skills to enable them to properly support EBPI, either because they do not value it or they do not fully understand the complexity of it. This situation has left them in the position of having little to draw upon in the way of experience to facilitate EBPI.*

Most NMs in this study did recognise that EBP and nursing research had been ‘introduced’ after they had completed their nurse training and so were considered to be new concepts, with which they were not entirely comfortable or cognisant. While they acknowledged the importance of EBP and it was generally seen as valuable to practice, they were not personally equipped to facilitate it.

#### **Proposition 5**

*NMs will rely heavily on individual nurses to take responsibility for EBPI or other staff, such as practice development nurses or CNSs, seeing it as a practice rather than management role.*

NMs did indeed rely heavily on other staff, some with designated roles, to undertake EBPI. Practice development nurses and units had significant roles in leading and co-ordinating EBPI and in the cases where these were absent or less engaged with EBPI, efforts were more haphazard and piecemeal. CNSs were most involved in EBPI, albeit, mostly in their own practice, as they were not linked to NMs or nursing management structures. However, a few had been able to implement EBP more widely. The joint NM/CNS role shows great promise for future EBPI, based on its success to date and this finding is a significant contribution to nursing of this research.

#### **CONCLUDING REMARKS**

The discussion presented in this chapter provides a mixed picture of the role of the NM EBPI. It suggests one of missed opportunities and misunderstandings that often occurred as a result of lack of clarity about roles and responsibilities exacerbated by ambiguous communication. NMs were not able to engage more fully with EBPI as a result of the competing priorities of management and practice, despite what many

would have liked. There was evidence of an incomplete understanding of the EBPI process and the strategies that might have progressed this were not used to their full potential.

Other than the joint NM/CNS role, which was in stark contrast to the single NM role, NMs were not able to provide the conditions and attributes highlighted in the literature as necessary for EBPI progress. The current situation is the result of a combination of numerous factors that have militated against greater NM involvement in EBPI.

To a significant extent this situation meant that studying the role of the NM in EBPI resulted in a search for evidence of processes and involvement that were largely non-existent. While the findings may appear to be quite negative in this regard, it was nonetheless important to acknowledge that the literature, in particular, portrays an expected role for the NM in EBPI and nurses' expectations of their managers in this. This was not congruent with the contemporary role of the NM and their wide remits. A mismatch exists between the theoretical or espoused role, one that is involved, facilitative, supportive and demonstrates knowledge and skills for EBPI and the actual roles, revealed in this study, which did not reflect these attributes.

The other priorities and responsibilities that compete for NM time have left them unable to meet the expectations of the literature and their staff. NMs were 'managing' as well as they were able in contextually difficult circumstances and these were further complicated by issues relating to EBP content and a limited ability, in terms of personal knowledge and skills, to progress EBPI.

Their expected role in EBPI has often been one of under-specified and unrealistic criteria, but was successful in tandem with the CNS role, where issues of practice and patient care predominated, rather than the achievement of operational goals.

This chapter has shown that the role of the NM in EBPI is one characterised by minimal involvement, reflecting the demands of their overall role and other constraints. The NMs in this study were largely unaware of the impact on nurses of their only partial engagement and on the overall progress of EBPI. Their role is

confounded by the complex interplay of contextual, content and process factors which combine to impede their ability to offer a more substantial contribution to the EBP process. A successful role, not previously noted in the literature was uncovered, that of the NM/CNS combined the autonomy and expertise of the CNS with the authority of the NM, which suggests potential for future development in relation to EBPI. However, the ability of the role in EBPI beyond their current discrete areas of practice, is, as yet, unknown.

Chapter eight provides the conclusion to the study, presenting its implications for policy, practice and research. It ends with reflections on the methodology and the researcher's experience of undertaking the study.



## **CHAPTER EIGHT CONCLUSION**

### ***Implications of, and reflections on, the research***

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This chapter completes the thesis by presenting the contribution of the study and considering the implications for policy and practice and further research. It concludes with reflections on the conduct of the study, including a reflexive account by the researcher.

#### **AIMS OF THE STUDY**

While the key findings of the study were provided in detail in the previous chapter, this brief review of the study aims is presented as a means of focusing both on the contributions of the research and reflections on the conduct of the study.

The research set out to explore and explain the roles of NMs in EBPI and to identify the strategies used by them to achieve this. It was based on literature that highlighted the potential importance of their role in EBPI, much of this arising from surveys of barriers to RU and EBPI. These drew attention to the lack of support and commitment and the authority and autonomy needed for EBPI as perceived by practitioners to be the responsibility of NMs to provide. The literature also provided information relating to the types of strategies, models and initiatives that have been used to drive and guide EBPI and the study sought to determine which, if any, of these were being used by NMs to support EBPI in their own area.

#### **THE CONTRIBUTION OF THE STUDY**

##### **Implications for policy**

At policy level, the need for greater monitoring of EBP and effective EBPI processes remains. While this is currently undertaken as part of NHSQIS reviews, closer scrutiny of health care organisations suggests that while they are able to produce some evidence of progress in the development of EBP and some EBPI in specific areas, such as coronary heart disease or cancer services, this is not necessarily indicative of

progress in wider practice. To date, many of these reviews have focused on the provision of services and medical treatments. Occasionally they make note of the provision of specialist nursing services, such as cancer or heart failure nurse specialists, but again these are not able to demonstrate the more intimate details of changes to most nursing practice. Currently, this has relied on the individual practitioner's attention to their professional responsibilities and perhaps to some extent, the belief that this was being monitored by their NM. While it is recognised that monitoring changes to practice is not straightforward, some studies, for example Rodgers (1994, 2000) have shown that it is possible to observe the use of research (or evidence) based care. This study has shown that neither scenario accurately reflects the current situation in which individual nurses are not able to undertake EBPI for a number of complex reasons and further that this situation is not being monitored, remedied or addressed by NMs. Policy needs to address issues of accountability in relation to EBP, the professional aspects of failing to adhere to the NMC Code of Professional Conduct (2004) and the local employment contractual aspects, by ensuring that it is included in contracts as an expectation of employment and by ensuring monitoring of this by senior nurses and NMs. Unless these become policy directives, it is unlikely that they will be considered enough of a priority in local health care Trusts, to be implemented.

There is a national and local lack of monitoring of the effectiveness of locally developed evidence products, with a considerable overlap with national products and duplication of effort involved. This is wasteful of scarce time and resources and the study has shown that this also leads to EBP 'involvement fatigue' and loss of goodwill from staff. The variable quality of locally developed products was highlighted in this research and if efforts are concentrated on EBPI, seeing these as the basis for influencing change to practice is a very real concern. There is clearly a need to maintain drivers at policy level to increase the knowledge and skills of nurses involved in product development, but also to recognise the EBP related educational needs of more senior staff, NMs and Directors of Nursing, who are validating these products for local use.

Although the study has shown that many roles are developed at local level, there is a need to consider the impact that policy directives could have on guiding this local

development. The roles of NMs were reasonably standard across the cases, but the extent of their involvement in EBPI was minimal. If they are considered to have a vital role in progressing EBPI and responsibility for it, then these will need to be determined at policy level to ensure consistent approaches to the adjustment of current roles and responsibilities to reflect the requirements for EBPI. Likewise, the roles of practice development nurses varied considerably across the cases and while this might be an important reflection of varied contexts, some consideration could be given to broad roles and responsibilities in relation to EBPI. If this were provided at policy level, it would inform the main aspects of the role, but still leave scope for local adaptation to reflect local needs. The importance of the co-ordinating role of the practice development unit for EBPI and the need for staff with a variety of skills for EBPI was demonstrated in the study. Appointing individual practice development nurses to undertake Trust-wide EBPI, was shown to be less likely to make EBPI progress than seeing it as a shared responsibility across a practice development unit comprising a number of staff with a variety of knowledge, experience and skills. These factors would be supported by policy that reflects the central role of practice development nurses in progressing EBPI in local contexts, but underpinned and supported by the national practice development unit that already exists as part of NHSQIS.

The success of the joint NM/CNS role in EBPI was clear and the role has scope for further development. The policy implications of this may depend on the outcome of future research into the current extent (in terms of numbers of practitioners) and the reach of these roles. It may also depend on decisions taken about the future of the NM role in relation to EBPI. If it is not seen as appropriate, the NM/CNS role would be even more significant since it has the potential to fill the management-practice gap that currently exists and to support nurses to progress EBPI.

Finally, issues of resourcing EBPI did feature in the research. If EBP is to make progress and become a reality in practice, some resource issues need to be considered. Lack of staff, which had an impact on the ability of nurses to engage with EBPI initiatives, had significantly hampered progress in two cases. If bottom-up approaches are thought to be important as a means of involving nurses in EBP, then adequate staffing to facilitate this will be crucial. The financial resources to ensure this are

unlikely to be local issues and their importance should be addressed at national level as a means of emphasising the commitment of the Scottish Government to improving health care through EBPI.

### **Implications for practice**

This study has identified through empirical research, that NMs do not have an active and facilitative role in progressing EBPI. Although this had been perceived as an impediment to EBPI by nurses in the numerous ‘barriers’ studies (for example, Funk, *et al.*, 1995; Sitzia, 2001; Bryar, *et al.*, 2003) before considering the implications of this finding for practice, it seems pertinent to consider whether NMs should have a role in EBPI. The author would suggest that the findings from this study support the need of nurses to have greater involvement of their NMs in EBPI. The need for improved, explicit communication around EBP was demonstrated and the desire of staff to have a visible management presence in clinical areas, as evidence of NM interest, support and commitment was clear. The study has shown the problems that arise from taking a ‘hands off’ approach to EBP and the passive roles of nominating and delegating have not been effective in progressing EBPI. Some dubiety remains in relation to suggesting greater involvement of NMs in EBPI, since the study has shown that their current role and remit militates against this and simply exhorting them to do so would be ineffective and unrealistic. Despite the assertions of nurses that they *need* NMs in a role that involves EBPI, consideration needs to be given as to whether this is indeed an appropriate role. While the need exists, NMs may not be the most appropriate staff to address this and other solutions or approaches may need to be identified and tested.

Review of some of the roles created by NMs to address EBPI suggested that this had not been an entirely trouble-free strategy either. Several nurses in these roles lacked the necessary knowledge and skills; others had these, but not the access that they needed to clinical areas to progress EBPI. Some had been given remits that were impossible to achieve in the time available to them, in addition to other responsibilities. At practice level, the role of the NM in relation to EBPI needs something of a radical rethink. Either they need adjustments to the wider aspects of their role to enable them to return to greater involvement with practice as a means of facilitating EBPI, or their role and wide remit remains unchanged, but the

expectations of this in relation to EBPI need to be taken forward by other staff, possessed of the knowledge, skills and position within the Trusts to enable them to do so. This would be a role that was explicitly given over from NMs, rather than delegated in a way that left all staff unsure of roles and responsibilities. It may be that individual Trusts could make individual decisions on which route to choose in this regard, to best reflect their context and staff abilities or interests.

Even if NMs lose an EBPI role, they are still ideally placed, as a result of their middle manager position, to act as a conduit between practice and senior management. The case studies demonstrated that EBPI is a largely 'top-down' process, and a role of disseminating information, in the main. However, there are clearly opportunities for NMs to make better links within their Trusts to other structures that are involved in EBP, such as clinical governance teams, audit departments and research and development staff. This would facilitate better co-ordination of EBP efforts, prevent costly (in time and money) duplication and enable access to expertise that is not currently available to nurses. In addition, this would provide opportunities for multi-disciplinary working which was lacking in each of the cases studied and has been identified as an important factor in progressing EBPI (Rycoft-Malone *et al.*, 2004a.).

NMs need opportunities to develop their own skills in relation to EBP, if this is to be a part of their role. A greater understanding of the process would enable them to assist nurses in overcoming the difficulties in practice to using evidence. Being able to engage in a more meaningful way with nurses would address some of the issues surrounding support and commitment, currently lacking. It would also enable them to become more closely involved in practice again, which many NMs desired. Greater knowledge of EBP would also enable NMs to be more involved in the development of evidence products and ensure their quality. While many staff expressed concerns with the quality of national products, fewer were concerned about the quality of those developed at local level. The ratification process, by Directors of Nursing, was seen as the mark of a quality product, but this was often undertaken by Directors who admitted to having little knowledge of research or EBP, which may have impacted on the quality of products verified for use in practice. These are issues that need to be addressed both nationally and locally, to ensure the safety and effectiveness of EBP products. In addition, but related to this, is the importance of reaching a local

consensus on what comprises evidence as this would save effort in creating products and disappointment when work was rejected as lacking an evidence-base.

The NHSQIS Practice Development Unit could have a role in facilitating discussion at local level about the nature of evidence and in ‘checking’ the evidence-base of locally developed products, as well as continuing to promote the use of good quality evidence-based products for nursing developed nationally and internationally.

In the case studies, there were examples of EBP product development that reflected individuals’ interests, but not necessarily local priorities. This meant that a great deal of time could be spent on creating products that would have limited application or only apply to limited number of patients. There is scope in each Trust to find a means of prioritising EBPI efforts, to reflect national and local priorities. One approach could be to give greater emphasis to national products, such as SIGN guidelines or NMPDU best practice statements and consider ways of applying the evidence to practice, rather than continuing to focus on local development of products, which may be less robust and yet time consuming to create. While EBPI has inherent challenges of its own, going for a ‘quick win’ might encourage nurses, rather than face the lengthy and (in the cases) often discouraging process of development, before they have to take on EBPI.

One role, which clearly has scope for EBP development and EBPI was the CNS. This study has shown that these nurses were the most involved in EBP in their own areas of practice, but due to the historical development of their posts, are not linked to nursing structures in any effective way. NMs need, as a matter of some urgency, to consider the ways in which this great nursing resource, of knowledge, skills and expertise, can be harnessed to support nurses to make progress with EBP. It is likely that this will not be a straightforward process, with resistance from CNSs anticipated, but it seems unacceptable to maintain the *status quo*.

NMs in this study lamented the ways in which their role had changed over recent years. The focus on clinical practice has waned and the managerial aspects of the role are now more significant. This has led to an increasing gap between management and

practice, into which EBP has fallen. Chief Executives and Directors of Nursing need to consider the impact on practice if this situation continues.

The role which has bridged this gap and which, until now, has not been described in the literature in relation to nursing, was the hybrid NM/CNS. This role has the potential to be effective not just in EBPI, which it has been to date, but also in supporting practitioners in wider aspects of practice, where management input is currently absent. Although only found in smaller, more self contained areas of practice in the study, it would seem possible, initially, at least, to develop this type of posts in small, clinically similar areas, such as one NM/CNS for a number of medical or surgical wards. Reminiscent of the unit nursing officer (Stapleton, 1983), the potential exists for this role to make a significant impact on progressing EBP.

### **Implications for research and the wider body of knowledge relating to EBPI.**

While much was already known about contexts that are favourable or unfavourable for EBPI and a little was already known about specific roles, such as facilitators, this study has provided an in-depth examination of the actual roles of significant actors in the process of EBPI. Previously, other than nurses' perceptions, very little was known about the actual role of NMs in EBPI. This research has highlighted deficits in the role of the NM, which empirically demonstrates the accuracy of perceptions found in previous studies and has uncovered the effective role of the hybrid NM/CNS. It has confirmed the findings of other studies in relation to the barriers to EBP, in the specific contexts studied and has shown that many of the contextual factors previously identified are either not known about in practice, or when recognised, are not tackled. The research has also demonstrated that there are still considerable knowledge deficits relating to EBP, particularly for NMs, despite efforts to address this at undergraduate and postgraduate level in nurse education. Many previous studies have identified a lack of knowledge about EBP, this study demonstrates that the situation has not improved significantly in the Scottish Trusts studied. The value of further studies to determine nurses' knowledge and understanding of EBP is therefore questionable.

However, there is scope for further research to be undertaken into three particular aspects of EBPI arising from this research. Firstly the role of the NM/CNS merits further study. It would be useful to determine the existence and extent of these roles in

other Trusts and their success in EBPI in other contexts. An in-depth study of these NM/CNSs has the potential to reveal more detail about the ways in which they influence, support, facilitate, implement and evaluate EBP in their own areas. Such research could be beneficial, prior to the recommendation that changes are made to the current NM structure.

Secondly, with so many evidence-based products being developed in organisations, it would be possible to study the extent of their use in practice. Rodgers (1994, 2000) observed the use of specific research-based practices and it would be possible to undertake a study of EBP products in a similar way. It now seems more important than ever to try to determine the extent to which these evidence-based products are leading to patient benefit. Given the time and financial investment to produce these, it is important to gain some understanding of their role in improving patient care. While measuring impact is not straightforward, it remains an under researched and crucial aspect of EBP.

The use of the CSBS data provided a valuable insight into EBPI progress within the organisations, although there was often an incongruity between the reports and the views of the staff interviewed. However, while NHSQIS continues to review progress against evidence-based standards across Scotland, there would be scope to review and compare reports over time highlighting gaps, identifying progress and studying the extent to which organisations have been able to meet previous recommendations made in relation to EBPI.

The literature reviewed in chapter two has shown that there are numerous models describing, guiding and developing the conceptual elements of EBPI. This study identified two models in use, albeit that they had not been chosen by staff to underpin or inform the EBPI process, they did describe the processes taking place. Not all of the necessary conditions of these models had been met, in their use in the cases, but despite this, their inadvertent or unknowing use aids understanding of the models and their use in practice.

The study, overall, adds to the theoretical and conceptual development of understanding evidence, EBP and EBPI. It highlights the need for clarity of the use of

terms regarding the nature of evidence and identifies the types of evidence that were most acceptable to practitioners. This information can be used to further the debates about evidence and EBP and attempt to address the concerns that practitioners have about some evidence. To researchers, these can sometimes seem little more than semantic debates, but these translate into real impediments in practice for the use of EBP.

In terms of developing understanding of implementation, the study has shown, once again, how complex the process is and how poorly understood by practitioners. The Pettigrew framework (1985a, 1988) demonstrated the specific role that history has played in the changing nature of the NM role and this was clearly significant in the current context in each of the cases. Contextual history has not been a significant focus of research into implementation, other than noted in relation to hospital or Trust mergers.

In addition, the challenge of researching implementation processes that were largely absent existed in this study. Future research of this nature needs to consider how best to study aspects of a process that may be very difficult to uncover, either because they do not exist, or because staff are unaware of them. The use of theoretical approaches that reflect different facets of overall implementation, such as the Pettigrew framework (1985a, 1988) or the PARIHS framework (Kitson, *et al*, 1998; Rycroft-Malone, *et al*, 2002; Kitson, *et al.*, 2008), clearly have an important contribution to make to providing an ‘in the round’ understanding of EBPI. These are able to provide the views of multiple actors, but also, multiple types of data, that contribute a more detailed understanding of complex processes, than, say, surveys can. While it is recognised that studies of this nature are by necessity, large and resource intensive, they do provide a significant amount of information that is useful in developing an understanding of EBP for suggesting practical solutions to tackle impediments and, as such, are very valuable.

Finally, this study has shown that many aspects of EBP were delegated to charge nurses. To date, there is a paucity of research relating to the EBP function of the charge nurse. Since this was a delegated responsibility and NMs recognised the inability of the charge nurse to tackle many aspects of their role, it is important that

further research into this is considered. The role of the charge nurse is known to be complex, stressful and one encompassing multiple roles and demands (Allen, 2001), one of which is now the responsibility to undertake EBPI. Moving a step closer to practice from NM level has the potential to provide a wealth of information, particularly through the use of case study methodology, about the evidence application process and its use in practice.

## **REFLECTIONS ON THE DESIGN AND CONDUCT OF THE RESEARCH**

### ***Choice of case study methodology***

Detailed analysis of the decisions made regarding the choice of methodology can be found in chapter three, but in brief, the methodology was selected as one that reflected the need for qualitative studies of nursing leadership roles and EBP (Gifford, *et al.*, 2007). As such, case studies would be appropriate for studying a social phenomenon, in its context, and for which there was ambiguity about the boundaries of the phenomenon and context (Yin, 1994; 2003). Its use in previous health services research and studies of change (Pettigrew, *et al.*, 1992; Ferlie, *et al.*, 1999; Bryar, 1999; Fitzgerald, 1999; Dopson, *et al.*, 1999), and more recently by experts in the field of evidence implementation (Stetler, *et al.*, 2007), underpins this as an appropriate choice. In addition it facilitates the study of a positive analysis of change (Dawson, 1994) and it was important to be able to capture the way that NMs were actually involved in EBPI, rather than study the ways that they should be involved through an intervention study. The methodology has the scope to provide an ‘in the round’ view of the phenomenon under study, and the use of multiple sources of data, which is appropriate to the methodology, was seen as one way of contributing to this (Robson, 1993). It proved to be able to provide the fine grain detail and breadth of understanding of the role of NMs in EBPI. Having undertaken four case studies, the methodology contributed to the contrast and comparison across the cases, which is again, a strength. As a methodology it met the methodological aims and objectives of this study.

### **The research design**

Case study research and studies of change processes are often longitudinal in nature (Pettigrew, 1988). However this study used a cross sectional design. The main reasons

for this were pragmatic, that is limited finance and time and the practicalities of arranging access to health care Trusts over time. These choices had to be made at a time when medical research ethics procedures were undergoing significant change, which temporarily hindered social science researchers. These were all considerations that impacted on this decision. There is also a recognition that there are several factors which make longitudinal research difficult to sustain (Pettigrew, 1990). One of these was the relative newness of EBP as an innovation and the length of time that any innovation takes to have an impact in an organisation might have meant that committing to a longitudinal study of an individual case might have involved a significant time commitment to a single case. Given the desire to undertake a study that was able to consider similarity and difference between cases, it was more fruitful to have undertaken a multiple case design.

Although a cross sectional study is only able to capture data from a single point in time, this is not thought to have hindered the research. The nature of the study concerned the role of the NM in an ongoing process (but not such a dynamic or rapidly changing process) and participants were able to provide detailed information about the present and given the recent introduction of EBP, the recent past. Many participants were able to provide great detail (in particular NMs) about changes to the organisation and their role over the years and it was clear that this detailed recall was due to the occasionally still very raw, nature of these memories. The use of multiple sources of data provided background information from the years following the introduction of clinical governance and EBP and contributed to the overall picture of the role of NMs in EBPI in all the cases.

### **Selection of cases**

The decision was made to select four cases for study. Since comparison, similarity and difference were seen to be an important aspect of the methodology, these cases were selected not to represent any particular type of Trust but as they were thought to be broadly typical. The cases selected took account of a number of variations possible across Scotland, such as large and small urban location and remote and rural settings, which would account for the majority of Scottish Trusts. Despite this, it is not possible to say to what extent they are typical Scottish Trusts, but the author's own experience of work in a number of different Trusts, has shown that no typical Trusts

exist, but rather features that are shared to some extent across all. This recognition reflects the belief that in studies of this nature similarities will exist that can be observed in other Trusts (Locock, *et al.*, 2005). However, each is influenced by its own particular context and as this was one aspect of the research enquiry, taking account of this in selection of cases, was deemed appropriate.

### **Selection of methods for data collection**

Use of multiple sources of data enhanced the rigour of the study (Miles & Huberman, 1994; Burns & Grove, 2001). While interviews were the main source of data, documents from each of the cases and independent reports relating to the implementation of clinical governance and those in relation to specific clinical conditions, including the use of EBP, were valuable additional sources of both subjective and objective data (Bradley, 1995). Access to a number of different research participants, with a variety of EBP roles, in each case was also seen as a way of providing multiple perspectives (Jick, 1979; McDonnell, *et al.*, 2000). As well as providing a completeness and depth to the data, the use of multiple sources of data added range to the analysis (Fielding & Fielding, 1986; Shih, 1998; Silverman, 2000; 2001; Williamson, 2005). These were seen as a strength of the study design and conduct.

### **Issues of rigour in the conduct of the study**

A detailed description is provided in chapter three of the ways in which issues of rigour were addressed in the study. However it is important to highlight several specific points which could have been seen as threats to these. It is worth noting that notions of rigour in qualitative research are the subject of ongoing debates (Horsburgh, 2003; Dixon-Woods, *et al.*, 2004; Parahoo, 2006). The issue of generalisability from qualitative research is often raised as a concern. The term used in this research to describe the extent to which the findings are generalisable to other cases is transferability, that is, the extent to which the findings from this study can be useful to other Trusts, NMs or settings similar to those studied (Parahoo, 2006). Findings can be '*exported*' (Horsburgh, 2003: 311) or extrapolated to other settings to provide insights there. It was important to recognise that in health care contexts nothing is ever exactly the same as in any other context, neither is it always completely different (Ferlie & Dopson, 2005). The shared elements and experiences

provide common ground to enable sound extrapolation of data from other settings. The transferability of the results in this way is seen as a strength of the study.

### ***The 'truth value' of results***

The '*truth value*' of a study is the extent to which it represents and supports understanding and believability of the findings (Miles and Huberman, 1994: 278; Lincoln & Guba, 1995; Pegram, 1999). These issues were addressed through the use of multiple sources of data (triangulation) as outlined above. Although the use of interviews depends upon accurate recall by research participants, this was less of an issue because they were required to describe and discuss a current situation, rather than rely on memory. Interviewing several participants with different roles in each site provided supporting data. The extent to which those interviewed was balanced with non-participants was influenced by the mode of selection of participants. This was dependent on those staff identified by the Directors of Nursing in each site, as having a role in EBPI and those with a NM role. Participants also suggested other staff who may have been able to contribute to the research as a result of their experience of EBPI which was a means of overcoming Director of Nursing's limited knowledge of staff involvement. Only one member of staff approached declined, the Director of Nursing in Case D. He felt that he would not be able to contribute to the study, but recommended other staff with more direct involvement in EBP in the Trust instead. No middle NMs were interviewed in Case D, due to their newness in post and long term sick leave of the other NM. However, two senior NMs were interviewed, both of whom had held more junior posts prior to recent promotion and so were knowledgeable about the Trust and EBP. Charge nurses in case C were not nominated by the Director of Nursing as having a role in EBP, and therefore access to them was not possible. Of those who were interviewed across the cases (n=51), the staff were considered to be providing their view of EBPI and the role of NMs, rather than seeking to be representative of all staff holding the same post or role. It was acknowledged that much of the literature concerning EBP and RU has focussed on the individual practitioner, staff nurses, in the main. However, limitations placed on access to clinical staff by the medical research ethics committee excluded them as potential participants. Nonetheless, this is not thought to have had a detrimental impact on the research as many charge nurses were interviewed and they are also individual practitioners.

Interviews always carry the inherent risk of the socially desirable response, to give a good impression to the researcher of knowledge or abilities (Bowling, 1997). The use of multiple methods and perspectives was able to corroborate interview data and is seen as a means of providing what Silverman calls '*synchronic reliability*' (Silverman, 2001: 288). It was recognised as important to reflect different views, rather than see one participant's response as 'the truth' and to acknowledge that there is no one truth but that participants' views are influenced by their work environment and own experience of the work (Mays & Pope, 1999).

### **Informant feedback**

Despite suggestions from several authors that it is important to obtain informant feedback (Burns & Grove, 2001; Horsburgh, 2003; Parahoo, 2006), there are also those who believe that it has the potential to jeopardise research (Sandelowski, 1993; McDonnell, *et al.*, 2000). A decision was made prior to commencing fieldwork that interview transcripts would not be returned to participants for verification. Apart from reasons of practicality, there were real concerns about the ability to maintain confidentiality and anonymity and of the potential for participants to change their responses once they had had time to consider them in more detail. In particular, nurses may have been concerned about their frank responses to questions about their NMs, particularly when they were less than complimentary. Candour was seen as more important in this instance than informant review of audio-taped interviews, where there was a limited chance of error.

One of the final contributing factors to the rigour of the study was the use of a robust theoretical framework. This not only guided data gathering, but also supported the management of large amounts of data and the subsequent analysis. This overcame concerns highlighted in the literature of undertaking case studies (Vallis & Tierney, 1999). The use of the framework is appraised below.

### **The theoretical framework**

The overriding question is to what extent did the framework facilitate an accurate portrayal of the research findings? The difficulty in selecting any framework or model to guide research is that it can only ever provide a single perspective on a research

question and only then, an incomplete view (Morgan, 1997). The problem, articulated succinctly by Pettigrew (1985a: 649) is that '*where we sit not only influences where we stand, but also what we see*'. In recognising this, it was important to acknowledge that selecting an organisational change framework as a means of understanding EBPI processes can only contribute one perspective to a wider body of literature that has taken many different approaches, but it has enabled valuable insights into the process to emerge. It is an organisational change perspective that sees the context, content and process of change as central to understanding that change. The strength of the Pettigrew framework (1985a) was that it had previously been used to study change in large organisations and specifically in health care organisations showing that it had the potential to support the development of a coherent understanding of change processes in complex health care organisations. The recognition within the framework of the importance of historical factors in understanding the antecedents of change (Pettigrew, 1985a; 1988, Pettigrew, *et al.*, 1992) was significant in terms of the impact that these had on current health care Trusts. The three factors, context, content and process mapped well to aspects of EBPI, each contributing to an understanding of the roles of NMs in this. Pettigrew (1985a; 1988) asserts that the impact of leadership (NMs in this study) cannot be studied and understood in isolation from the whole environment in which they work. The framework enabled the study of NMs in the EBPI process to be set in each individual case environment and against the wider health care environment in Scotland.

Implementation of evidence into practice has also previously been viewed as a change process (Mulhall & Le May, 1999) and the combination of the two views suggested that it had the ability to serve as an appropriate and robust tool in the research. The consideration that it gives to wider context was useful in recognising the background to clinical governance and the introduction of EBP, and Dawson (1994) and Collins (1998) highlight the importance of acknowledging wider contextual influences on change in organisations. Studies of process have become an aspect of work organisation that is more of a focus in the NHS than previously (Warburton & Black, 2002). They are seen to have the ability to elucidate many factors, such as the strengths and weaknesses of particular approaches to organisational processes, aspects of motivation, power, inter-professional relationships and managerial competencies (Warburton & Black, 2002). The framework does not give precedence to any single

factor, but emphasises the combination or interplay of each and this had utility for iteration between the factors and cases when undertaking the analysis of the data. It had the ability therefore to present an 'in the round' picture which is the aim of case study methodology and therefore was an appropriate tool in this regard. It has enabled the author to show the complexity of the processes of EBPI and the roles of NMs within this in the cases.

While the framework was both useful and helpful in undertaking data collection, analysis and writing up results of the research, it was not without its challenges. The complex and haphazard nature of organisations (Pettigrew, *et al.*, 1988) is further complicated by the ways in which managers (or in this study, all staff) have the potential to manipulate aspects of their environment to legitimise their version or vision of events (Pettigrew, *et al.*, 1998). In addition, Dawson (1994) highlights the importance of the contextualist approach as one that is able to reveal important aspects of the change process such as the subjective views of managers and their perception of the history and potential outcomes of change. This was demonstrated in the research and contributed significant data about the context, content and process of change.

However useful, it was difficult to portray the complex interactions between the factors and some pieces of data were not easily attributed to a single factor. While this was not a problem during analysis, writing up results, while minimising duplication was not a straightforward task. Acknowledging the fluid boundaries, rather than fixed nature of the categories, went some way to overcoming this.

EBPI and the role of all individuals within this (although especially NMs) is not a linear, stepwise or single action process. It is lengthy, iterative, complicated and influenced by numerous relationships, interactions, actions and lack of action. It takes place against a background and within a setting and relies on poorly understood notions of evidence, which all impact on the process. One of the difficulties in using the contextualist approach was in its view of change as dynamic and non-linear (Pettigrew, 1988). Trying to portray active, ongoing processes of EBPI, was complicated by the portrayal, by many of participants, of processes that were not active, not dynamic and were viewed as step-wise and linear. In addition, in seeking

to understand the role of the NM in the EBPI process, analysis revealed that it was a largely absent role, in terms of their involvement in this aspect of change. However, this, as an outcome, does not detract from the appropriateness of the theoretical framework. In explaining his view of researching change Pettigrew recognises that the unexpected may also emerge from data, as it did in this study:

*'Explanations of change have to be able to deal with continuity and change, actions and structures, endogenous and exogenous factors, as well as with chance and surprise'. (Pettigrew, 1988:658)*

However, these are not thought to be weaknesses of the theoretical framework, nor indeed the way in which it was used in this study. Buchanan and Boddy (1992) in their review of the contextualist approach, see this as a strength in that the context and content of change can be shown as inhibiting or constraining change processes as well as acting as triggers. This study has shown the interaction between the factors and the ways in which they have, to some extent, impeded and limited a greater role for the NM in EBPI. Finally, many of the criticisms of studies of organisations relate to their linear view of change (Buchanan & Boddy, 1992), the lack of robust theory to support them (Collins, 1998) and the failure to produce *'tools for action'* (Buchanan and Boddy, 1992:66) from the study findings. The contextual approach taken in this research has addressed each of these concerns.

The choice was taken to present the data across the cases by the three factors to enable the complexities of the process and involved roles to 'speak for themselves' rather than by presenting case by case results. This was combined in chapter four and five with presentation within the factors of case by case data. The case descriptions were provided at the beginning of the results to give background and facilitate cross-case comparison, by providing enough information to highlight similarities and difference between them. In addition to preserving confidentiality of participants and anonymity of cases, using this format has kept the focus on the research question overall rather than on the cases themselves. However, the tension was always in finding an approach to presenting the data that balanced the individual case, with its rich context, content and process and the interplay of individual factors, seen as the key to understanding EBPI across the cases. The decision to present the data by factor, was

balanced by the inclusion of case by case data in two chapters, to facilitate a holistic view of the cases and still focus on NM roles in the EBPI process.

In essence, the framework has enabled an accurate and utilitarian approach to data collection, analysis and presentation of results that is true to both the methodology and the research question.

### **Reflections on research methodology and methods: a summary**

In brief, the sections presented above have demonstrated that the research has been conducted in such a way as to accurately follow the methodology, show rigour in the design and conduct of the case study fieldwork and it has been underpinned by an appropriate theoretical framework. The methods chosen were appropriate, complimentary and fruitful. Individually they would have been adequate, but in combination, they resulted in detailed, rich data. Pettigrew's framework (1985a; 1988) has provided the means to analyse, understand and present an accurate and satisfactory account of the exploration and explanation of role of the NM in EBPI and the strategies used by them to this end.

### **Reflections of the researcher on the conduct of the study**

In concluding the thesis, this final section presents the reflections of the researcher in undertaking the study. As personal reflections, they are written in the first person.

Reflecting on the conduct of the research highlighted three types of challenge; the practical issues of carrying out case study research; reconciling the findings of the study with previous researcher experience and personal issues arising from and interacting with the research process.

The practical issues that I had not experienced in any of the previous research that I had undertaken, really began with the complexities and intransigence of the research ethics approval procedures. While I recognise that these were in a state of flux in 2002, when the application was made, and have since changed, it was incredibly frustrating to have to apply for approval to a system that did not properly recognise the qualitative paradigm and its contribution to health services research. The misfit between the study and the ethical approval process was disheartening and also

influenced the conduct of the study, although only to a minor degree. It was some consolation that my peers faced the same (if not worse) situations.

The other practical issues were those of managing such large amounts of data, again a new experience. Well-honed organisational skills and a methodical approach to filing and storage meant that data was always readily accessible and safe. While, seemingly of lesser importance to the overall conduct of the research, dealing with the numerous CSBS reports, written documents, such as annual reports, newsletters and copies of procedures or policies from four cases as well as 51 interview transcripts, was not an insubstantial task and one which had the potential to (if not managed appropriately) impact on the data analysis and findings. Wrestling with this amount of data to make sense of EBPI processes was complex and often challenging, but again, a very methodical approach to coding data and emerging themes facilitated the analytical process and led to a satisfactory conclusion of the research endeavour.

Reconciling the findings of the research with my previous experience has only taken place after the writing up has been completed. The role of the NM in EBPI which emerges from the research is very different from that of my own experience of managing nurses and leading EBPI in my previous posts (discussed in chapter three). While I had no expectation that the findings would reflect my experience, it was understandable, but nonetheless something of a surprise (recognised by Pettigrew, [1988] as one aspect of the study of organisational change) that it was a role that did not reflect the importance of EBP in contemporary nursing practice. The complexities that I had faced in trying to facilitate EBPI in a small, coherent health care team were exponentially increased for the NMs in the research. I managed a small team, was focussed on EBPI and had few resourcing issues to contend with. That is not to say that it was always straightforward, there were difficulties relating to management and practice that had to be resolved. However, while most of the difficulties that I faced concerned the content of evidence-based products and monitoring and ensuring adherence to EBP, the contextual factors in the cases had a much greater impact for the NMs. Inter-professional relationships in a small general practice were not always without conflict, but it was more often different groups of nurses that disagreed about EBPI and mostly as the result of perceived increased workload. In the case studies, difficult relationships between medical and nursing staff concerning EBP were more

prominent and NMs were not able to mediate in these instances. Probably the most striking contrast between my experience and that of the NMs in the study related to autonomy and authority. In my post, I had both and these were recognised by other staff. I also had (not endless, but adequate) resources to enable me to undertake EBPI without concern about the financial implications. Neither of these conditions were reflected in the case study sites.

Despite the somewhat negative findings relating to the role of the NM in EBPI, it is still important to have uncovered the reality of the situation and the wider influences of context and evidence content on this. Overall, undertaking the study and reviewing the findings have given me important insights into the complexities of the EBPI process. It has emphasised what I knew about the contentious nature of evidence and highlighted that these debates will not be readily concluded. It has shown that the impact of context is crucial to an understanding of all aspects of EBP and needs to be given the importance that it deserves in practical and theoretical approaches to EBPI.

Finally, no work of this magnitude can be without personal challenges. For me, these were, in the early days, those of adjusting to the very different environment of academia, after years in clinical practice. The challenges of being a mature student did not escape me, those of having to juggle multiple demands on time, energy and resources. Latterly, it was necessary to take a lengthy leave of absence from the study due to ill health. Returning after a time away was daunting and has also required an ability to regain momentum and sustain motivation over such a long period of time, which at times was very challenging. However, my final reflection is that it has not only proved to be possible, but well worth it.

*APPENDIX ONE*

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## ***Implementing EBP in Nursing: Interview schedule***

***Introduction:*** Remind them of research information sheet. Re-iterate that my interest is in EBP and how it becomes used in practice. Interested in the role that nurse managers have in this. My interest is in *their* views and *their* experiences. Give opportunity for any questions before starting tape.

### ***General Trust Information about EBPI:***

- What structures (e.g. groups/meetings) are in place relating to EBP?
- Is EBP in nursing part of these or does it have its own structures? How do they fit with wider initiatives such as clinical governance? How is CG implementation organised? Which nurses are involved with it?
- Are there explicit strategies for developing EBPI? What are these? What are they based on (for example: nursing models, information from nursing journals, expert guidance...?) Who chooses these and why and do they change over time?
- Are any nurses (or other staff) employed specifically to undertake EBPI, to facilitate it (in any way) or to monitor it?
- What are these posts? When and why did they begin and what skills or experience were thought to be necessary for the posts. Does interviewee consider these a success and why? What practices have changed as a result of this?
- Who else is involved in EBPI? In what ways and how does this link with nursing?
- Who has the main responsibility for EBPI in nursing? To what extent are individual nurses involved? Any examples of EBP initiated by nurses?
- Have any areas of practice been identified that need to become more EB? How are they identified and what happens next?
- What was the outcome of previous attempts/initiatives to change practice? What went well/not so well? What help and hindered? What was missing, if anything? How were any gaps remedied?

### ***Specifics about evidence use and implementation strategies:***

- In what ways is evidence currently being used in practice (**JW**: try to think about wider EBPI, not just instrumental use)? Does any type of evidence predominate?
- What influences the decision to implement or use any particular evidence (e.g. local, national priority, someone's area of interest, clinical problem/audit, new evidence published, identified as a need within an overall service development...)
- Once the decision is made to consider changing practice, to reflect EB- what happens next? Go it alone, involve PDU, CNS, NM, link nurses, others-who?
- Before making changes to practice, do you discuss it with anyone? Do you need 'permission' from anyone, either in nursing or medicine, or wider hospital staff? Are you able to go ahead without doing this? Do you feel able to-why or why not?
- What skills and experience do you have relating to EBP and changing practice?
- What happens within the Trust about specific evidence products, such as SIGN guidelines, NMPDU statements, RCN guidelines. Which are they using in practice? If so how, if not, why not? Trust wide strategy for dissemination and implementation or not?
- Discuss something that they have implemented, or has been implemented in their area.

### **Implementation of EBP and nurse managers**

- What are the main responsibilities of NM for EBPI? In what ways are they involved? What knowledge and skills do they have for EBPI?
- What organisational structures/strategies support EBPI? What makes it difficult? How are these problems overcome? What helps?
- Literature suggests NM commitment to EBP is important. How do NMs demonstrate this, give examples (for nurses: how is it manifest, give examples?).
- NM support is important part of EBP. In what ways do NMs show or provide support for nurses re: EBP? (For nurses: how is it manifest, provide examples)
- Authority & autonomy: are nurses 'allowed' to make changes to practice, without prior permission? Why is it (if it is) necessary (and why not if it is not)? Who would grant permission? Could NM over-rule? How do NMs 'give' authority and underpin autonomy of nurses? Examples. For nurses: how are these manifest?
- Attitude of NM to EBP. Significant? How demonstrated? From nurses-examples of how they view NMs attitude.
- Is the need for use of EBP in employment contracts? Who monitors and how? What if nurses fail to achieve, given NMC clause 6.4? Is EBP ever used as a defence of practice?

### ***Round up:***

- Any final points?
- Anything they want to clarify
- Anything they want to add
- Anything they want to ask?

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