Evidence-Based Practice from the perspectives of Mid-level and Frontline Nurse Managers
A Qualitative Descriptive Study

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I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Professional Doctorate is entirely my own work, that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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15th January 2013.

Dedicated to Joe and Bridgie Doolan, my beloved parents, whose lives were short but influence ever-lasting.

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ABBREVIATIONS

ADON	Assistant Director of Nursing
ANMC	Australian Nursing and Midwifery Council
ANP	Advanced Nurse Practitioner
CNM	Clinical Nurse Manager
CNM2	Clinical Nurse Manager 2 (Traditional Ward Sister).
CNM1	Clinical Nurse Manager 1 (Junior Ward Sister)
CNS	Clinical Nurse Specialist
DEBP	Developing Evidence Based Practice
DNM	Divisional Nurse Manager
DoH	Department of Health
DoH&C	Department of Health and Children (Rep of Ireland)
EBM	Evidence- Based Medicine
EBP	Evidence- Based Practice
EBPQ	Evidence Based Practice Questionnaire
EBMWG	Evidence Based Medicine Working Group
FAME	Feasibility, Appropriateness, Meaningfulness and Effectiveness
HIQA	Health Information and Quality Authority
HRB	Health Research Board
HSE	Health Service Executive

IOM	Institute of Medicine
NCEC	National Clinical Effective Committee
NCNM	National Council for the Professional Development of Nursing and Midwifery
NHS	National Health Service (UK)
NHSI	National Health Service Institute for Innovation and Improvement
NICE	National Institute for Health and Clinical Excellence
OHM	Office of Health Management
PARiHS	Promoting Action on Research Implementation in Health Services
PAEiHS	Promoting Action on Evidence in Health Services
PPPGs	Policies, Procedures, Protocols, Guidelines
QJBC	Queens Joanna Briggs Collaboration
QJBC-MAPS	Queens Joanna Briggs Collaboration Model for Activating Patient Safety evidence
RCN	Royal College of Nursing
RCT	Randomised Control Trials
REC	Regional Ethics Committee
Reps	Representatives
TOMH	Office for Health Management
TOPIC	The Older Person Improving Care
WHO	World Health Organisation

APPENDICES

ABSTRACT

The quest for evidence-based practice in the Irish healthcare system has not abated as theorists, policy makers, academics, educationalists, strategists, and clinicians strive to determine and ultimately achieve evidence-based practice. Contemporary scholarly literature presents a plethora of research papers outlining the steps to achieving Evidence-Based Practice (EBP). Many theorists concur that professions, including nursing, adopted the Evidence Based Medicine (EBM) model to achieving EBP; yet, there is no consensus that following sequential steps will achieve EBP.

Having reviewed the literature I concluded that many of the research studies focused on research utilisation without consideration of other sources of evidence that inform evidence-based decision-making, including clinical expertise and the patient's perspective. This research study utilised a qualitative descriptive approach based on naturalistic inquiry to gain insight into mid-level and frontline nurse managers' understandings of EBP. In-depth interviews were conducted with nurse managers (n= 23) in three acute hospitals. Findings are presented using three main themes, '*Nurse Managers' Perceptions of Evidence-Based Practice', 'Nurse Managers' Views on Enablers and Barriers to EBP',* and '*Nurse Managers' Opinions on making EBP a Reality'.* Data were subsequently presented using categories, which captured participants' understandings of evidence-based practice. 'Knowing the patient' was considered fundamental to evidence-based decision-making. 'Achieving positive patient outcomes through effective clinical governance' incorporated service user involvement in policy formation and sharing clinical decision-making. 'Interdisciplinary collaboration and communication' was perceived as contributing to evidence-based practice. 'Policies, procedures, protocols and guidelines' (PPPGs) were linked to EBP, although the extent to which PPPGs contributed to EBP was not confirmed. The current environment of staff shortages impacted on clinical nurse managers' abilities to achieve EBP, as fundamental patient care took precedence over strategic issues including leadership.

The small sample size limits generalisation of the findings; however, participants' accounts of EBP provide further understandings into enablers and barriers of EBP. Recommendations include re-instating the role of the ward sister/charge nurse as the gatekeeper of quality safe patient care and revising the scope of mid-level nurse managers such that these professionals have clear responsibilities for EBP. Furthermore nurses at all levels must value the contribution of truly knowing the patient, which is the critical first step to achieving evidence-based decision-making.

CHAPTER ONE: OVERVIEW OF THE STUDY

1.1 Background to the study

Healthcare in Ireland must reflect 'national and international evidence of what is known to achieve best outcomes for service-users' (HIQA 2012a, p.42). Policy documents and strategies stipulate that Evidence-Based Practice (EBP) must be established and supported throughout healthcare in Ireland (Government of Ireland 2008, Department of Health & Children 2009a, HRB 2009). EBP is a problem solving approach to clinical decision-making that involves the conscientious use of scientific evidence combined with one's clinical expertise and patients' values and preferences to improve patient outcomes (Melynk & Fineout-Overholt 2011). A core competency for frontline, mid-level, and top-level nurse managers in Ireland is the promotion of evidence-based decision-making, which incorporates using a wide range of information sources (Rush, McCarthy & Cronin 2000).

1.2 Theoretical development of the concept of evidence-based practice in nursing

The concept of EBP can be traced back to the 17th Century when Pierre Louis questioned routine medical practices; however the concept of Evidence Based Medicine (EBM) evolved in the latter part of the 20th Century (EBMWG 1992). Much of the literature states that professions, including nursing, followed the evidence-based medicine model; however, having reviewed the literature, EBP in nursing could be linked to Carper's (1978) four fundamental patterns of knowing, which, in her view, informs nurses' decision making.

1.3 Review of the literature

The literature review highlighted much debate and confusion regarding evidence-based practice. Literature pertaining to the sources of knowledge used by nurses to inform their clinical decision-making concurred that nurses relied heavily on past experiences, colleagues and patients rather than research to inform their decision-making. Yet the majority of studies exploring the barriers and facilitators of EBP, focused on research as the dominant source of evidence. 'Time' and 'workload' were consistently identified as major barriers to research utilisation and EBP, although widespread use of the BARRIERS scale (Funk *et al* 1991) may have influenced these studies' findings. The recent development of questionnaires to explore nurses' use of EBP incorporated other sources of evidence such as policies and guidelines; nonetheless time re-emerged as a barrier to EBP. Models and frameworks developed to promote the use of EBP have evolved in line with the development of the concept of evidence, with nurse theorists changing their focus from 'research' based practice to 'evidence' based practice (Titler et al 1994, Titler et al 2001). These models propose steps for achieving EBP, incorporating addressing clinical questions, sourcing valid evidence, and utilising evidence to support clinical practice. Focusing on the role of nurse managers and EBP, there is a dearth of research exploring their understandings of translating knowledge into evidence-based practice. Yet the role of the nurse manager as an enabler of knowledge translation to clinical practice is emerging in contemporary literature (Kitson et al 2011).

1.4 Research methodology

The philosophical assumptions of naturalistic inquiry and social constructionism underpin this study, supporting the epistemological view that the development of knowledge was dependant upon my interaction with nurse managers and their worlds, resulting in multiple realities that were socially constructed. Subsequently, a qualitative descriptive methodology was adopted to socially construct new levels of understandings from managers' accounts of evidence-based practice.

1.5 Research design

The aim of this study was to explore mid-level and frontline nurse managers' understandings of evidence-based practice. The study was conducted in Acute Hospitals (n=3) in an identified Health Service Executive Region in Ireland. Unstructured interviews (n=23) were conducted to gain insights and understandings into evidence-based practice. Conventional content analysis was utilised to code and categorise data, resulting in the formation of three themes, which represented nurse managers' understandings of EBP. Data collection, analysis and interpretation were deemed a moral obligation, resulting in worthy findings that represented participants' accounts of EBP.

1.6 Study findings

Findings were presented using three main themes, which illustrated participants' understandings of evidence-based practice: *Nurse Managers' Perceptions of Evidence Based Practice*, *Nurse Managers Views on Enablers and Barriers to EBP* and *Nurse Managers Opinions on making EBP a Reality*. Themes consisted of categories. The category 'knowing the patient' involved the development of

meaningful relationships, which informed clinical decision-making. The category 'Governance' provided insight into responsibilities for standards of patient care. 'Development, implementation, and evaluation of local guidelines and policies highlighted differences regarding the extent to which policies and guidelines informed clinical nursing practice. 'Service user involvement' was considered an essential component of EBP, although nurse managers requested further guidance to enable service-user involvement at both strategic and clinical levels. The theme, 'Enablers and Barriers to Evidence-Based Practice', identified 'staff motivation', 'willingness to learn', and 'availability of resources' as facilitators of EBP. Availability of 'National Guidelines' was also identified as an enabler of EBP. Barriers to EBP related to 'limited capacity to fulfil roles and responsibilities', 'staff resistance to change practices that were familiar to them' and 'the current environment of staff shortages and increased workloads'. Theme three 'Nurse Managers Opinions on Making Evidence-Based Practice a Reality' included facilitating nurses to question clinical practices, promoting nursing students contribution to EBP and enhancing nurses' confidence to speak as part of the multidisciplinary team.

1.7 Discussion, Recommendations and Conclusion

The discussion focused on enabling nurses to know their patients which necessitated understanding the patient's psychological, emotional and physical state. This level of knowledge of each patient was considered necessary to facilitate evidence-based decision-making. Achieving positive outcomes through effective clinical governance necessitated service user involvement and shared decision-making. Participants highlighted complexities associated with service user involvement at both strategic

and clinical levels. Capacity to fulfil one's roles and responsibilities was discussed in the context of participants' frustration and disillusionment with the current environment of staff shortages. Policies, procedures, protocols and guidelines (PPPGs) were linked to evidence-based practice although the extent to which PPPGs contributed to EBP was inconclusive. The current environment impacted on EBP as Clinical Nurse Managers (CNMs) juggled priorities on a daily basis with fundamental patient care taking precedence over strategic issues.

Although the small sample size limited generalisability of these findings, recommendations for management, clinical practice and education were formulated to enhance implementation of Evidence-Based Practice, based on mid-level and frontline nurse managers' understandings of EBP.

CHAPTER TWO: THEORETICAL DEVELOPMENT OF THE CONCEPT

2.1 Introduction

In the early 1990s professional literature pertaining to Evidence-Based Practice (EBP) was dominated by medicine and to a lesser extent nursing, with little representation from other healthcare professionals. However, contemporary scholarly literature presents a plethora of interdisciplinary papers engaging in the rhetoric of EBP (Edmond et al. 2006; Gambrill 2006; Mace 2006; Scott et al. 2006; Gambrill 2007; Hamlin 2007; Satterfield et al. 2009). There is an urgent need for the creation of a culture, which supports questioning of clinical practices at all levels throughout the health service in Ireland. Evolution of EBP in nursing over the past twenty years relates to government and professional organisations requesting standardised quality indicators and better outcomes of care (An Bord Altranais 2005; HSE 2006, HIQA 2007; HSE 2007a; HSE 2007b; HSE 2007c; Government of Ireland 2008; An Bord Altranais 2010; HIQA 2010; HIQA 2011; Government of Ireland 2012; HSE 2012). This chapter traces the evolution of Evidence-Based Medicine (EBM) and the subsequent development of Evidence-Based Practice (EBP), with specific emphasis on nursing.

2.2 Evolution of Evidence-Based Medicine

Views on medical decision-making can be traced back to the beginning of Western Civilisation. It is interesting that Ancient Greek philosophers of the second century such as Galen and Alexander of Aphrodisias were divided regarding the stochastic nature of medicine (Ierodiakonou and Vandenbroucke 1993). Stochastic relates to

the unpredictability or uncertainty associated with medical decision-making, whereby a doctor who administers appropriate treatment cannot determine the patient's outcome (Vandenbroucke 1996). Alexander proposed that medicine and medical decision-making were not based on syllogisms (theories) in that something was necessarily and always the case; therefore, physicians could not determine what would happen to any individual patient. In other words, Alexander proposed that theories needed to be tested in order to establish the facts and predict outcomes. Conversely, Galen believed that theories informed medical practice and physicians could reason in a logical way focusing on disease mechanisms and treatments (Vandenbroucke 1996). Almost two thousand years later William Cullen (1710-1790), a teacher of Scottish medicine in the 18th century, likewise claimed that two schools of thought informed medical decision-making, 'the dogmatic and the empirical' (Vandenbroucke 1996, p.1336). Dogmatic relates to theoretical reasoning whereas empirical corresponds to theory testing to establish facts. Cullen advanced the opinions of his Greek ancestors, stressing in his teachings that both schools had their limitations; hence, physicians were advised to combine theoretical reasoning with findings from empirical studies to inform their decisions. No doubt Cullen was ahead of his time in recognising that both theoretical and empirical knowledge were necessary to inform medical decision-making.

Principles of a 17th century movement called 'Medecine d'Observation' further informed reasoning underpinning medical decision-making. This movement originated in Paris led by Pierre Charles Alexandre Louis (1787-1872) (Vandenbroucke 1996). The movement advised physicians not to rely on speculation and theory or single experiences to make clinical decisions, rather physicians ought

to make a large series of observations and derive numerical summaries from which real truth would emerge. Louis, a physician himself, became disillusioned by his inability to combat disease and decided to devote his time to observing and recording disease patterns and their response to treatments. Based on analysis of his observations for the treatment of pneumonia, Louis subsequently questioned the effectiveness of medical practices such as leeching and bloodletting that still existed in the 1800s (Morabia 1996). He introduced medicine to a standardised method of data collection and analysis that he called 'the numerical method' (Morabia 1996, p.1327). At this time the 'position of the stars in heaven and their interplay with Galenic humours' continued to inform physician decision-making (Vandenbroucke 1996, p.1335). Louis's seminal papers, including his criticisms of bloodletting, are described as legendry (Morabia 1996).

A French physiologist, Claude Bernard (1813-1878) advanced Louis's numerical method, claiming that medical knowledge could only be derived from laboratory-based experiments (Morabia 2006). Bernard denounced physicians who refused to rely on comparative experiments to inform their decision-making and who purported that medicine was an art and therefore could not be quantified (Morabia 2006). Bernard knew that exact knowledge of the physiological mechanisms underlying a specific disease process was necessary to inform medical decision-making; yet, he was realistic about his expectations, acknowledging that medicine could not be totally based on physiology (Morabia 2006). Medicine ultimately had a speculative component, in the sense that physicians had to make decisions without access to the exact basis of all illnesses. Physicians relied on group comparison and probabilistic thinking (logical empiricism) to inform their decision-making. According to

Bernard, logical empiricism and experimentation fused to inform medical decision-making, further condemning physicians who claimed that medicine was an art that could not be quantified (Morabia 1996).

Former pupils of Pierre Louis, William Farr and George Shattuck formed the new public health movement in the middle of the 19th century by reintroducing numerical reasoning to medicine (Vandenbroucke 1996). The 'numerical method' returned to medicine under the guise of 'clinical epidemiology', a final victory for Pierre Louis (Vandenbroucke 1996, p.1337). David Sackett, a leading member of the Evidence Based Medicine Working Group (EBMWG), applauds the contribution of 'clinical epidemiologists' to the evolution of EBM (Sackett 2002, p.1165); however he does not acknowledge the work of Pierre Louis.

David Sackett worked with Alvan Feinstein in McMaster University in Canada and clinical epidemiology advanced with the establishment of the Department of Clinical Epidemiology and Biostatistics at McMaster in 1967 (Sackett 2002). Physicians who provided direct patient care were taught to apply the study of populations (classical epidemiology) and statistics to the diagnosis and treatment of patients in order to achieve an improvement in health (Sackett 2002). Clinical epidemiology was constantly redefined with some countries such as Canada focusing on the evaluation of treatments and compliance with outcomes from controlled trials (Sackett 2002). The approach spread rapidly across Africa, India, China, and South East Asia, yet other countries like the United Kingdom, Germany, Spain, and South Africa resisted this egalitarian approach until the emergence of the Evidence Based Medicine (EBM) movement in the early 1990s (Sackett 2002).

In 1992 the first paper outlining EBM as 'the new paradigm' was published (EBMWG 1992, p.2420). Whilst the title refers to a new approach to teaching the practice of medicine, the paper actually presents and justifies a new approach to medical decision-making. This new approach directed physicians to appraise and utilise findings from clinical research to guide their decision-making, with less emphasis on disease pathology, clinical experience and intuition (EBMWG 1992). Whilst clinical experience and the development of clinical instincts were considered a crucial and necessary part of becoming a competent physician, caution was expressed that knowledge derived from experience and intuition could be misleading (EBMWG 1992). Intuition related to unsystematic observations from clinical experience and common sense that informed one's knowledge base (EBMWG 1992). EBM incorporated 'being sensitive to patients' emotional needs and understanding patients' suffering and how that suffering can be ameliorated by the caring and compassionate physician…'(EBMWG 1992, p.2421). Subsequently, Sackett et al. (1996) define EBM as:

> 'the conscientious, explicit and judicious use of current best evidence in making decisions 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' (p 71).

Sackett et al. (1996, p.71) define clinical expertise as the 'proficiency and judgement that individual clinicians acquire through clinical experience and clinical practice'. Although not explicit in the definition, clinical expertise incorporates 'thoughtful identification and consideration of individual patients' predicaments, rights, and preferences in making clinical decisions about their care' (Sackett et al. 1996, p.71). Therefore, patients' preferences are a fundamental component of EBM. However, Thornton (2006) challenges this combination of knowledge, whereby evidence from

research studies is integrated with professional judgement and patient values, stating that these three elements cannot be unified as they differ fundamentally. Greenhalgh (2006) concentrates on numbers and ratios, with no reference to clinical expertise in her revised definition of EBM:

> EBM 'is the use of mathematical estimates of the risk of benefit and harm, derived from high quality research on population samples, to inform clinical decision-making in the diagnosis, investigation or management of individual patients' (p1.)

EBM is not without its critics who focus on the 'uncontrolled world of clinical practice with real people' and their varied responses to empirical evidence (Biswas et al. 2007, p.529). In other words, despite results from controlled trials it is difficult to predict individual patient outcomes; therefore, empirical evidence must be considered in the context of each individual patient's response.

2.3 Critiques of Evidence-Based Medicine

Critics of the new approach to medical decision-making, EBM, contend that findings from empirical studies may not contribute to positive patient outcomes. Applying the results of population based research to individual patients neglects the vagaries of the complex biological, cognitive, and sense making individual, in a social environment with associated political, economic and health influences (Biswas et al. 2007). EBM fails to capture the complexities of the real world; hence, the challenge for the physician is to match individual patient needs with the population generated data that EBM generates (Biswas et al. 2007). Sackett et al. (1996) refute these critics postulating that empirical evidence does not replace clinical expertise, as it is the physician who makes the clinical decision incorporating the needs of the patient.

EBM may not address all the issues surrounding the practice of medicine, but has the potential to facilitate an 'anti authoritarian spirit' (Liberati and Vineis 2004, p.121), whereby different stakeholders, including patients, contribute to clinical decision-making. Liberati and Vineis (2004) contend that the potential of EBM has not been fully exploited, narrowly focusing on interventions such as the effectiveness and efficacy of various drugs**.** Consequently little evidence exists for more complex interventions such as disease prevention and patient empowerment.

Tanenbaum (1993) raises a fundamental question about the knowledge base of medicine, referring to the superiority of statistical analysis inferred by the EBM movement. She rejects the premise that statistical analysis and empirical science enhance medical decision-making; rather, in her view this information compliments other forms of medical knowledge. Theorists such as Engel (1977) have tirelessly advocated a move away from the medical model[1] long before the emergence of EBM. Engel's argument to move beyond the biomedical model to a model that incorporates psychological and social aspects of care is largely ignored by proponents of the EBM movement. However, 'the appeal to the authority of evidence that characterises evidence based practices does not increase objectivity, rather it obscures the subjective elements that inescapably enter all forms of human inquiry' (Goldenberg 2006, p.2630). According to Gillet (2006), EBM neglects the social context of medical practice and this claim to scientific objectivity is tainted with probability theories, personal interpretations and implicit biases. Critics of EBM highlight that one form of evidence is not superior to the other (Resnik 2004;

[1] Medical model defined as the biomedical model, which assumes disease fully accounts for deviations from the norm of measurable variables, excluding social, psychological and behavioural dimensions of illness (Engel 1977, p.196).

Tanenbaum 2005), contending that decision-making relies on interpretation of the evidence by the practising physician.

The relatively recent adoption of the concept of Evidence-Based Practice by other healthcare professionals, including nursing, fails to acknowledge the historical tensions evident in the literature pertaining to EBM. In the United Kingdom the establishment initially of the Centre for Evidence-Based Medicine in Oxford and a subsequent Centre for Evidence-Based Nursing in York, led to joint initiatives and multidisciplinary endeavours to achieve clinical effectiveness, broadening the focus from EBM to Evidence-Based Practice (EBP) (Pearson, Field and Jordan 2007).

2.4 Development of the concept of Evidence Based Practice (EBP) in nursing

Reflecting on the development of EBP in nursing, one could argue that nurse theorists documented the need for empirical and theoretical reasoning well in advance of the EBM movement. In fact, the key tenets of EBM, as presented by the EBM Working Group in 1990, corroborate with Carper's (1978) seminal paper on the fundamental ways of knowing.

In 1978, Barbara Carper, an American nurse theorist established four fundamental patterns of knowing 'from an analysis of the conceptual and syntactical structure of nursing knowledge' (Carper 1978, p.14). The four patterns of knowing incorporating 'empirics', 'esthetics', 'personal knowledge' and 'ethics' determine the kinds of knowledge that inform nurses' decision-making. Empirics, the science of nursing, aims to provide explanations that inform nursing practice that are valid,

reliable, objectively descriptive and generalisable (Carper 1978). Esthetics, the art of nursing is the 'creative process of discovery in the empirical pattern of knowing (Carper 1978, p.15). Unlike empirical knowledge that is implicitly formulated and verifiable, esthetic knowledge captures other modes of helping unique to individual patients. Carper (1978) identifies 'empathy' as an important form of esthetic knowledge enabling the nurse 'to design and provide nursing care that is effective and satisfying' (p. 16). Personal knowledge as a pattern of knowing is the most difficult to master involving the promotion of wholeness and integrity in a personal encounter between the patient and the nurse, with emphasis on creating an authentic personal relationship (Carper 1978). The fourth pattern of knowing is 'ethics', the moral component that focuses on matters of obligation of what ought to be done (Carper 1978). Nurses must understand different philosophical positions regarding what is good, what ought to be done, what is right and ethical decision making frameworks to assist their decision making processes (Carper 1978).

Whilst empirical knowledge may provide objective facts on the most effective interventions, personal knowledge provides the nurse with further insights such as the patient's ability to tolerate the particular intervention, for example compression bandaging. There is empirical evidence that compression bandaging will improve venous return and assist venous ulcer healing. However, if the nurse knows that the patient will not tolerate this intervention, s/he must explore alternatives to suit the patient's needs. The uniqueness of the patient ultimately determines his or her response to empiricist findings; therefore, the nurse must know and understand the individual patient's beliefs and abilities. Respecting the patient's beliefs and wishes may conflict with the nurse's professional opinion regarding the treatment,

provoking further consideration of what ought to be done to achieve a positive patient outcome.

Carper's (1978) paper concludes with a discussion of the interdependent nature of the four patterns of knowing. She asserts that no pattern of knowing is sufficient on its own. Rather the four patterns of knowing collectively inform ethical decision-making, whereby scientific explanations are considered in terms of patients' preferences and personal circumstances by an empathetic nurse. Interestingly, Carper's paper resembles contemporary discussions on EBP whereby the best available evidence from systematic research (empirics) is integrated with individual clinical expertise (esthetics) and patient preferences (personal knowledge) to make the right decision (ethics). Whilst Carper acknowledges that nursing depends on the four patterns of knowing, she reiterates that some questions may not be answered by these patterns of knowing as knowledge is constantly revised and modified based on new information, necessitating further research and insight. Carper does not refer to the term 'evidence based practice', yet her insights into different sources of knowledge necessary to inform nurses' decision making resemble many of the arguments presented by Sackett et al. (1996). Nurse theorists continue to explore nurses' use of knowledge to inform their clinical decision-making.

Estabrooks (1998) conducted a survey with practicing nurses (n=600) in Canada to determine the frequency with which nurses used various sources of knowledge including personal, ethical and empirical. The findings illustrate that nurses relied heavily on their pre-registration nursing education as a source of knowledge. In relation to EBP, Estabrooks (1998) concludes that clinical practice is complex and

the ability to decipher evidence and match it to the context of a given situation is a critical attribute of the registered nurse. Whilst Estabrooks (1998) does not refer to the question posed in the title of her article *'Will evidence-based nursing practice make practice perfect',* she does recommend that nurses develop critical thinking skills as a matter of urgency, enabling them to appraise scientific evidence in the context of the given situation. The dangers of relying solely on clinical experience as a source of knowledge to inform clinical decision-making are highlighted by Estabrooks (1998) and relate to one's selective memory of interventions that had 'unusually good or unusually bad outcomes' for patients (Estabrooks 1998, p.29). Therefore, nurses should combine different sources of knowledge including empirics, personal knowledge and ethics to inform their decision-making.

In America, some nurse theorists do not relate the development of EBP in nursing to EBM, stating the drive for EBM paralleled with nursing efforts to achieve EBP in nursing (Titler et al. 2001). Other American theorists define EBP in nursing as an off shoot of EBM, whereby EBP in nursing is defined as a problem solving approach to practice, incorporating evidence from quantitative and qualitative studies, patients' preferences, and clinicians' expertise, in order to make the best decisions about patient care within the context of caring (Melnyk and Fine-Overholt 2005). Less is written about the development of EBP in nursing in the United Kingdom, although Kitson (1997) took the lead with her influential paper exploring the position of nursing in relation to EBM. Acknowledging at the outset the need for a clear distinction between EBM and clinical effectiveness, Kitson (1997) proceeds to examine assumptions upon which EBM is based. These assumptions state that clinicians directly influence patient outcomes; hence, clinicians assume full

responsibility for their practices and clinicians base their practice on scientific evidence. Kitson (1997) purports that these assumptions equally apply to nursing practices; however, she cautions that the rules of EBM relate to medical diagnosis, single clinical interventions and randomised controlled trials. For nurses to subscribe to the EBP movement, the title EBM must be changed to EBP, necessitating a re-writing of the rules underpinning EBM. Subsequently EBP would involve true inter professional collaboration with the ultimate aim of achieving patient centred outcomes, incorporating pharmacological and non-pharmacological interventions (Kitson 1997).

The development of EBP in nursing lacks consensus in the literature. Some American theorists (Titler et al. 2001) argue that evidence based practice in nursing developed in tandem with EBM, whilst other writers suggest that EBP in nursing is an offshoot of EBM. Lack of consensus regarding evolution of the concept is matched with theoretical arguments aiming to clarify EBP in nursing.

2.5 Defining and critiquing Evidence Based Practice (EBP) in nursing

Academic literature pertaining to the development of the concept of EBP in nursing is littered with cautionary notes and warnings for the nursing profession regarding the esoteric nature of the concept 'evidence'. Consequently nurse theorists across the globe continue to define and critique EBP in nursing.

Dobbins et al. (2007) conducted semi-structured interviews among senior decision makers in public health units in Canada (n=6) in an attempt to define evidence-based decision-making. The rationale for this qualitative study stemmed from their belief

that the first step in meaningful engagement with EBP is to develop a working definition of the process. The agreed definition considers 'evidence-based decision making as a process whereby multiple sources of information, including research evidence, were consulted before making the decision' (Dobbins 2007, p.158).

Likewise, Kitson (2002) re-defines EBP as an attempt to reconcile tensions between the narrow definition of 'evidence' adopted particularly by the EBM movement, and the patient centred ideology, which dominates the health service. Kitson (2002) highlights the importance of posing clinical questions, acknowledging that randomisation as a gold standard for evaluating the effectiveness of healthcare interventions, is limited. Practitioners need to consider the research question being asked in the context of why certain things happen and how they happen, thus paving the way for other approaches such as qualitative studies that explore the effectiveness of interventions from patients' perspectives (Kitson 2002).

Whilst EBP in nursing seeks to answer clinical questions using both quantitative and qualitative studies, the Randomised Controlled Trial (RCT) retains its place at the top of the hierarchy. Expert opinion and qualitative research are often denigrated to the bottom of the hierarchy by the proponents of EBP in nursing (Titler et al. 2001; Melnyk and Fine-Overholt 2005). It is at this stage that defining evidence-based practice often evolves into a critique of the concept of 'evidence'.

Stickley and Phillips (2005) assert that the tenets of EBP may appear laudable on the surface but they pose a fundamental question regarding what constitutes evidence. With backgrounds in mental health nursing they acknowledge the relevance of

evidence and trials for pharmacological interventions; however, caring for patients in therapeutic relationships is less easily quantified. Stickley and Phillips (2005) caution that EBP cannot be authoritatively applied to the human experiences between mental health nurses and their clients. Ultimately practice must be based on credible and valuable knowledge whether this knowledge is based on findings from empirical research or practice wisdom. Practice wisdom is defined as 'the ability to base sound judgements on deep understandings in conditions of uncertainty' incorporating 'distinctive knowledge production processes', the ability to make reasoning explicit and a credible knowledge base (O'Sullivan 2005, p.222). Therefore, the notion of absolute truth or certitude is replaced with a more open and flexible approach to knowledge acquisition. In fact O'Sullivan (2005) recommends using 'knowledge based practice' as distinct to 'evidence based practice', enabling a more open approach to determining credible and valuable knowledge (pg 233). Likewise Higgs and Jones (2000) propose that 'evidence based practice' be considered as 'knowledge' derived from a variety of sources, which have been tested for dependability in contributing to decision-making.

More recently two leading nurse theorists in the UK engaged in a critical discussion to explore and learn about EBP (Rolfe and Watson 2008). This lively debate between Gary Rolfe and Roger Watson, published as a series of emails between the two academics, presents two differing perspectives on evidence-based practice. Rolfe claims that EBP, which evidently challenges ritualistic practice, is itself uncritical, unquestioning and unevaluated (Rolfe and Watson 2008). Rolfe rejects the adoption of EBM to nursing arguing that the technical elements of medicine, such as prescribing a drug, although requiring the use of scientific evidence, is less

useful as a nursing intervention (Rolfe and Watson 2008). Watson, on the other hand, argues that nurses have long defied the medical model, implying that EBP in nursing differs to EBM. Watson admits he finds the RCT limiting in nursing but proposes other methods to evaluate nursing interventions, including new hierarchies of evidence that rate qualitative research (Rolfe and Watson 2008). The debate evolves into a heated argument regarding decision-making based on intuition versus scientific evidence with Rolfe favouring intuition whereby 'decisions are taken on the accumulated authority and expertise of many years of reflective practice' (Rolfe and Watson 2008, p.490). Rolfe steers the discussion back to the fundamental question of effectiveness in a 'messy and unpredictable' clinical setting (Rolfe and Watson 2008). Rolfe suggests that nurses engage in action research and structured reflection to generate knowledge from practice in order to ensure effectiveness. Watson agrees that action research conducted in the clinical setting is desirable; however, he questions nurses' abilities to engage in such practices (Rolfe and Watson 2008). Regrettably, the critical discussion dissipates to a convergence of positions with neither theorist 'totally convinced about EBP' (Rolfe and Watson 2008, p.492).

Pearson, Field and Jordan (2007) present the Joanna Briggs Institute (JBI) framework for EBP whereby 'evidence' is defined as 'the basis of belief, the substantiation or confirmation that is needed in order for us to believe that something is true' (pg. 19). Evidence is assessed in relation to feasibility, appropriateness, meaningfulness, and effectiveness (FAME), and any indication that a practice is feasible, appropriate, meaningful or effective, whether derived from

experience or scientific research, is considered as evidence (Pearson, Field and Jordan 2007).

> Feasibility relates to evidence about the extent to which an intervention is practical. Appropriateness relates to the extent to which evidence is ethical or culturally apt, Meaningfulness relates to the personal opinions, experiences, values, opinions, beliefs, thoughts, beliefs or interpretations of clients and their families or significant others. Effectiveness relates to evidence about the effects of a specific intervention on specific outcomes' (Joanna Briggs Institute 2008).

This broad approach to defining evidence is appealing as the FAME framework enables practitioners to judge and rate the evidence. However there is a real risk of reverting back to decision-making based on intuition should the practitioner truly believe the intervention to be feasible, appropriate, meaningful, and effective without consideration of the empirical evidence or the patient's perspective.

2.6 Evidence-Based Practice in Ireland: Policy

Irish policy documents and strategies, including the Report of the Commission on Patient Safety and Quality Assurance (Government of Ireland 2008), recognise that EBP must be embedded and supported throughout healthcare in Ireland. In the current climate of concern about effectiveness of practice and risk reduction, the term 'evidence' meets political and organisational requirements in terms of implied consistency and quality patient care. The Report of the Commission on Patient Safety and Quality Assurance, *Building a Culture of Patient Safety'*, articulates the vision of the Irish heath system as

> 'knowledgeable patients receiving safe and effective care from skilled practitioners in appropriate environments with assessed outcomes' (Government of Ireland 2008, p.3)

The Commission on Patient Safety and Quality Assurance proceed to define EBP as a component of evidence-based healthcare comprised of three stages:

> ‘producing evidence; making evidence available; using evidence for decisions regarding individual patients (evidence-based clinical practice and evidence-based patient choice) or for populations or groups of patients (evidence based public health and health service management’ (Government of Ireland 2008, p.148).

A number of recommendations aimed at ensuring the implementation of evidence-based practice in Irish healthcare are outlined by the Commission on Patient Safety and Quality Assurance including:

> ‘A leadership role in relation to the analysis of international evidence and research, and to the production of evidence-based information and guidance for use in policy making, system reform, and individual patient and professional interactions should be developed…’(Government of Ireland 2008, p.151).

The Department of Health & Children endorse this report and an Implementation Steering Group was established to drive the implementation of its recommendations (Department of Health & Children 2009a). There is no doubt that EBP remains high on the agenda at all levels throughout the Irish healthcare system and the quest continues to deliver a safe and high quality service.

The Health Research Board (HRB) in Ireland published the *HRB Strategic Plan 2010-2014* (HRB 2009) with one of its main goals ‘to build and develop models designed to help establish evidence-based healthcare in Ireland. A four-step ‘Evidence-based healthcare cycle’ is presented (HRB 2009, p.21). Although the Health Research Board implies that consideration is given to ‘all valid, relevant, national and international research or information at that time’ (HRB 2009, p.20), emphasis is on research as the main source of evidence. At the outset the HRB could be accused of adopting a context free approach to evidence-based practice whereby a logical and linear sequence is anticipated to achieving evidence-based healthcare; however, the objectives outlined to achieve their goal implies recognition of the complexity of their ambitions. It is worrying however that the patient is not

represented in the 'Evidence-based healthcare cycle' (HRB 2009), and no reference is made to other forms of evidence such as clinical judgement or expert knowledge. Nonetheless, the Department of Health & Children in its *Action Plan for Health Research 2009-2013* recognise the need to 'increase the proportion of funding assigned to high quality patient focused research projects and programmes and research into evidence-based care' (Department of Health & Children 2009b, p.30).

The National Council for the Professional Development of Nursing and Midwifery (NCNM) supports 'use of clinical practice guidelines to assist clinicians in getting evidence into practice' (NCNM 2009, p.3). This guidance document provides nurse managers and nurses in clinical practice with a framework for adopting / adapting clinical guidelines to implement EBP. The document advocates the adaptation of existing international standards such as National Institute for Health and Clinical Excellence (NICE) standards and guidelines published by the National Health Service in England. These recommendations and guidance information are certainly welcomed as nurse managers and practising nurses spend vast amounts of time duplicating protocols and guidelines, which have been developed nationally and internationally and are available for adoption or adaptation. Paradoxically the literature indicates that availability of protocols and guidelines does not guarantee evidence-based practice (Marchionni and Ritchie 2008; Gifford et al. 2011). Whilst the National Council guidance document is very informative, assisting nurse managers and nurses to avoid duplication of work, it does not address the broader elements of evidence-based practice such as the context (Rycroft-Malone 2008a; Kitson et al. 2011) or the arguments against organisational adherence to protocols and guidelines (Holmes et al. 2008).

According to the Health Service Executive (HSE) 'the implementation of evidence-based practice through use of recognised standards, procedures and guidelines should be promoted by the organisation as a matter of policy' (HSE 2009b, p.36). A *Quality and Risk Management Standard* (HSE 2007a) incorporates criteria to facilitate the development of policies, protocols and guidelines using the best available evidence. Guidance for meeting the criteria includes the provision of support and guidance for staff on the 'sourcing, appraising and implementation of evidence based practice' (HSE 2007a, p.7).

2.7 Impact of evidence-based practice on patient outcomes

It is unclear from the literature whether an EBP approach to decision making enhances the standard of nursing care. Whilst nurse theorists in the US (Titler et al. 2001) promote an EBP approach similar to EBM, nurse theorists in the UK (Nolan and Bradley 2008; Reed and Lawrence 2008; Rolfe and Watson 2008; Rycroft-Malone et al. 2009) are not convinced that this approach to EBP results in better outcomes for patients. Greenhalgh and Russell (2009) explore evidence-based policy-making in the context of the different paradigms that exist within social research. They compare evidence-based policy making to assumptions associated with positivism and the associated belief that evidence-based policy-making follows a logical and linear sequence of events in a controlled environment. However, policymakers cannot isolate the current reality that exists including everyday practicalities such as available resources (Greenhalgh and Russell 2009). Recognising the need for robust clinical trials, well-designed research studies, and indeed the hierarchy of evidence to guide clinical practice, the aforementioned authors caution policy makers and practitioners that this information will not inform

them of the right policy in any particular situation. In their view, the context and circumstances of the situation, and the overall goal of an effective patient outcome, must be taken into consideration.

2.8 Summary and Conclusion

The historical development of Evidence Based Practice (EBP) traces the concept back to the 17th Century when Pierre Louis questioned routine medical practices such as leeching, however Pierre Louis was not confident enough to ban such practices, as doctors relied on these routines to treat their patients. The subsequent development of mass volumes of research in the latter part of the 20th century led to the formation of the Evidence Based Medicine Working Group (EBMWG 1992) endeavouring to organise masses of information to inform medical decision-making. Much of the literature states that professions, including nursing, followed the EBM model and subsequently adopted the mantra of the EBMWG. On the contrary, EBP in nursing could be linked to Carper's (1978) four fundamental patterns of knowing, which in Carper's view informs nurses' decision making.

Whilst the ingredients for evidence-based practice are monotonously debated in contemporary literature, there is no consensus regarding a recipe for ensuring evidence-based practice. However, the Department of Health & Children in Ireland are committed to supporting evidence-based practice.

The next chapter further explores contemporary views, incorporating the development and testing of instruments to measure attitudes towards EBP, barriers to EBP, and further perspectives on what constitutes evidence in evidence-based

practice. The Health Service Executive's position on EBP is further explored, ultimately focusing on the role of the Clinical Nurse Manager and evidence-based practice.

CHAPTER THREE: LITERATURE REVIEW

3.1 Introduction

Having explored the evolution of Evidence-based Practice (EBP) it is evident that there is still much debate and confusion in contemporary literature regarding the concept. Despite any real agreement of what constitutes EBP, the quest continues at political, organisational and individual levels to ensure EBP is achieved. The nursing profession across the globe has embraced EBP, and professional bodies present EBP as a core competency for the practising nurse (ANMC 2006; An Bord Altranais 2010).

This chapter appraises research studies, which explore factors that influence nurses' understanding and use of EBP, including the types of evidence that nurses use to inform their clinical decision-making. Literature exploring the barriers to, and facilitators of research and EBP, and models to promote the use of EBP, are examined.

3.2 Sources of evidence used by nurses to inform their clinical decision-making

Nurse theorists utilise a variety of research methods to gain insight into the sources of evidence, which inform nurses' clinical decisions (Estabrooks 1998; Thompson et al. 2001; Rycroft-Malone et al. 2004a; Estabrooks et al. 2005; Mi Mhaolrunaigh and O'Leary 2007; Gerrish et al. 2008; Yadav and Fealy 2012a). The findings from these studies are presented in Table 3.1.

Table 3.1: Studies that explore the types of evidence nurses use to inform their decision-making.

Author (s)	Aim of study	Population	Methods	Findings
Estabrooks 1998 Canada	To determine the types of knowledge nurses use in their nursing practice	Nurses (n=600)	Survey	The two most frequently used knowledge sources were experiential (information from the patient and personal experience of nursing), followed by knowledge from their basic education and workplace sources.
Thompson et al. 2001 UK	To examine those sources of information which nurses find useful to inform their clinical decisions	Nurses	Case study design Two phases to data collection Semi-structured interviews (n=108) 180 hours of observation; Audit of documents /ward resources; Q sorts and Q methodological modelling (Pg. 13).	Perspective one: The humanists. Nurses considered human sources as most accessible and trusted source of evidence. Perspective two: Local information for local need, which related to local sources of information including experienced colleagues, clinical nurse specialists and link nurses. The need for closeness to ward teams was emphasised. Also important were ward files and notice boards Perspective three: Local protocols and guidelines and databases were relatively accessible. Librarians were not considered a resource for clinical problem solving. All perspectives considered the nurse-managerial structure as not easily accessible for resolving clinical uncertainty.
Rycroft-Malone et al. 2004b UK	To establish if 'evidence', 'context' and 'facilitation' represent key elements of a framework for implementing evidence-based practice. These same three elements constitute the *Promoting Action on Research Implementation in Health Services* (PARIHS) framework as developed by Kitson et al. (1998) and refined by Rycroft-Malone et al.	Practice Development Nurse Experts (focus group one n=7) (focus group two n=5)	Phase one consisted of two focus groups informing the development of a semi-structured interview guide for phase two of the study. Phase two of the study utilised a case study approach in two sites that met specific	The findings indicate that research may not be available to inform practice; therefore other forms of evidence including findings from clinical audit, patients' experiences, and professional knowledge are combined to support clinical decision-making. As regards 'context', the findings highlight that the 'evidence' must be relevant and fit the organization's priorities with a multi disciplinary focus, increasing the chances of successful implementation.

	(2002).		criteria including 'the ongoing or recent implementation of a change project.	
Eastabrooks et al. 2005 Canada	To describe knowledge sources of staff nurses To describe the frequency of use of knowledge sources To determine if patterns of knowledge preferences correlate to research utilisation scores Profile knowledge source patterns over time	Staff nurses	Survey administered twice (n=230). Interviews Focus groups Cross study comparisons	Individual patient information and personal experience in nursing tied as the top sources of knowledge used by nurses in daily practice. Relative under use of journals, text books and the internet
Egerod & Hansen 2005 Denmark	To determine the sources of knowledge nurses rely on when making clinical decisions	Nurse managers (n= 27) Staff nurses (n=41)	Survey which was validated by conducting a pilot study	Danish nurses primarily rely on personal experience to inform their decision-making.
Mi Mhaolrunaigh & O'Leary 2007 Ireland	To evaluate nurses' use of research based evidence in their decision-making, specifically focusing on how nurses sought and used different information sources.	Phase 1: Registered nurses were interviewed from Acute Hospitals (n=10), Community Hospitals (n=5), Intellectual Disabilities (n=5), Mental Health (n=6) and Public Health (n=3). Phase 2: Survey (n=377).	Qualitative phase: Nurses analysed vignettes and were interviewed. Quantitative phase: Survey developed from findings of phase 1.	Conceptual continuum to inform nurses decision-making whereby research is at one end of the continuum and information from previous experience or colleagues referred to as 'experiential knowledge' at the other end. Findings from phase 1 indicate that nurses refer to human sources of knowledge (eg colleagues) rather than research articles to inform their decision-making. Information sought from clinical guidelines, Clinical Nurse Specialists, or study days are referred to as indirect sources of research and were used by participants to inform their decision-making.

Gerrish et al. 2008 UK	To compare factors influencing the development of evidence-based practice identified by junior and senior nurses.	Registered nurses in two hospitals in England (n=598).	Data were collected in section 1of the Developing Evidence Based Practice Questionnaire (DEBP) (Gerrish et al. 2007)	The findings indicate that nurses seek evidence to support decision-making from experiential sources including patients and fellow professionals in addition to education programmes and clinical guidelines Senior nurses were more likely to access research publications and organizational information than their junior colleagues.
Spenceley et al. 2008 Canada	To determine what information sources registered nurses use, to support patient care	32 research articles	Integrative review of the literature	Nurses frequently turn to human sources of information such as context specific interaction with colleagues around clinical issues. However the complexity of decision-making is acknowledged and recognition is given that sources of information cannot be studied in isolation of the desired outcomes of the information use.
Scott et al. 2008 Canada	To explore how organisational context influences nurses use of research	Nurses, nurse leaders, physicians, allied healthcare professionals (n=29) working in a paediatric critical care unit	Ethnographic study using in-depth observations (over a 7 month period) and interviews	Uncertainty arises from various sources: 1. The patients are extremely ill 2. Work differs from day to day and sometimes hour to hour 3. Numerous healthcare professionals work together to care for these vulnerable patients 4. Nurse managers and physicians often differ in their approach to patient care Nurses tended to rely on the immediately available knowledge gained from clinical experience rather than on research. Clinical experience provides timely, context-specific answers to specific patient-focused questions (the "tried and true"), whereas research, often both unknown and less accessible to them, can only offer broad principles. Thus, research might increase uncertainty rather than decrease it (pg. 351).

James et al. 2010 Sweden	To examine which forms of knowledge are used and how knowledge is constructed in daily work	Nurses and assistant nurses	Ethnographic and hermeneutic approach: Participant observation (285 hours) Informal conversations (190) Interviews with nurses (n=14) Interviews with assistant nurses (n=11) Review of job descriptions and department guidelines.	Nurses' ways of constructing knowledge in their daily lives involved life long learning where episteme (empirical knowledge or knowledge connected to science/research), techne (knowledge of the art of nursing, combination of action and reflection) and phronesis (moral deliberation concerning which actions are least harmful, practical knowledge or wisdom) are intertwined. In other words, research, skill or art of nursing and moral considerations are combined to inform nurses decision-making.
Yadav & Fealy 2012a Ireland	To investigate nurses sources of knowledge or evidence for practice	Psychiatric nurses (n=145).	The Developing Evidence Based Practice Questionnaire (DEBP) (Gerrish et al. 2007).	The most frequently used source of knowledge was ' I learn about each patient as an individual'. 'My personal experience', MDT members discuss with me, Local policies and protocols ranked second, third and fourth as sources of nurses knowledge. Nurses rely more on local and experientially derived sources of knowledge than empirical derived sources.

Whilst some researchers engage in qualitative research (Thompson et al. 2001, Estabrooks et al. 2005, Mi Mhaolrunaigh and O'Leary 2007), the majority rely on questionnaires to gain insight into the types of evidence used by nurses. Yadav and Fealy (2012a) highlight the importance of combining different sources of evidence to achieve satisfactory patient outcomes, yet it seems that nurses rely heavily on their previous experiences and colleagues, referred to as experiential knowledge, to inform their decision-making (Mi Mhaolrunaigh and O'Leary 2007). There is no doubt that nurses prefer to base their decisions on knowledge received from patients and colleagues (Estabrooks 1998, Thompson et al. 2001; Estabrooks et al. 2005) which they consider trust worthy, timely, and context specific (Scott et al. 2008). Use of empirical research as a source of knowledge is less evident among nurses. Rycroft-Malone et al. (2008) contribute this to a lack of available research to inform nurses' decisions.

In Ireland, The Nursing and Midwifery Planning and Development Unit, Health Services Executive South (Cork & Kerry) commissioned a study in 2007 to evaluate nurses' use of research based evidence in their decision-making, specifically focusing on how nurses sought and used different information sources (Mi Mhaolrunaigh and O'Leary 2007). The findings are presented as a conceptual continuum, with experiential knowledge at one end of the continuum and research at the other end. The research end of the continuum was utilised less frequently, with nurses rarely accessing direct sources of research such as databases or journals. Mi Mhaolrunaigh and O'Leary (2007) acknowledge the limitations of predominately accessing experiential knowledge to inform decision-making stating that 'confusion existed between best practice and common practice' (p.92). 'Best practice' from

participants' perspectives was 'doing what everyone else was doing', with little insight into the limitations of not questioning routine or 'common practice' (Mi Mhaolrunaigh and O'Leary 2007).

Findings from research studies conducted in Ireland, Canada and the UK concur that nurses rely heavily on readily available knowledge gained from past experiences, colleagues and patients, rather than research, which is perceived as less accessible.

According to Scott et al. (2008) 'uncertainty' influences nurses use of evidence whereby 'uncertainty is a cognitive state of being unable to anticipate the meaning and/or the outcome of an experience' (Scott et al. 2008, p.353). Uncertainty is associated with the unpredictable nature of nurses' decision-making, multidisciplinary team working and associated challenges including conflicting opinions within the team. To avoid uncertainty nurses evaded decision-making by complying with nurse managers or physician instructions. Referred to as the 'zone of safety' nurses did what they were told, focusing on perfecting rather than questioning routines (Scott et al. 2008, p.355). Similarly, the crux of Mi Mhaolrunaigh and O'Leary's (2007) study relates to 'non-questioning of routine practices and subsequent use of non-evidence-based practice' (p.92). Whilst these findings are not substantiated with findings from either phase one or phase two of their study (Mhaolrunaigh and O'Leary 2007), the non-questioning of routine practices could be linked to the 'zone of safety' (Scott et al. 2008). Nurses favour the familiarity of routines, basing their decisions on instructions from managers and other members of the team.

Knowledge from previous experiences, colleagues, and patients inform nurses' decision-making with research the least dominant source of evidence. Barriers to research utilisation continue to intrigue nurse researchers as they endeavour to gain insight into the complexities associated with nurses' decision-making.

3.3 Barriers and facilitators of Evidence Based Practice (EBP)

It was the early 1980s when nurse theorists in Ireland and the UK began investigating research utilisation (Myco 1981; Hunt 1987). Since then a plethora of research studies exploring the barriers and facilitators of research utilisation has been published. It is reasonable that studies conducted in the 1990s focused on research utilisation, as the mantra of EBP only became audible in the late 1990s. Nurse theorists (Funk et al. 1991; Closs et al. 1999; Parahoo 2000), recognising the importance of underpinning nursing practice with scientific research, endeavoured to identify key barriers and facilitators to research utilisation. The authors anticipated that this information would result in enhanced use of nursing research to inform clinical decision-making. Healthcare systems subsequently evolved with EBP becoming common parlance. Many researchers, (Hutchinson and Johnston 2004; McKenna, Ashton and Keeney 2004; Olade 2004), whilst acknowledging the difference between research utilisation and EBP, proceeded to investigate the barriers to, and facilitators of research utilisation. Others (Stickland and O'Leary-Kelley 2009; Timmins, McCabe & McSherry 2012) refer directly to EBP but deliberately choose to focus on factors that influence research utilisation, assuming that an understanding of the barriers to research utilisation will inform the broader application of EBP. A small sample of this research is presented in Table 3.2

Table 3.2: Studies that explore barriers to, and facilitators of, EBP

Author (s)	Aim of study	Population	Methods	Findings	Primary focus
Myco F. 1981 Northern Ireland	To assess the degree to which those most concerned with administering, managing and teaching patient care were managing to implement information on nursing research**.**	Senior nurse tutors (n=26); Nurse tutors (n=31); Clinical Teachers (n=73); Nursing Officers (n=118); Charge Nurses (n=500)	Questionnaire	Participants have not yet begun to identify to any great extent the importance of research to nursing practice, or the need to devise a process through which research can be implemented and evaluated.	Research
Hunt M. 1987 UK	To assist nurse teachers to source, appraise and implement evidence into clinical practice	Groups of nurse teachers (n=2) consisting of nurse teachers (n=7) and librarian (n=1) in each group.	Action research consisting of three phases: Sourcing the evidence; Evaluating the evidence; Implementing the findings into clinical practice	Implementation phase was as challenging as sourcing and evaluating the research. Challenges to implementation included: Resistance to change related to no incentive for making the required efforts to change; Left to the ward sister to implement the policy; The ward sister was accountable for all care therefore easier to stay with routine which worked rather than introduce change over which the ward sister had no control. Hence it is not sufficient to rely on individuals to introduce change, context and resources must be taken into consideration.	Research
Funk et al. 1991 US	To develop an instrument for the assessment of perceptions of barriers to the utilisation of research findings in practice	Practising nurses (n=1948)	29-item BARRIERS Scale, which was refined to 28 items following factor analysis.	Factor analysis utilised to develop 28-item BARRIERS scale. Four factors identified within the BARRIERS scale correlate with the four major concepts of Rogers model of innovation diffusion: Factor 1: Characteristics of the adopter (the nurse) Factor 2: Characteristics of the organisation Factor 3: Characteristics of the innovation Factor 4: Characteristics of the communication process	Research

Funk et al. 1995 US	To determine nurse administrators (managers) of the barriers to research utilisation and their perceptions of the factors that facilitate using research in clinical practice	Nurses who returned questionnaires in the 1991 study who were classified as Directors of Nursing or nurse administrators (n=414)	BARRIERS Scale Funk et al. (1991)	'The nurse is unaware of the research' ranked highest, followed by 'there is insufficient time on the job to implement new ideas'. 'Enhancing administrative support' and 'increasing research knowledge base are identified rank highest as facilitators to research utilisation.	Research
Parahoo 2000 Northern Ireland	To determine nurses' perceptions of barriers to, and facilitators of, research utilisation	2600 nurses in 26 hospitals. The response rate was 52.6% (n= 1368) 71.1% of the respondents were staff nurses, 10.5% were charge nurses/ward sisters, 5.3% were enrolled nurses, 3.5% were specialist nurses and the remaining 1.2 % were managers.	Survey using Funk et al.*'s* (1991) BARRIERS Scale. Parahoo made minor changes to terms used in the questionnaire including changing the word 'barrier' to 'obstacle'. Respondents were also afforded the opportunity to add perceived barriers not included in the scale and factors that might facilitate research utilisation.	Support from managers was ranked as a facilitator for research utilisation 'The nurse does not feel she/he has enough authority to change patient care procedures' was identified as the greatest obstacle to research implementation (pg 92)'. Another obstacle identified by nurses relates to doctors not co-operating with the implementation of research findings in areas such as wound care and pre-operative preparation, further restricting nurses autonomy regarding utilization of nursing research (Parahoo 2000). Other obstacles to research utilisation emerging in this study include 'the nurse's ability to evaluate research findings' and 'lack of time to source and read emerging nursing research' (pg. 92).	Research
Closs et al. 2000 UK	To identify key areas presenting barriers to the implementation of research into practice.	Registered nurses employed within two Yorkshire Hospitals (n=712).	Survey using Funk et al.*'s* (1991) BARRIERS Scale.	Greatest barriers to research utilisation were insufficient time to implement new ideas, doctors not co-operating with implementation, nurse does not feel she has enough authority to change patient care procedures.	Research

Crawford et al. 2002 UK	To determine the inhibiting factors or barriers to EBP	Community Mental Health Nurses	Focus group with six participants and Individual interviews (n=10)	Personal barriers related to nurses knowledge deficits in understanding and appraising research. Professional and ethical barriers related to custom and practice, negative consequences of relying on research versus clinical judgement and conflict between what the patient wants and what the research says. Organisation barriers related to the time factor, lack of resources including access to information, culture that opposes change. Authors infer that nurses may be purposefully avoiding EBP due to incompatibility between their daily practices and the mechanistic application of EBP methods.	Evidence Based Practice
Pallen & Timmins 2002 Ireland	To review the literature pertaining to the barriers to research utilisation		Review of literature	Development of a systematic framework using similar categories to the BARRIERS scale Funk et al. (1991) and the nursing process, to guide research utilisation.	Research
McCaughan et al. 2002 UK	To describe perceived and observed barriers to research utilisation	Nurses working in acute hospitals in three NHS Trust in the North of England	Qualitative interviews (n=108); Observation (180 hours) Statistical modelling Q methodology	Four perspectives on the barriers to research were revealed: Perspective 1: Confidence and products of research; Perspective 2: Organisational and cultural barriers Perspective 3: Prescription, Direction and Clinical Credibility Perspective 4: Individual scepticism and a desire to work through others	Research
Hutchinson and Johnston 2004 Australia	To establish nurses' perceptions of the barriers to, and facilitators of, research utilisation in the practice setting.	Nurses (n=317)	Survey using Funk et al.*'s* (1991) BARRIERS Scale.	Barriers to research utilisation included time constraints, lack of awareness of available research, insufficient authority to change practice, inadequate skills in critical appraisal and lack of support to implement research findings. Facilitators to research utilisation included availability of more time to review and implement research findings, availability of more relevant research and colleague support.	Define evidence based practice but focus is on research utilisation

McKenna, Ashton and Keeney 2004 Northern Ireland	To identify barriers to evidence-based practice in primary care.	General practitioners (n=203) and community nurses (n=259) from across Northern Ireland took part in the study.	Due to 'lack of fit' of existing tools, the authors developed a new Evidence-based Practice in Primary Care Questionnaire.	Findings indicate that general practitioners (GPs) differ in their perceptions of barriers to evidence-based practice in primary care. Whilst GPs consider the limited relevance of research to practice and the uncertainty created by conflicting results as significant barriers to evidence-based practice, community nurses perceive lack of computer facilities and patient compliance as significant barriers. Patient compliance is not perceived by GPs to be a major barrier to evidence-based practice.	Title refers to evidence based practice. Yet focus of study is 'Research'.
Glacken & Chaney 2004 Ireland	To ascertain what nurses & midwives perceive as barriers to, and facilitators of research utilisation	Staff nurses (n=112) CNM1 (n=9) CNM 2 (n=22) CNM3 (n=1) Others including Clinical Placement Co-ordinator and nurse practitioner (n=5)	Survey using Funk et al.*'s* (1991) BARRIERS Scale. Respondents were also afforded the opportunity to add perceived barriers not included in the scale and factors that might facilitate research utilisation.	'Perceived lack of authority' appears to be the most commonly cited barrier to research utilisation. 'Insufficient time on the job to implement new ideas' and 'insufficient time to review research were ranked second and third respectively. Committed managers who empower their staff to strive to deliver evidence-based care and to question their practice and inter-disciplinary team working are cited as facilitators to utilising research in practice.	Research
Olade 2004 US	To identify barriers to research utilisation	Nurses working in rural setting (n= 106).	Questionnaire, which was designed by the investigator and verified for content validity by two doctoral nurses, two RNs and a sociologist.	Barriers to research utilisation included lack of time due to poor staffing, lack of research knowledge, lack of interest by nurse managers, lack of experienced nurses to serve as role models.	Research

Fink et al. 2005 US	To identify nurses perceived barriers and facilitators to nurses use of research in practice to determine which factors are correlated with research utilisation	Nurses (n=215) completed the pre-intervention survey and nurses (n=239) completed the post intervention study. The intervention related to access to a user-friendly manual to facilitate learning about evidence based practice and research.	The BARRIERS scale (Funk et al. 1991) and the Research Factor Questionnaire were administered pre and post the intervention.	The Barriers related to difficulty in changing practice, lack of administrative support and mentoring, insufficient time, and lack of education on the research utilisation process. Participants commented on their lack of knowledge on statistical analysis, inability to critique research, difficult to analyse studies and lack of familiarity regarding latest research. Identified facilitators of research included exposing staff to relevant research and interactive education that enabled staff to critique research findings and discuss their application to clinical practice.	Research
Egerod & Hansen 2005 Denmark	To compare nurse managers and staff nurses self reported attitudes towards and knowledge of EBP	Nurse managers (n= 27) Staff nurses (n=41)	Survey which was validated by conducting a pilot study	Barriers to evidence based practice include inadequate education, unfamiliarity with English, and low organisational position. Facilitators include implementation of guidelines, provision of continuing education and an increase in the accountability of bedside nurses.	Evidence-based practice
French 2005 UK	To specify contextual factors affecting UK nurses' practical reasoning about whether to use research during the construction of policy for a range of nursing practices	Clinical Nurse Specialists (n=27); Nurse Managers (n=8); Practice Development Nurses (n=3); Staff nurses (n=7); School Nurses (n=3).	Constructionist approach whereby group discussions on policy development (n=3) were recorded and analysed.	Contextual issues influence evidence-based decisions. Contextual issues are described as: *The Clinical Context of Care*: Clients in different settings have varied needs and nurses have varied resources to utilise *The Team Context of Care:* The medical profession continue to influence nursing practices. *The Organisational Context of Care:* Reliance on practitioners to formulate policy. The Clinical Nurse Specialist organises, facilitates and makes links across professional, team and organisational boundaries. However the ability of the CNS to implement policy decisions was limited by lack of managerial responsibility for care. *The Wider Context of Care:* Influences of the wider health care context including resources	Research

Morris & Maynard 2006 UK	To evaluate nurses EBP skills following an EBP programme and the impact of this module on their clinical practices.	Nurses (n=191).	Multi method approach using survey (n=191) and interview (n=7).	These nurses identify 'lack of time' as a major inhibiting factor to adapting an EBP approach and much of their 'searching for information' is conducted outside of the workplace. In addition difficulties navigating the intranet and sourcing the information are identified as constraining factors. Lastly nurses perceive managers as unfamiliar with EBP, resulting in problems around the culture of EBP in the workplace.	Evidence-based practice
Brown et al. 2008 US	To explore nurses' practices, knowledge, and attitudes to evidence-based practice incorporating the perceived barriers and facilitators to EBP.	Nurses (n=458) working in an academic medical centre in California	Two questionnaires: BARRIERS scale (Funk et al. 1991) and the Evidence-Based Practice Questionnaire (EBPQ) (Upton & Upton 2006).	Themes representing greatest barriers to research utilisation were time, knowledge, support and culture. 'Time related to nurses lack of time to source and read research while 'on' or 'off' duty. Knowledge related to difficulty in finding and understanding research reports and applying relevant findings to practice. Culture related to implementing change in practice including resistance from other members of the team including doctors, in addition to resistance due to custom and practice. Learning environment, building culture and availability of evidence are identified as facilitators. Education alone was not enough to change practice, importance of putting the patient first and egos second; ensuring research is available and understandable.	Title refers to evidence based practice but focus of study is research.
Gerrish et al. 2008	To compare factors influencing the development of evidence-based practice identified by junior and senior nurses.	Registered nurses in two hospitals in England (n=598).	Data were collected in sections 2,3 and 4 of the Developing Evidence Based Practice Questionnaire (DEBP)	*Barriers to finding and reviewing the literature*: I do not have sufficient time to find research reports; I do not have sufficient time to find organizational information; *Barriers to changing practice:* There is insufficient time at work to implement changes in practice; *Support for changing practice:* My colleagues are not supportive of changing practice My managers are not supportive of changing practice.	Title refers to evidence based practice but focus of study is research.

Strickland & O'Leary-Kelley 2009 US	To determine clinical nurse educators perceptions of the barriers to research utilisation. To compare nurse educators perceptions of the barriers and facilitators to research utilisation with staff nurse, managers, and academics perceptions.	Clinical Nurse Educators (n= 122)	BARRIERS Scale (Funk et al., 1991)	Barriers to research include the nurse feels she lacks authority to change patient care procedures; time to implement new ideas; and nurse feels she is not capable of evaluating the quality of the research. Facilitators include colleague and physician support, resources, funding and network; management support and encouragement, employment of nurses with advanced degrees and research skills. The development of journal clubs and collaborative communication.	Research
Children Act Advisory Board (CAAB) 2009 Ireland	To provide a review of the literature on the barriers and facilitators to research use; To consult with staff regarding the extent of use of research, the barriers and facilitators to its use, preferred methods of dissemination To report on knowledge brokerage mechanisms pertaining to Irish Childrens Services	At a two-day seminar Focus groups (n=13) with representatives from health, welfare, justice, and community and voluntary groups providing child services (n=155). Questionnaire from participants who attended day two of the seminar (n=122).	International literature review on research utilisation issues; Elicit views of managers and practitioners on research utilisation; Review of relevant knowledge brokering mechanisms	'The use of research evidence in practice could be promoted by each of the main stakeholders involved, research commissioners, service provider organisations, and research providers; Strategies are required at national level to identify and address gaps in research and to facilitate the dissemination and integration of both Irish and international research that is relevant to children's services' (CAAB 2009: 97). Barriers to research utilisation included: Lack of time to read and to attend learning events were commonly identified barriers to individual research use; No funding, limited access to literature and lack of research materials were also cited as barriers.	Research
Brown et al. 2010 US	To explore the relationships between perceived barriers to research use and the implementation of EBP among nurses To investigate perceived barriers to research utilisation as the predictors of implementation of EBP	Convenience sample of nurses employed in four hospital systems (n=974)	Electronic survey using the EBPQ (Upton & Upton 2006) and the BARRIERS scale (Funk et al. 1991).	Barriers to research utilisation as measured by the BARRIERS scale have minimal influence over the implementation of EBP for nurses. This may be related to the busy schedules of nurses whereby research is far removed from their daily workload. However further research is required	Research utilisation measured using the BARRIERS scale and EBP measured using the EBPQ.

Timmins, McCabe and McSherry 2012 Ireland	To establish the attitudes towards research and levels of research awareness among Irish nurses with the objective of highlighting differences between nurses and nurse managers.	General nurses (n=221) of which 65.6% worked as staff nurses, 20% were employed as CNMs, remainder were ANPs/CNS	Self report survey using the Research Awareness Questionnaire (RAQ)	Barriers to research utilisation include lack of time, resources and staff shortages. Lack of knowledge of the research process is also identified as an obstacle. Nurse managers play a pivotal role in ensuring that research based nursing takes place.	Reference is made to evidence based practice yet the focus is on conducting and utilising research in practice.
Yadav & Fealy 2012b Ireland	To examine and describe barriers, facilitators and skills for developing EBP.	Psychiatric nurses (n=145).	The Developing Evidence Based Practice Questionnaire (DEBP) (Gerrish et al. 2007)	Barriers to EBP were ranked as follows: I do not have sufficient time to find research reports; Research reports are not easy to find; I do not feel confident in judging the quality of research reports. Facilitators to EBP were ranked as follows: Practice Development Co-ordinators /facilitators are supportive of my changing practice; Multidisciplinary team with whom I work are supportive of my practice.	Reference is made to evidence based practice yet the focus is on conducting and utilising research in practice.

Mapping the studies chronologically illustrates the dominance of quantitative methods using self-report surveys, focusing specifically on barriers to research utilisation. These studies were conducted in the UK, Ireland, Northern Ireland and the US with the aim of exploring nurses' perceptions of the barriers to, and facilitators of, research utilisation.

For the past twenty years, the BARRIERS scale (Funk et al. 1991) has guided data collection on research utilisation in nursing. The scale was devised in the United States, consisting of 28 items classified into four categories that 'translate into characteristics of the nurse, the setting, the research, and its presentation and accessibility (Funk et al. 1991, p.44). Participants who complete the BARRIERS scale (Funk et al. 1991) rate the items based on their perceptions of barriers to research utilisation, rather than their actual experience of research utilisation. Nonetheless, the BARRIERS scale has been utilised by nurse researchers (Glacken and Chaney 2004; Brenner 2005) and other health care professionals (Lyons et al 2011). In these studies, 'time' is consistently identified as a major barrier to research utilisation.

Of late, there is increasing scepticism regarding Funk et al.'s (1991) BARRIERS scale. Mi Mhaolrunaigh and O'Leary (2007, p.10) at the outset of their study, conducted to evaluate nurses' use of research-based evidence, consider the BARRIERS scale 'insufficient to address the questions posed for EBP today'. Kajermo et al. (2010) conducted a systematic review of research studies (n=66), which used Funk et al.'s (1991) BARRIERS scale. Whilst the review confirms reliability of the BARRIERS scale regarding ranking the order of the barriers,

validity of the scale is questioned. Kajermo et al. (2010) claim that non-specific wording of items in the scale limits its ability to delineate the problems with research utilisation. 'Time', for example, is consistently identified as a major barrier to research utilisation; however, the broad phraseology of the two items relating to 'time' provide little insight into what actually constitutes time barriers, and 'time is a complex phenomenon' (Kajermo et al. 2010, p.19). Whilst some researchers (Fink et al. 2005; Brown et al. 2008; Lyons et al. 2011) complement the BARRIERS scale with additional questionnaires for their respective studies, further descriptive studies using the BARRIERS scale are not advised, as they are 'unlikely to provide an accurate picture of the barriers that exist in the current clinical setting' (Kajermo et al. 2010, p.20).

McCaughan et al. (2002), recognising the limitations of self-report questionnaires, used mixed methods to gain insight into nurses' use of research in their clinical decision-making. Their findings presented four perspectives relating to the barriers to research utilisation. The four perspectives identified as 'products of research', 'organisation and culture', 'clinical credibility' and 'individual scepticism' resembles the four factors of Funk et al.'s (1991) scale. However, elements of McCaughan et al's (2002 pg 50) qualitative study elaborate on barriers associated with research utilization. 'Availability of time in practice' describes complex bureaucratic controls that prevent nurses using research in their clinical decision-making (McCaughan et al. 2002, p.52). Nurses interviewed as part of the study describe how straightforward changes in clinical practice, such as measuring a patient's urine in his/her toilet rather than going to the sluice room, involved a series of consultations with managers, consultants and infection control staff. Despite

gathering all the evidence to support the safer practice of measuring and emptying the urine into the patient's toilet, nurses were not allowed to proceed with the change. Hence the theme 'availability of time in practice' provides some insight into the complexities of not just sourcing the evidence, but the organisational and cultural barriers that influence use of best available evidence (McCaughan et al. 2002, p.52).

Addressing the need for research tools to examine factors influencing EBP as distinct from research utilisation, nurse researchers (Upton and Upton 2006; Gerrish et al. 2007) developed and validated questionnaires. Upton and Upton (2006) developed the Evidence-based Practice Questionnaire (EBPQ) to measure attitudes towards, knowledge of, and implementation of EBP. Two surveys were administered to nurses from hospital and community units across Wales (n=751), resulting in the development of the 24-item questionnaire. Having deemed the questionnaire reliable and valid to measure the implementation of EBP, the questionnaire was organised into three sub scales. The first subscale measures nurses' use of Sackett et al.'s (1997) five steps to EBP, incorporating formulation of clinical question, tracking down the evidence, appraising the literature, integrating the evidence into clinical practice and evaluating the outcome. The second sub scale measures nurses' attitudes, although it is unclear which items relate to this sub scale. The final subscale comprehensively examines nurses' skills. There is reference to the nurse's ability to review his/her own practice, in addition to research and information technology skills. Regrettably the steps to EBP are described as a logical and linear process, failing to capture the complexities involved for practitioners. Posing the

clinical question is certainly the logical first step; however, the reality of sourcing new evidence to answer the question from clinicians' perspectives is not addressed.

The availability of different types of evidence presents further challenges for practitioners as they strive to align this evidence with patient preferences and their own professional experiences and knowledge. Thus Sackett et al.'s (1997) logical and linear process is converted into a cyclical and revolving quandary that is further ambushed by influencing factors such as availability of resources and conflicts of interest. Hence studies that utilise EBPQ (Upton and Upton 2006) are tinged with scepticism, as these studies may not capture the reality of nurses' use of EBP. Furthermore, nurses' attitudes to EBP are explored based on statements such as 'workload', which have negative connotations. Since there are no positive attitude statements noted, research studies that utilise Upton and Upton's (2006) EBPQ will ultimately present negative attitudes towards evidence-based practice.

Rice et al. (2010) utilised the EBPQ (Upton and Upton 2006) to explore social workers' (n=180) attitudes towards, knowledge of, and use of EBP. Whilst the findings provide little insight into social workers attitude towards, knowledge of, and use of EBP, the EBPQ is deemed as 'demonstrating adequate psychometric properties in a sample of social workers' (Rice et al. 2010, p.170). It is interesting that Rice et al. (2010) justified their omission of item 1 of the EBPQ, which relates to 'workload', on the basis that the item 'did not fit well' with a sample of social workers. According to Rice et al. (2010, p.166), 'social workers are able to relate to workload demands and the impact these demands have on their daily activities'.

Geerish et al. (2007) conducted two studies in the UK to develop and validate their *Developing Evidence-based Practice* (DEBP) questionnaire. The first study involved hospital nurses (n=598) in two contrasting hospital sites during 2002-2003 and the second study sampled community nurses from twelve primary care teams (n=689) in 2005. At the outset Gerrish et al. (2007) acknowledge the lack of clarity regarding EBP, exclaiming that existing questionnaires focus on nurses' use of research as the dominant form of evidence. Consequently the authors expand Sackett's (1996) definition of research to incorporate national guidelines and local information such as protocols and audit reports. However, the reality of clinical decision-making is not reflected in four out of the five sections of the DEBP questionnaire, limiting its ability to inform the development of EBP. Section two of the DEBP questionnaire, for example, measures barriers to finding and reviewing evidence whereby evidence is defined in terms of research reports, policies, and guidelines. Patients' perspectives or professional opinions, as sources of evidence, are not considered. Although Gerrish et al. (2007) refer to two studies in their paper; the findings from either study are not presented. Yet the DEBP questionnaire is deemed to be 'a reliable instrument with ten identifiable factors, although it is not a single scale' (pg. 336).

Using the DEBP questionnaire, Gerrish et al. (2008) identify three categories of barriers relating to 'sourcing and reviewing the literature', 'changing practice', and 'supporting change in the clinical setting'. Significantly, lack of time for finding the evidence and implementing changes in practice re-emerge as major barriers to EBP. Likewise, Brown et al. (2008, p.377), using the EBPQ (Upton and Upton 2006) and the BARRIERS scale (Funk et al. 1991), echo similar findings in 'barrier and

facilitator themes'. One facilitator theme, 'building culture', suggests that research utilisation may be enabled by 'putting the patient first and egos second' (Brown et al. 2008, p.377), implying that a more collaborative approach to decision-making is required to facilitate EBP.

In summary, 'time' is consistently identified as a major barrier to research utilisation. Although the BARRIERS scale had guided research to date, its validity is now questioned, as further insights are required into practitioners' use of EBP. The recent development of questionnaires to explore nurses' use of EBP endeavour to include other forms of evidence including local policies and audit of clinical practice; however, findings indicate that lack of 'time' re-emerges as a barrier to EBP without understanding of what constitutes 'time' as a barrier to EBP. Nevertheless, theorists continue to develop models to promote the use of EBP.

3.4 Models to promote the use of Evidence Based Practice (EBP)

Researchers continue to develop and refine conceptual models that consider the myriad of influences on clinical practice within an organisational context (Kitson, Harvey and McCormack 1998; Haynes Devereaux and Guyatt 2002; Kitson et al. 2008; Satterfield et al. 2009). The medical profession presented their conceptual model of Evidence Based Medicine (EBM) as a Boolean diagram of concentric circles containing three categories of evidence, 'clinical expertise', 'research evidence' and 'patient preferences' (Haynes and Haines 1998). However, this model is criticised for its inability to explain the integration or application of the categories of evidence (Satterfield et al. 2009; Wyer and Silva 2009). Further revision of the model by Haynes, Devereaux and Guyatt (2002), with the addition of

'clinical state and circumstances', fails to enlighten practitioners regarding integration of these categories of evidence (Wyer and Silva 2009). The EBM model (Haynes, Devereaux and Guyatt 2002) fails to establish the relationship between 'what we know' (as determined by research, clinical expertise, clinical state and circumstances, patients preferences and actions) and 'what we do with what we know' (wisdom) (Wyer and Silva 2009, p.900). In contrast models and frameworks developed by nurse theorists endeavour to bridge the gap between what is known and its translation into effective patient outcomes.

In the United Kingdom, Kitson, Harvey and McCormack (1998, p.149) acknowledged the complexities associated with implementing research into clinical practice and subsequently developed a conceptual framework to represent three distinguishing but intertwining factors identified as the 'nature of evidence', 'the environment or context', and 'the facilitation or process of change'. This conceptual framework, '*Promoting Action on Research Implementation in Health Services* (PARiHS)', symbolises the interplay and interdependence between 'evidence', 'environment', and 'facilitation' factors, which impact on the utilisation of evidence in clinical practice (Kitson, Harvey and McCormack 1998).

The development and refinement of the PARiHS framework between 1998-2008 is presented in Table 3.3

Table 3.3 Development of the *Promoting Action on Research Implementation in Health Systems* (PARiHS) Framework (1998-2008).

Author(s)	Methodology	Propositions
Kitson, Harvey and McCormack (1998)	Case studies	• PARiHS has three key factors (elements) and sub elements • The factors/elements: ➢ Evidence (Sub elements: Research, Clinical experience, Patient preferences) ➢ Context (Sub elements: Culture, Leadership, Measurement) ➢ Facilitation (Sub elements: Characteristics, Role, Style) • Sub elements are rated *Low*_____*High* • If sub elements are judged to be at the high end of the continuum, successful implementation of the evidence is more likely. For example 'context' which incorporates 'culture', 'leadership' and 'measurement', scores at the 'high' end of the continuum when the environment is people centred, roles are clearly defined, with effective teamwork and leadership. On the contrary, 'context' rates at the 'low' end of continuum when culture is task driven, poor leadership, with little or no continuing education and an absence of audit or peer review • Evidence', 'context', and 'facilitation' are individually defined and relationships between the concepts are explored using case studies • 'Successful Implementation (SI) of research is a function of (f) the relationship between the nature of Evidence (E), the Context (C) within which the proposed change is to take place, and the mechanisms by which the change is Facilitated' (F) (Kitson, Harvey & McCormack 1998, p.150) or SI=f (E, C, F)
McCormack et al. 2002 UK	Concept analysis of 'Context'	• Context in its most simplistic form means the physical environment in which practice takes place, but this does not reflect the complexity of the concept • The themes 'culture', 'leadership' and 'measurement' are used to frame the concept analysis, capturing the complexity of factors that enable effective practice • Sub elements are rated *Weak* _____*Strong* • Context is rated at strong end of continuum when: Boundaries are clearly defined, decision making is transparent, power and authority is understood, appropriate resources,

		information and feedback systems in place, receptiveness to change • Culture is rated at strong end of continuum when: Able to define prevailing values and beliefs, values individual staff and clients, learning organisation is promoted, consistency of role/experience to value relationship with others, teamwork, power and authority, rewards and recognition. • Leadership is rated at the strong end of the continuum when: Transformational leadership, role clarity, effective teamwork, effective organisational structures, democratic inclusive decision-making processes, enabling/empowering approach to teaching/learning/decision-making. • Measurement (considered in terms of evaluation incorporating an eclectic multi-method approach) is rated at the strong end of the continuum when: Feedback on individual, team and system performance Use of multiple sources of information on performance Use of multiple methods of (clinical, performance, economic, experience) evaluation (Pg 98-100).
Harvey et al. 2002	Concept analysis of 'Facilitation'	• Facilitator role is about supporting people to change their practice. It is an appointed role from internal or external to the organisation in which the change is being implemented. • The role is about helping and enabling, rather than telling or persuading • The focus of the role may range from achieving a task to enabling team to change attitudes, habits, skills, ways of thinking and working; • Complex issues and lack of clarity does not enable definitive conclusions • Facilitation is rated *Low*_____*High* whereby High facilitation means appropriate mechanisms for facilitation are in place. Purpose, Role and Skills of facilitator are explored.
Rycroft-Malone et al. 2002	Concept analysis of the key elements of the PARiHS Model	• Three elements remain the same, however sub elements are refined with additional descriptors inserted on the continuum ➢ Evidence (Sub elements: Research, Clinical experience, Patient preferences) ➢ Context (Sub elements: Context, Culture, Leadership, Evaluation) ➢ Facilitation (Sub elements: Characteristics, Purpose, Role, Skills and attributes)

Rycroft-Malone et al. 2004b	Debate on the nature of 'evidence'	➢ Evidence (Sub elements: Research, Professional knowledge/ clinical experience, Patient experience and preferences, Local data and information)
Rycroft-Malone et al. 2004a	Exploratory research using focus groups (n=2) and semi-structured interviews (n=17) in two acute hospitals in the UK to validate the PARiHS model and establish factors that influence practitioners' use of evidence in clinical practice.	• 'Evidence', 'context', and 'facilitation' remain key elements in getting evidence into practice ➢ Evidence (Sub elements: Research, Clinical experience, Patient experience, Information from local context) ➢ Context (Sub elements: Receptive context, Culture, Leadership, Evaluation) ➢ Facilitation (Sub elements: Role, Skills and attributes)
Kitson et al. 2008	Discussion of the conceptual and theoretical thinking so far and introduction of the next phase of the development of the PARiHS model.	• 'The PARiHS model remains untested and therefore its contribution to the overall development of theory is largely unquantified' (pg. 1) ➢ 'Evidence (Sub elements: Research, Clinical experience, Patient experiences, and routine information. Melding and implementing evidence involves negotiating and developing shared understandings. It is a dialectical process) ➢ Context (Sub elements: Context, Culture, Leadership, Evaluation. Some contexts are conducive to the introduction of new ideas/innovations. It is the interplay of the elements and sub-elements that make implementation easier or more difficult. Big complex area operating at multiple levels. Important to be able to see the whole picture when changing practice) ➢ Facilitation (Sub elements: Purpose, Role, Skills and Attributes). Broad term describing the human support, guidance,

		learning, coaching offered by a trained facilitator when initial diagnosis of the 'readiness' of the individuals, team and context for the introduction of the innovation' (pg 7) • ' The notion that the framework becomes a diagnostic and evaluative measure on the evidence and context axes and informs the facilitation or intervention process has been an important development' (pg. 8). Therefore SI $\neq$ f (E, C, F) rather F is dependent upon E+C.

Whilst analysis and research (Harvey et al. 2002; McCormack et al. 2002; Rycroft-Malone 2004) resulted in changes to sub-elements, the elements of the PARiHS framework 'Evidence (E)', 'Context (C)' and 'Facilitation (F)', retain their validity, remaining unchanged. However, the relationship between the elements (E, C, F) has evolved. It is now proposed that PARiHS is a diagnostic and evaluative measure of E and C, which subsequently informs F (Kitson et al. 2008). The continuum, a dominant feature in earlier versions of PARiHS that ranked sub-elements as high or low based on specified criteria (Kitson, Harvey and McCormack 1998; Rycroft-Malone 2004), is extinct in Kitson et al.'s (2008) more recent refinement. Instead, users of the PARiHS framework are provided with draft questions to guide individuals or teams 'to rank the readiness of the team to embrace the new practice, evidence or innovation' (Kitson et al. 2008, p.8).

Accepting that further research is required, the authors plead with practitioners and researchers to utilise the revised PARiHS framework and engage in collaborative research to validate its use. Ten years on from its conception the language of the PARiHS model has changed from 'successful implementation of evidence equals' (Kitson, Harvey and McCormack 1998, p.150) to the complexities of knowledge translation (Kitson et al. 2008). Despite their refinements, Alison Kitson and Jo Rycroft-Malone retain the 'R' in PARiHS, implying that implementation of research remains their priority. However, having exhaustingly considered the hierarchy of evidence and integration of sources of evidence in their academic writings, surely 'R' could become 'E', whereby practitioners and researchers engaging in collaborative research to validate the model focus on *Promoting Action on Evidence Implementation in Health Services* (PAEiHS).

In the United States, the *Iowa Model of Evidence-Based Practice to Promote Quality Care* is a practical framework to enable nurses to infuse research into their clinical practices (Titler et al. 2001). Problem focused triggers and knowledge focused triggers initiate the process and nurses are encouraged to seek answers to clinical problems as they emerge in clinical practice for example 'management of a patient with urinary incontinence' or 'the risk of using bed rails'. An algorithm guides nurses through the process of seeking to resolve the triggers, resulting in changes in clinical practice and monitoring of outcomes (Titler et al. 2001). The change to 'evidence based practice' in the *'Iowa Model of Research-Based Practice to Promote Quality Care'* (Titler et al. 1994), related to the emergence of the term 'evidence' in nursing literature, and the need to distinguish research from other types of evidence (Titler et al. 2001).

In comparison to the PARiHS model (Kitson et al. 2008), the *Iowa Model of Evidence-Based Practice to Promote Quality Care* (Titler et al. 2001) assumes a logical relationship between evidence and context. Once the evidence is available, a guideline is developed, and the change is introduced without reference to challenges or the need for facilitation. From an Irish perspective, the PARiHS framework is a more realistic reflection of the challenges that currently exist in our healthcare environment. Surprisingly, the Research Strategy for Nursing and Midwifery in Ireland (Government of Ireland 2003) adapts Titler et al.'*s* (1994) *Iowa Model of Research-Based Practice to Promote Quality Care* as a framework for promoting the development of a 'research-based' culture in Ireland (p.37). It seems policy makers in Ireland support the American view that a step-by-step approach to the promotion of research based practice as presented in the 'Iowa Model for Ireland' will result in enhanced outcomes. Yet *Implementing Research-based Practice to*

Improve Quality of Nursing Care: Adaptation of the Iowa Model for Ireland (Government of Ireland 2003, p.37) has not been updated to incorporate the revised title whereby 'Research-based Practice' was replaced with 'Evidence-based Practice' by Titler et al. (2001).

In Canada, the Queen's Joanna Briggs Collaboration (QJBC) builds on the principles of the Knowledge to Action framework (Graham et al. 2006) to develop the QJBC Model for Activating Patient Safety evidence (MAPS) (Harrison et al. 2012, p.53). The focus of QJBC-MAPS is patient safety, incorporating analysis of incidents and risk management with its cyclical approach incorporating knowledge generation and application to practice. Barriers to knowledge utilisation form part of the QJBC-MABS, acknowledging that knowledge generated from analysis of incidents and risks may not necessarily result in knowledge use (Harrison et al. 2012). A key feature of the QJBC-MABS (Harrison et al. 2012) is the academic-practice partnership. Researchers and practitioners work together to achieve sustained knowledge use in clinical practice.

In comparison to the PARiHS model (Kitson et al. 2008) and the *Iowa Model of Evidence-Based Practice to Promote Quality Care* (Titler et al. 2001), the QJBC-MAPS (Harrison et al. 2012) focuses on patient safety. Nonetheless, there are many similarities between the three models including addressing clinical questions, sourcing valid evidence, and utilising evidence to support clinical practice. The academic-practice partnership underpinning the QJBC-MAPS (Harrison et al. 2012) is enticing, although availability of academics to engage in such collaboration dampens expectations of applying the QJBC-MAPS in Ireland. That said, the QJBC-MAPS (Harrison et al. 2012) provides useful guidance to policy makers and

clinicians regarding utilising evidence in practice as the partnership approach engages academics in supporting clinicians and managers to maintain patient safety by monitoring use of clinical knowledge.

Clinical guidelines are a key part of the QJBC-MAPS and the Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al. 2001), enabling synthesised research to be adapted to the local context. Guidelines are defined as 'systematically developed statements, based on a thorough evaluation of the evidence, to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances, across the entire clinical spectrum' (HIQA 2011, p.11). However, clinical guidelines do not feature as part of the PARiHS model (Kitson et al. 2008). In fact Kitson (2009) argues that 'guidelines are not literal objects, which are universally applied; rather they are complex mechanisms to stimulate discussion, learning and ultimately behaviour across multiple knowledge, professional and organisational boundaries' (Kitson 2009, p.137). Whilst the Iowa Model of Evidence-Based Practice to Promote Quality Care (Titler et al. 2001) and the QJBC-MAPS (Harrison et al. 2012) both cite clinical guidelines as part of their EBP models, Kitson (2009, p.136) is not convinced, referring to guidelines as 'conduits' through which complex pieces of information are communicated. 'Receptive context', 'culture' and leadership now constitute successful implementation of an intervention in the revised PARiHS framework (Kitson et al. 2008) without any overt reference to clinical guidelines. Yet Squires et al. (2012) recommend nurse leaders use the PARiHS framework to design strategies to enhance nurses use of research based policies and guidelines. Squires et al. (2012) describe the PARiHS framework as a theory driven approach to assist nurse leaders to engage nurses with evidence based policies and procedures.

3.5 Illuminating the role of Clinical Nurse Managers in the context of Evidence Based Practice.

The publication of the Commission on Nursing (Government of Ireland 1998) established a career pathway for Irish nurse managers, resulting in the development of a new nursing management structure. Subsequently the Office for Health Management in Ireland (TOHM) commissioned a mixed method research study resulting in '*The Report on Nursing Competencies'* (Rush, McCarthy and Cronin 2000). Three levels of nurse management (Top-level, Mid-level, Front-line level) were agreed following phase one of the study. Phase two involved consultation with groups of nurse managers and key stakeholders and the subsequent refinement of competencies for each of the three levels of nurse manager (Rush, McCarthy and Cronin 2000). Quantitative and qualitative data were collated and analysed in the context of international literature resulting in the development of eight generic competencies to underpin effective performance for all levels of nurse managers in Ireland. In addition broad competency categories were identified for the generic competencies, 'professional credibility, facilitation and enablement of staff, sustainability under pressure, and service contribution' (Rush, McCarthy and Cronin 2000, p.17). Additional 'role critical' competencies were published for each level of nursing management (Rush, McCarthy and Cronin 2000, p.37,48, 57).

Collectively the eight generic competencies serve as a 'core skill set', which nurse managers must develop and build upon (Rush, McCarthy and Cronin 2000, p.20). *'Promotion of Evidence Based Decision Making'*, one of the eight generic competencies, is defined as 'making decisions in a well judged and timely manner bringing all relevant information to bear when addressing problems or issues; using logical analysis to break complex problems into their component parts; applying research findings to improve nursing practice and processes' (Rush, McCarthy and

Cronin 2000, p.20). Fourteen behavioural indicators typify mechanisms for achieving this competency. Indicators of 'more effective performance' correlate with indicators of 'less effective performance', enabling the user to gauge performance in the *'Promotion of Evidence Based Decision Making'*. For example the positive indicator 'uses analysis and logic in considering problems and issues' correlates with the negative indicator 'tends to be overly intuitive or jump to conclusions' (Rush, McCarthy and Cronin 2000, p. 21).

Ann Flood utilised the Office for Health Management generic competencies (Rush, McCarthy and Cronin 2000) to inform part of her data collection (Flood 2010). This study was conducted in Ireland throughout 2005 and 2006 with the aim of describing the role of the CNM2 in the context of a changing healthcare system (Flood 2010). Using a mixed methodology the study involved in-depth interviews with CNM2s working in the Health Services Executive West Area (n=15). Flood (2010) presents her findings using twelve themes, which include 'Care delivery', 'Competence', 'Evidence-Based Practice' and the 'Patients journey'. Arguably there is overlap between the themes, yet disappointingly discussion around 'Evidence-based Practice', is limited to one negative comment regarding participants not having time or resources to find the evidence to support EBP.

For the second part of this study, the eight competencies of the front line manager (Rush, McCarthy and Cronin 2000) were utilised to form part of the Delphi instrument, facilitating direct reference to evidence-based decision-making. CNM2s, and senior nurse managers (n=93) completed the questionnaire. The findings indicate that CNM2s engage in evidence-based decision-making; however, time and resources are major barriers to sourcing the evidence. In an effort to authenticate

these qualitative findings, Flood (2010) incorporates the quantitative results of round two of the Delphi process into the discussion. Central themes 'evidence-based practice' and 'patient focus' contributed to the theme 'Maintenance of Standards of Care'.

The key objective of the role of the CNM2 is described as ensuring that 'high standards of patient care are identified and maintained' (Flood 2010, p.257). Subsequent discussion of the theme emphasises the support needed for CNM2s to have access to evidence in order to ensure patient care is evidence-based. Whilst this discussion is brief, the eight statements that formed the questionnaire deserve further exploration. One statement relates to the CNM2s professional and clinical knowledge and the need for continuing professional development; yet there is no insight into the sources of knowledge, which inform the CNM2s clinical decision-making or the corresponding need for continuing professional development. Another statement relates to supports required for the CNM2 to develop policies for change and improve patient care. There is reference to clinical facilitators, nursing practice development units and centres of education. There is no reference to governance structures and the need for mid-level nurse managers to contribute to the 'Maintenance of Standards of Care'. Nevertheless, these eight statements could inform the development of a useful framework to guide the development and maintenance of standards of care.

Flood's (2010) study is unique as it presents a contemporary perspective on the role of frontline nurse managers in Ireland. Maintenance of standards of care emerges as the most crucial part of the role of the CNM2. Standards are monitored and action is taken to rectify poor standards (Flood 2010, p.353). Whilst there is extensive

reference to EBP in the study, the focus is on the broad role and responsibilities of the CNM2 with little insight into how nurse managers can achieve or maintain these competencies.

A review of *The Report of Nursing competencies* (Rush, McCarthy and Cronin 2000) was conducted by McCarthy and Fitzpatrick in 2009. This review advocates using the identified competencies as a framework in relation to performance effectiveness and alignment of education and training with competency indicators. The authors recommend 'further use of these competencies in relation to recruitment and retention, orientation and training, performance criteria for development, recognition and feedback' (McCarthy and Fitzpatrick 2009, p.349). Regrettably, ten years on, the competency framework (Rush, McCarthy and Cronin 2000) has not been utilised to guide selection of nurse managers at any of the three nurse management levels. Nonetheless, behavioural indicators for the promotion of evidence-based decision-making could serve as a useful guide for nurse managers to aid evidence-based decision-making.

According to O'Halloran, Porter and Blackwood (2010) nurse managers are faced with a dilemma regarding adopting an evidence-based practice approach whereby they promote use of best practice guidelines at the risk of stifling nurses' critical thinking. Without doubt, nurse managers' 'understanding and involvement in clinical practice issues is important to guide implementation efforts' (Gifford et al. 2011, p.129). The emphasis has shifted from considering individuals as rational practitioners who will source, appraise and implement new evidence and guidelines, to the complexities involved and the substantial contribution of nurse managers in

the development and implementation of best practice guidelines (Rycroft-Malone 2008b).

Johansson, Fogelberg-Dahm and Wadensten (2010) conducted a survey among head nurses in two hospitals in Sweden to explore the use of evidence-based practice among head nurses (n=99). More specifically, the study aimed to capture head nurses' attitudes to EBP and seven research questions were identified at the outset. The study equates 'evidence-based practice' with 'research based practice' and the tool developed specifically for this study was based on the Research Utilization Questionnaire. Unfortunately this questionnaire does not capture the complexities of EBP and the seven research questions are not addressed in the study. Despite these limitations, findings highlight the need for nurse managers to be educated in research and EBP, and develop strategies for supporting nurses with the implementation of EBP.

Kitson et al. (2011) explores the experiences of nursing and medical service managers (n=11) as part of a project called 'The Older Person and Improving Care (TOPIC7) Project in a South Australian State. Semi-structured interviews, conducted at the 4-and 12-month intervals, elicited managers experiences of the innovation and the impact on the organisation. Emergent themes from these interviews incorporated 'Pressure on the service', 'Role/identity', 'Innovation despite the culture', and 'Patient-centred care'. Specific examples from interviews reflect familiar challenges for Irish nurse managers including 'lack of time', 'working in silos', 'conflict', and 'fragmentation rather than integration' (Kitson et al. 2011).

Emerging literature focuses on knowledge translation with the role of the nurse manager directly linked to EBP (Rycroft-Malone 2008a, 2008b; Gifford et al. 2011; Kitson et al. 2011); yet, there is a dearth of research exploring nurse managers' perspectives of their abilities to translate knowledge to evidence-based practice. This study endeavours to enable mid and front-line nurse managers to describe their current roles and responsibilities, focusing specifically on evidence-based practice.

3.6 Summary and Conclusion

Nurses working in Ireland are not currently required to demonstrate proficiency in evidence-based care. It is imperative that an understanding of what constitutes 'evidence' in evidence-based practice be agreed at the outset, enabling leaders and practitioners to work together towards achieving an evidence-based practice approach to patient care. Nurses base their decisions on knowledge gained from past experiences, patients, and colleagues with research the least dominant source of evidence used. The main barriers to nurses' use of research relates to time constraints although non-questioning of practice is a contributory factor. There is some evidence that nurses, as autonomous practitioners, may not use their autonomy to question routine practices, preferring to rely on instructions from managers.

Research into the barriers and facilitators of research and EBP is dominated by self-report questionnaires that have produced similar results over the past two decades. However, the body of research fails to explore mechanisms for addressing the barriers to EBP. Models to promote the use of EBP have identified the complexities of knowledge translation, highlighting the necessity to consider factors such as 'context or environment', 'the evidence' and 'facilitation' of change. Although some

models assume a linear relationship between evidence and its utilisation in practice, others address complexities including anticipated barriers. Without exception, all frameworks and models are continually refined and adapted to reflect new insight and knowledge into the complexities of knowledge translation. Clinical guidelines are considered part of knowledge translation in some models whereas others are less convinced of their usefulness in achieving EBP. More recently, the role of the nurse manager as an enabler of knowledge translation is emerging in the literature.

The next chapter describes the entire process of this qualitative descriptive study, which incorporates the underpinning philosophical assumptions of the design and links the philosophical assumptions to the study methods.

CHAPTER FOUR: RESEARCH METHODOLOGY

4.1 Introduction

Methodology refers to the research design or plan of action that determine the choice of methods and the particular ways these methods are used in the research (Crotty 2003). Clarification of the aim and formulation of research questions determines an appropriate methodology. According to Guba and Lincoln (1998, p.195), 'questions of method ought to be secondary to questions of paradigm, which is defined as the basic belief system or world view that guides the researcher, not only in choices of method but in ontologically and epistemologically fundamental ways'. Justification of the choice of methodology and method questions the researcher's assumptions about reality (Crotty 2003), providing a rationale for the way the researcher conducts the study.

Methodology is dependant upon the researcher's epistemological and ontological views (Briggs and Coleman 2007). In other words, it was essential for me at the very outset to explore my own beliefs and clarify my thinking regarding how knowledge is obtained (epistemology) and the nature of reality (ontology) (Creswell & Clarke 2007). The nature of reality from a naturalist perspective purports multiple constructed realities (Lincoln and Guba 1985); consequently, the outcome of any naturalistic inquiry will be the achievement of a new level of understanding rather than the discovery of a 'single tangible reality' (Lincoln and Guba 1985, p.37). The aim of this qualitative descriptive study was to achieve new levels of understanding of evidence-based practice from the perspectives of mid-level and front-line nurse managers. The epistemological and ontological underpinnings of this study

subscribe to the philosophical assumptions associated with constructing multiple useful insights into nurse managers' perceptions of evidence-based practice.

4.2 Epistemological and Ontological underpinnings of the study

Epistemology is a way of understanding and explaining 'how we know what we know' (Crotty 2003, p.8). Reflecting on Evidence-Based Medicine (EBM), which is rooted in objectivism, an epistemological view that things exist as meaningful entities independently of perception and experience, with truth and meaning residing in them as objects, I did not believe that rigorous observation and experimentation with nurse managers would determine an objective truth and meaning of EBP. From an objectivist perspective, participants' values and understandings can be set aside and the objective truth can be discovered (Crotty 2003). The objectivist's view of 'truth' relates to the correspondence theory of truth whereby one is committed to a claim about the world, thus offering assurances of how things are in the world (Bhaskar 1998). The correspondence theories and their associated claims of objective truths flourished in the mid 1900s during the mid-century supremacy of logical positivism (Bhaskar 1998); however, they do not influence this study as no attempt is made to present the findings as either claims or assertions.

Logical positivism is a philosophy that recognises only scientifically verifiable propositions as meaningful (Goldenberg 2006); hence, no statement is meaningful unless it is capable of being verified by science. This school of thought originated in Vienna in the early 1920s and became known as the Vienna Circle. The Circle dismissed metaphysics and many of the claims made in theology and ethics as nonsensical or unverifiable (Goldenberg 2006). Logical positivists are concerned

with ‘truth’ and a clear distinction is maintained at all times between facts and values, with the aim of upholding value neutral science. I believed that nurse managers’ perspectives of EBP were informed by their beliefs and values. I made no attempt to control these variables; therefore, the philosophical assumptions associated with logical positivism did not inform this study.

The naturalistic paradigm (Lincoln and Guba 1985) acknowledges that research is value-bound in the sense that all forms of inquiry are influenced by context. Paradigms represent what we ‘think’ about the world with the naturalistic paradigm proposing the existence of multiple constructed realities, which result in some level of understanding (‘verstehen’) (Lincoln and Guba 1985, p.15). Consequently, the outcome of any naturalistic inquiry will be the achievement of a new level of understanding rather than the discovery of a ‘single tangible reality’ (Lincoln and Guba 1985, p.37). These philosophical assumptions resonate with those of interpretivism, the theoretical perspective that supports ‘culturally derived and historically situated interpretations of the social life-world’ (Crotty 2003, p.67). Both the naturalistic paradigm and interpretive perspective propose that research is concerned with understanding (Verstehen) of multiple constructed realities. The philosophical assumptions associated with naturalistic paradigm and the interpretive perspective inform this study as multiple realities of evidence-based practice are constructed.

The naturalistic paradigm proposes that the concept of ‘causality’ be replaced with ‘mutual shaping’, which acknowledges unpredictable variables and circumstances that influence all situations and outcomes (Lincoln and Guba 1985). ‘Mutual shaping’ relates to elements in a situation that are in constant interaction with other

elements referred to as 'potential shapers' (Lincoln and Guba 1985, p.155). These potential shapers influence the environment in unpredictable ways, altering the circumstances and the patterns of events. Consequently, findings cannot be inferred beyond the 'here and now' (Lincoln and Guba 1985, p.15). There were many shapers that influenced this study's findings for example 'embargo on recruitment of staff', and 'care delivery systems'; therefore, the findings represent 'relative plausibility' rather than 'certitude or causality' regarding nurse managers' understandings of evidence-based practice (Lincoln and Guba 1985, p.153).

Social constructionism derives from the work of Karl Mannheim (1893-1947) and Berger and Luckmann (1967) (Crotty 2003). Constructionism is an epistemological view that the development of knowledge is dependant upon the interaction between human beings and their world. Social constructionists construct meaning as a result of the interplay between subject and object (Crotty 2003). In contrast to structuralist, post structuralist and post modernist thinking, espousing a subjectivist epistemology, meaning is not created, conjured up or imposed on the object (Crotty 2003); rather, human beings construct meanings as they engage with the world. This conscious engagement with the object may result in the same reality being interpreted in different ways and there is no true interpretation. However useful, illuminating and informative interpretations emerge, and one of these interpretations will be dominant in understanding subsequent events and this will be the social reality (Harre 2002). Social constructionists consider the human brain as one of the tools people use to accomplish understanding, which is dependant on contextual factors such as culture, history and power. According to Burkitt (2003) most social constructionists reject the realist theory of science and do not accept that there is a reality independent of human interpretation. Applying these assumptions to this study, I agree that EBP

does not exist independent of nurse managers because the concept is dependant upon the interplay between mid-level and frontline nurse managers and their environments.

McCormack (2006), a leading writer in the area of EBP in Ireland, purports that 'games of truth' exist in the complex world of EBP in nursing. McCormack, whilst acknowledging that these games relate to political and economic issues, is concerned with the quality of nursing practice 'on the ground' and the reality of evidence-based practice. He claims that amidst all the rhetoric on EBP, it is not recognised that 'the reality of practice is messy, complex and enmeshed in ethical conflict' (McCormack 2006, p.90). Having explored the concept of EBP from epistemological and ontological perspectives I subscribe to the axioms of the naturalist paradigm (Lincoln & Guba 1985) and social constructionism whereby realities of evidence-based practice are socially constructed. In order to explicate the proposed methodology for this research project, it was necessary to examine methodologies used to explore EBP from other disciplines.

4.3 Methodologies adopted in relation to Evidence Based Practice.

Having reviewed the concept of EBP from a philosophical perspective I diverted my attention to 'the reality of practice on the ground' and 'clinical decision-making' in order to focus the concept, which necessitated a review of various methodologies. According to Carr (1994), methodology refers to the theoretical rationale or principles that justify the methods appropriate for a research study.

Methodologies used by nurses to grasp 'the reality of practice' and 'clinical decision making' are similar to methodologies adopted by the evidence-based medicine movement. However key theorists, particularly in the United Kingdom and Ireland,

(Kitson, Harvey and McCormack 1998; Bonell 1999; Crawford et al. 2002; Kitson 2002; French 2005; McCormack 2006) are now engaging in philosophical debates regarding the complexity of evidence-based practice, advocating the adoption of multiple methodologies to seek clarification. Yet in America, theorists present studies relating to EBP in nursing with precision and certitude (Good et al. 2001; Grimshaw et al. 2001; Meade, Bursell and Ketelson 2006).

Melnyk et al. (2004) conducted a survey to determine nurses' level of knowledge and beliefs about EBP, the extent to which their practice was evidence based and the relationship among these variables (n=160). Although not explicit from Melnyk et al.'s study (2004), there is a perceived urgency for knowledge and truth as inferential statistics are used to establish causal relationships between variables. In line with literature from the discipline of medicine, Melnyk et al. (2004) assume that the 'reality of practice' and 'clinical decision-making' can be reduced to measurable outcomes reflecting EBP in nursing. However these assumptions are not supported by the entire discipline of nursing (Crawford et al. 2002; French 2005a). Crawford et al. (2002) adopted a qualitative approach in the United Kingdom to capture the unique perspectives of mental health nurses and EBP. A focus group interview, and individual un-structured interviews with nurses (n=10) were conducted to elicit knowledge of EBP. This methodology provides valuable insights into 'the reality of practice' and 'clinical decision making' including the possibility that nurses may be avoiding EBP related to incompatibility between their daily clinical practice and the mechanistic application of EBP. Similarly, Banning (2005) explored nurses' comprehension and use of evidence-based practice in the management of patients using an unstructured questionnaire and semi-structured focus group interviews (n=16). The findings reveal that nurses have difficulty comprehending EBP and lack

confidence articulating its use in clinical decision-making. Whilst it is evident that both studies (Crawford et al. 2002; Banning 2005) employ qualitative methods to answer research questions, the philosophical underpinnings of the methodologies are less evident and it is unclear if meanings are socially constructed or imposed.

Considering that the appropriate theoretical perspective for a given project should be the research question itself, rather than any personal preference on the part of the researcher for a particular paradigm (Pearson, Field and Jordan 2007), I chose qualitative description as the chosen methodology for this study. Qualitative descriptive studies provide a 'comprehensive summary of an event in the everyday terms of those events' (Sandelowski 2000, p.336), with language used as the vehicle to capture the depth of penetration into the reported events (Sandelowski 2000). Qualitative descriptive studies subscribe to the general values of naturalistic inquiry whereby events are studied in their natural state and the target phenomenon is not manipulated, influenced or controlled in any sense (Sandelowski 2000). Interestingly, Sandelowski (2010) recently elaborated on her understanding of qualitative descriptive research in order to clarify misconceptions, which emerged following publication of her seminal paper in 2000. Reiterating that she did not invent this approach, qualitative description consists of many different combinations of sampling, data collection and analyses, producing findings close to the data (Sandelowski 2010). She vehemently refutes reader interpretations of her 2000 paper, which imply that 'findings emerge from data' or 'data speak for themselves' (Sandelowski 2010, p.79). She is resolute that qualitative descriptive research is interpretative, necessitating the researcher to analyse and 'make something of his or her data' (Sandelowski 2010, p.79). Qualitative content analysis is largely based on the 'factist' rather than 'specimen' perspective of interview data (Sandelowski 2010

p.80). The 'factist' perspective assumes data are 'more or less accurate and truthful indices of reality' (Sandelowski 2010 p.80); in other words, interview data, which I collected from nurse managers, reflected their realities of evidence-based practice. On the contrary, 'the specimen perspective' considers data as part of the reality under investigation, rather than an expression of the reality.

Thorne (2011, p.443) reflects on recent enthusiasm for qualitative research over the past decade, recognising its ability to capture 'nuances and subtleties' associated with complex health and illness processes. Referring to the positive impact on patient outcomes as a result of capturing subjective experiences, Thorne (2011) begins her paper by tracing the origins of qualitative health research. She questions the 'rule bound culture of qualitative health research', and her critical appraisal of concepts such as 'theoretical sampling' and 'member checking' questions the researcher's capacity to discover and interpret human experiences. Acknowledging limitations throughout the body of qualitative health research including citing 'manipulative language signifiers' to meet the requirements of the genre, Thorne (2011, p.448) refers to a new generation of applied health methodological options. Building on past research traditions in the context and complexity of the real world of clinical practice, this new approach enables researchers to adopt the position that 'no specific tool or technique is inherently useful; rather, its usefulness depends on context and coherence' (Thorne 2011, p.449). Ultimately the research question determines the research approach and procedures; however, the researcher must justify the entire process in the context of the research question as distinct from the methodological package (Thorne 2011).

Although Sandelowski (2010) denies qualitative description as her method, Thorne (2011) credits Sandelowski as one of the new generation who is carving out new directions for answering research questions, listing qualitative description as a new approach. Conscious of justifying and substantiating all aspects of the research process from clarifying the research question through to interpreting the data and generating findings, I adopted the obligations of the researcher set out by Thorne (2011) to guide the design of this qualitative descriptive study including sampling, data collection and data analysis.

4.4 Summary and conclusion

The EBM movement favour research conducted using a positivist theoretical perspective. This is reflected in their use of hierarchies of evidence. Whilst patients' perspectives and the clinicians' personal judgements are incorporated into the definition of EBM, these elements of clinical decision-making are devalued in the hierarchies of evidence. Proponents of EBM believe that rigorous observation and experimentation of patients' treatments will determine an objective truth and meaning. Intertwined with objectivism is realism, an ontological position that reality exists independently of perception whereby it is possible to discover valid knowledge of all existences. From the outset, I was uncomfortable with objectivism and realism, as I do not believe that knowledge of evidence-based practice exists independently of influencing factors such as education or culture.

I adopted naturalistic inquiry and social constructionism as the philosophical basis for this study, supporting the epistemological view that the development of knowledge is dependant upon my interaction with nurse managers and their worlds, resulting in multiple factist realities that are socially constructed. Subsequently a

qualitative descriptive methodology was adopted to socially construct understanding (‘verstehen’) of managers’ accounts of evidence-based practice. The next chapter details data collection, analysis and interpretation of the findings based on the philosophical underpinning of the naturalistic paradigm.

CHAPTER FIVE: RESEARCH DESIGN

5.1 Introduction

The research design of a study outlines the procedures for collecting, analysing, interpreting and reporting the findings (Creswell and Clarke 2007). Acknowledging that context is central to emerging perspectives, semi-structured interviews, which are 'appropriate to humanly implemented inquiry', were conducted in the clinical setting (Lincoln and Guba 1985, p.187). Application of standards of evidence in qualitative inquiry involves the systematic and careful documentation of all the elements of the design, providing the reader with a record of the researcher's deliberations and decisions (Freeman et al. 2007). The researcher must make explicit his/her decisions, procedures and thinking in ways that readers find clear and comprehensible (Freeman et al. 2007). This chapter outlines my thinking and decisions regarding the design of this qualitative descriptive study. The objectives of this study were:

- To explore mid-level and front-line nurse managers' interpretations, conceptions, and understandings of evidence-based practice;
- To establish the extent to which nurse managers use evidence-based practice to inform their decision making;
- To determine the mechanisms that nurse managers employ to enable them to use an evidence-based approach;
- To explore factors that influence nurse managers' use of evidence-based practice;
- To determine what supports are needed to enhance nurse managers' use of evidence-based practice working in the region,
- To make recommendations for action to develop nurse managers' decision-making using an evidence-based approach.

The research question was:

- What were mid-level and frontline nurse managers' understandings of evidence based practice?

5.2 Research setting

Nurse managers from three acute hospitals in one HSE region participated in the study. All three hospitals had an emergency department and each hospital had bed occupancy of approximately 200 patients. There were similar senior management teams in each hospital comprised of a Director of Nursing, General Manager and Business Manager. There were Library and Information Services Departments in each hospital.

5.3 Access

Access and entry are sensitive components of qualitative research and the researcher must establish trust, rapport, and authentic communication channels with the participants (Denzin and Lincoln 1998). Having received ethical approval from the Regional Ethics Committee on June 24th 2009, I sent a letter to the Directors of Nursing (n=3) in the Region, seeking access to the nurse managers (Appendix A). Silverman (2006) purports that the terms associated with access provide a valuable insight into the setting as access can be accompanied with associated terms and conditions. The Directors of Nursing responded with letters that openly welcomed the research, and provided me with direct access to a population of nurse managers at all levels, without associated conditions attached.

5.4 Sampling and recruitment

Sampling is an integral part of the research design, contributing to the quality of the study (Abrams 2010). Naturalistic inquiry is linked to contextual factors and sampling is based on informational and not statistical considerations (Lincoln and

Guba 1985). The purpose of sampling is to maximise the amount of information received rather than to generalise the findings (Lincoln and Guba 1985). Qualitative researchers acknowledge that some participants are better equipped to provide key insights and understandings (Abrams 2010); therefore, the ultimate goal of purposeful sampling is to select respondents who are information rich for the purpose of the study (Sandelowski 2000). My primary concern was to gain in-depth information about particular issues from 'knowledgeable people' who were in a position to share their experiences (Cohen, Manion and Morrison 2007, p.115); therefore, purposive sample of nurse managers was employed. One of the generic competencies for nurse managers is the *'Promotion of Evidence Based Decision-Making'* (TOHM 2000); hence, mid-level and frontline nurse managers were knowledgeable and willing to share their experiences of Evidence-Based Practice (EBP).

The total population of mid-level nurse managers (n=32), and frontline nurse managers (n=45) in the region received a *Letter of Invitation* (Appendix B), *Information Leaflet* (Appendix C), and *Expression of Interest Form* (Appendix D). Some participants chose to return the *Expression of Interest Form* whereas others replied by email. All mid-level nurse managers (n=13) who returned an *Expression of Interest* participated in the study. Of the frontline managers who returned the *Expression of Interest* (n=13), ten participated. One CNM 2 left the organisation and two CNM2s who completed an *Expression of Interest* were not available for interview. The total sample consisted of twenty-three nurse managers.

5.4.1 Profile of sample

Directors of Nursing, Clinical Nurse Specialists, Advanced Nurse Practitioners and Clinical Nurse Managers 1 were excluded, as the focus of this study was to explore

mid-level and frontline nurse managers' perspectives in the context of their daily clinical decision-making. Mid-level nurse managers consisted of Assistant Directors of Nursing and Clinical Nurse Managers 3 and frontline nurse managers were employed as Clinical Nurse Managers 2 as set out in Table 5.1.

Table 5.1 Participants demographics (n =23)

	Number of Participants	**Percentage**
Title		
Assistant Director of Nursing *(Mid-level nurse managers)*	10	43.5%
Clinical Nurse Manager 3 *(Mid-level nurse managers)*	3	13 %
Clinical Nurse Manager 2 (*Frontline nurse managers*)	10	43.5%
Gender		
Male	3	13.0%
Female	20	87.0%
Age profile		
20-25 years	0	0%
26-35 years	0	0%
36- 45 years	10	43.5%
46-55 years	11	47.8%
56-65 years	2	8.7%
Length of time in current post		
0 - 5 years	4	17.0%
6 - 10 years	8	35.0%
> than 10 years	11	48.0%
Professional Qualifications		
Registered General Nurse	23	100%
Additional professional qualifications		
Registered Paediatric Nurse	1	
Registered Psychiatric Nurse	0	
Registered Midwife	2	
Education qualifications		
Certificate in Nursing	21	91%
Diploma in Nursing	2	9%
Additional educational qualifications*		
BSc in Nursing	6	
Higher diploma	4	
MSc in Nursing	6	
PhD	0	

***** Some participants achieved more than one additional educational qualification.

Participant demographics illustrated that almost half the sample (48%) had more than ten years experience in their current posts.

5.5 Data collection

The nature and shape of experiences or events is a crucial part of data collection in qualitative descriptive studies (Sandelowski 2000); therefore, I interviewed participants in their respective units/departments. The qualitative interview produces knowledge through the social interaction between the researcher and the participant (Kvale & Brinkmann 2009, p.162); however, interviews are often too long and littered with 'idle chatter'. Hence the researcher must know 'what to ask', 'why she is asking', and 'how to ask', in order to achieve a quality interview that is rich in meaning (Kvale and Brinkman 2009). The quality of the original interviews determines the quality of subsequent analysis, verification, and presentation of the findings (Kvale and Brinkman 2009).

Following naturalistic inquiry methodology, I was aware of my ability to process data as soon as it became available, to generate understanding, and to test my interpretation with respondents in the very situation where interpretations were formulated (Lincoln and Guba 1985). Aware of the potential pitfalls associated with qualitative interviewing, I endeavoured to interpret participants' responses and verify these interpretations throughout the interviews. I was sensitive to the context and in particular participants' cues including their reservations and hesitations. Although my own knowledge of the topic enhanced my ability to clarify and engage in meaningful dialogue with participants, I was careful never to influence participants' perspectives.

Generation of data depends on the researcher's skills and personal judgement in posing appropriate questions. As part of the preparation for data collection, I took advise from Kvale and Brinkman (2009) and I devised two interview guides.

Thematic research questions were formulated in formal theoretical language. Interview questions used participants' colloquial language, thus generating spontaneous and rich descriptions in a natural conversational style format (Kvale and Brinkman 2009). Table 5.2 depicts the translation of thematic research questions to interview questions, which I anticipated would guide data collection.

Table 5.2 Thematic and research questions Adapted from Kvale & Brinkman (2009)

Thematic Questions	**Interview Questions**
What is the *Context* for EBP from the perspective of the nurse manager ? →	What does EBP mean to you as a nurse manager? Can you describe the current environment for EBP? How do you promote EBP in the current environment?
What constitutes '*Evidence'* for the nurse manager? →	What types of evidence do you use to make clinical decisions? How do you combine different types of evidence?
How does the nurse manager *'Facilitate'* EBP? →	How do you enable colleagues and staff to engage in EBP? Who supports you with EBP? How do you monitor EBP in your department?

Armed with the interview schedule, the format of each interview was similar. I spoke with each participant in advance of the interview, reiterating the importance of capturing the true context of the nurse manager's understanding and use of EBP. The 'human-as instrument' senses and responds to all personal and environmental cues that exist (Lincoln and Guba 1985, p.194). I sensed at a very early stage that participants were apprehensive regarding their abilities to discuss evidence-based practice; consequently, I forwarded each participant the *Interview Questions* (Table 5.2) via email two to three days in advance of his/her interview. Although some participants didn't access the *Interview Questions* in advance of the interview, they

were satisfied that the questions were available. Participants who did access the *Interview Questions* did not revert back to them during the interview; therefore in reality, the first question was usually enough to initiate the discussion. On reflection, I referred to the *Interview Questions* at the beginning of the data collection process, as I was anxious to ensure that key areas were addressed. I quickly learned to leave the *Interview Questions* aside and focus instead on participants, and their responses and experiences. In fact probing certain responses revealed valuable insights and understandings, which might not have evolved had I focused on the *Interview Questions.* This unstructured approach to questioning enabled participants to candidly share their experiences and views without the influence of pre-determined questions.

The clinical environment was certainly busy and unpredictable; nevertheless, I endeavoured to allow ten minutes following each interview to debrief participants (Kvale and Brinkman 2009). Truthfully, debriefing of frontline nurse managers was limited as participants were anxious to return to the clinical setting. I spent a further ten to fifteen minutes after each interview reflecting on the environment, the format of the interview and my initial impressions. I noted contextual material such as interruptions and the general mood of the interview. These notes were an invaluable aid memoir, which reignited for me the context of each interview during transcription. These same notes (Appendix E) subsequently informed my interpretations and analysis. According to Green et al. (2007), an understanding of interview context brings depth to data analysis, enabling interpretation beyond the interview transcripts. These notes capture context such as 'hesitations', 'confidence in answering the questions', and 'tone of the conversation' (Green et al. 2007).

Conducting interviews in the natural setting allowed me to engage in the real world of the nurse manager. Naturalistic inquiry demands time and resources as the researcher engages in 'sloppy research', taking account of the many variables of interest and influences in that context, and the mere entry of the investigator disturbs the context (Lincoln and Guba 1985, p.191). I was mindful that my role as a nurse tutor might influence participants' responses; however, the informal nature of the interview enabled each participant to openly share his/her views.

5.6 Interview Setting

Acknowledging that no phenomenon can be understood in isolation of 'the time and context that spawned, harboured or supported it' (Lincoln and Guba 1985: 189), I conducted the interviews in participants' offices. I did a rough sketch of each office following the interview as the physical environment provided useful insights into the research setting. Sample sketches (Appendix F) outline context in terms of available resources such as workspace, desk, computer, shelving and storage space, which might influence nurse managers' use of evidence-based practice.

5.7 Data analysis

Researchers have a professional and ethical responsibility to conduct and report data analysis in a comprehensive manner, demonstrating to the reader that a careful and rigorous process has been undertaken (Green et al. 2007). According to Kvale & Brinkman (2009, p.190) 'the ideal interview is already analysed by the time the sound recorded is turned off', reiterating the researcher's responsibility to interpret and verify the participant's responses during the interview. Therefore, data analysis began as soon as the interviewing phase commenced. As the timing of the interviews

depended entirely on participants' availability, I did not segregate data collection for mid-level and frontline nurse managers. In retrospect, this worked well from a practical and operational perspective, as frontline nurse managers were difficult to access relating to their clinical responsibilities whereas interviews with mid-level managers were easier to organise. I commenced transcribing the interviews immediately; therefore, data collection and data analysis occurred simultaneously. As I listened and re-listened to interviews, initial interpretations informed and assisted probing and questioning during latter interviews.

Repeated reading and re-reading of interview transcripts considered in the context of notes in my research diary, coupled with listening and re-listening to elements of the recorded data, enabled me to eventually gain meaning from substantial volumes of data. According to Green et al. (2007, p.547) data immersion brings meaning to the interaction between the researcher and the participant, enabling the researcher to begin the process of linking ' disjointed elements into a clearer picture of the issue being investigated'.

Qualitative content analysis subsequently facilitated subjective interpretation of the different perspectives of evidence-based practice through a systematic classification process of coding and identifying themes (Hsieh and Shannon 2005). Three approaches to content analysis are used to interpret meaning from the content of text data, adhering to the naturalistic paradigm (Hsieh and Shannon 2005). Of the three approaches to content analysis, I chose 'conventional content analysis' because it enabled me to describe evidence based practice from participants' perspectives (Hsieh and Shannon 2005, p.1277). I considered the other two approaches 'directed content analysis' and 'summative content analysis' (Hsieh and Shannon 2005,

p.1277). I initially thought the directed approach was appropriate, as I devised *Interview Questions* from *Thematic Questions* (Table 5.2). However, since the *Interview Questions* were redundant after the first few interviews, directed analysis based on thematic questions would not capture participants' actual responses. The summative approach was not considered, as quantification of certain words or text could result in the omission of insightful perspectives. I subsequently used 'conventional content analysis' to gain direct information from raw data in the form of codes and categories, without imposing preconceived theories (Hsieh and Shannon 2005, p.1277).

Having read and re-read the transcripts (n=23), I separated the transcripts into mid-level and frontline nurse manager bundles to facilitate analysis. Although, I initially anticipated the generation of two distinct sets of categories, similar codes led to similar categories and I eventually merged the categories, whilst retaining participants' different perspectives. I commenced coding transcripts by highlighting words from the text that appeared to capture meaningful thoughts or concepts. Codes that contained related concepts were then linked and grouped into meaningful categories (Hsieh and Shannon 2005). This process seems very logical and straightforward; however, it was far from simple. According to Thorne (2008), an effective coding scheme gathers data with similar properties, which can be contrasted, to other groupings with different properties. I used spider diagrams (Appendix G) to bring together pieces of data that I thought might be related, visually mapping my evolving thoughts. Alerted to the dangers of 'premature coding', I was conscious not to create artificial links between elements of data, and I afforded myself extended time to re-read, reflect and determine relationships between data (Thorne 2008). I understood that findings would not emerge from the

data; rather, I actively engaged my mind to organise, conceptualise and eventually write up worthy findings by combining categories to form themes (Thorne 2008) as outlined in Appendix J.

Qualitative research generates multiple, frequently conflicting views and accounts; hence, honest representation of various perspectives necessitates careful, ethical, and reflective decision-making (Holley and Colyar 2012).

5.8 Ethical Considerations

Research that exposes and examines a particular life experience is demanding and complex (Boman and Jeune 2000). Acknowledging that this qualitative descriptive study is contextual, value laden, rife with values and perspectives (Strohm Kitchener and Kitchener 2009), I ensured that all stages were fundamentally ethical. At the outset, I sought and received permission from the Regional Ethics Committee (REC), adhering to Health Service Executive (HSE) guidelines (HSE 2010a).

Institutional Review Boards serve to ensure that proposed research methods, sampling procedures for protecting participants, and more recently the design of the study adhere to fundamental ethical principles (Lincoln 2009). On reflection, this process served as a valuable learning curve as I had not anticipated the depth of information and clarity of procedure that was required. In retrospect the process clarified my own thinking, compelling me to reflect on, and justify, all stages of the research process from conceptualisation and refinement of the research question to presentation of the findings. Having received ethical approval for the study from the REC, I complied with recognised ethical standards, which involved respecting the safety and focus of the participants for the entire study (HIQA 2012b).

I sent a letter to each frontline and mid-level nurse manager in the region inviting him/her to participate in the study. Nurse managers interested in participating returned an *Expression of Interest Form* without any coercion or influence; therefore, each participant willingly volunteered to share his/her views. *An Information Leaflet* accompanied each *Letter of Invitation*, outlining the purpose of the study and my intention to tape record the informal interview. Nurse managers were provided with enough information to make an informed choice regarding participation prior to returning the *Expression of Interest Form*; hence, the right of the participant to full disclosure (An Bord Altranais 2007) was acknowledged and addressed.

Hawkes (2007), as Data Protection Commissioner, published guidelines for researchers that must be addressed when undertaking research that involves personal data. Whilst these guidelines focus on patients' records, I considered the advice in relation to informed consent as applicable to this research study. Consequently, I ensured each participant understood his/her right to withdraw from the study at any time without consequence (An Bord Altranais 2007) as stated explicitly in the *Information Leaflet.* I ensured the principle of autonomy was respected by ensuring that participants had the right to self-determination whereby they choose whether or not to participate (An Bord Altranais 2007).

I spent time at the beginning of each interview explaining the purpose of the study and the format of the interview, reiterating the voluntary nature of his/her participation. Each participant received a copy of the signed *Informed Consent Form* (Appendix H) and *Statement of the Investigator's Responsibility* (Appendix I). Reiterating that participants' involvement was entirely voluntary, they were assured

anonymity and confidentiality. As regards 'anonymity', Hawkes (2007, p.9) advises that 'irrevocable anonymisation of personal data places it outside data protection requirements as it can no longer be linked to the person and therefore cannot be considered as personal data'. However, he cautions that the process of rendering data anonymous could potentially result in instances when these data may be identifiable and the researcher must be conscious of this. Therefore, I was particularly careful regarding participants' first names, titles, and areas of work, which potentially could reveal participants' identities. In addition, I employed comprehensive security and access controls in relation to the storage of manual and electronic data. I conducted and transcribed all the interviews and I stored the tapes and transcripts in a locked press. I had sole access to these data and I take full responsibility to destroy the tapes and the transcripts when the research is complete. I was particularly vigilant during transcription to maintain participants' anonymity.

Each participant was treated 'fairly and equitably before, during and after the research study' (An Bord Altranais 2007, p.8). The researcher has ethical responsibility for all stages of the study (Silverman 2006), and I recognised that some participants could perceive the interview as exposing a perceived lack of his/her understanding or knowledge of evidence-based practice. Consequently, I explained to each participant, at the outset of each interview, that scholarly papers are littered with academic and scientists views of the phenomenon, without consensus. The participant's views and experiences reflected his or her unique understanding and use of evidence-based practice in the real and often unpredictable world of clinical practice, contributing to a deeper description and subsequent understanding of the concept.

Analysis of data required further ethical considerations. I was mindful to present a balanced and honest view of the findings, representing participants' views (Silverman 2006). I acknowledge that there was a temptation to over represent the views of some participants. On reflection, this probably related to views, which were articulated differently, humorously, or correlated with my own views of a particular concept. Accordingly, I was cognisant during analysis to present a balanced, fair, and just description of participants' views.

The ethical principle of fidelity was particularly relevant during presentation and analysis of these findings, as honesty and promise keeping are central to trust (Strohm Kitchener and Kitchener 2009). Trust is central to the participant-researcher relationship, involving the creation of a contract with associated terms and conditions for both parties (Strohm, Kitchener and Kitchener 2009). There is an onus on both the researcher and participants to present information that they believe is an accurate and honest representation of their views. Deception in research breaks the researcher's ethical responsibility to be truthful (Strohm Kitchener and Kitchener 2009); hence, I was attentive during analysis and presentation of the findings to truly represent participants' views.

According to Silverman (2006, p.328), feedback to participants is a proper 'ethical goal'. At the end of each interview, I provided each respondent with a summary of the interview, enabling clarification, correction and amplification of the data (Lincoln and Guba 1985). Having analysed the data using conventional content analysis, I considered returning to participants to ascertain their views of the tentative themes. However, I was aware that member checking may lead to 'false confidence' if all participants agreed to the tentative findings (Thorne 2008). I anticipated that

participants would be more interested in their own experiences rather than some abstract synthesis, which incorporated other participants' views (Sandelowski 1993). According to Thorne (2008, p.159) the researcher is not 'simply a vehicle through which participants speak, but an interpretative instrument who makes sense of multiple cases that would not normally be understood with only one particular case. Morse et al. 2002 consider it timely to reconsider the absolute necessity for researchers engaging in qualitative studies to build in verification strategies which constantly monitor and confirm all stages of analysis and interpretation; however they firmly reject member checking as an appropriate strategy. In fact, Morse et al. 2002 caution researchers that their efforts to represent individual perspectives during member checking may invalidate their findings by restricting their level of analysis. Whilst I did not engage in member checking, I did revert back to some participants throughout the analysis phase, as I required clarification and differing perspectives. Participants willingly shared their opinions and experiences, which ultimately contributed to a meaningful, rigorous and satisfying set of findings (Thorne 2008, p.142).

5.9 Rigour

Rigour incorporates demonstration of what was done to the data and why it was done rather than adhering to a set of rules (Rose and Webb 1998). Sandelowski (1986) discusses three criteria, identified by Guba and Lincoln (1981), as establishing confirmability or objectivity in qualitative research. The first criterion is credibility, referring to the extent to which the interpretation of individuals' experiences represents those experiences (Sandelowski 1986). I used 'conventional content analysis' to describe participants' unique perspectives of evidence-based

practice, aware of the risk that this type of analysis could potentially 'fail to present a complete understanding of the context, thus failing to identify key categories' (Hsieh and Shannon 2005, p.1280). Consequently, I was meticulous during data collection and analysis to ensure the findings accurately represented the data. I endeavoured to present truthful interpretations of all the evidence I gathered, by clarifying my observations during and immediately following the interviews. I returned to some participants at different stages during analysis to seek further clarification and reassurance that I was accurately representing their views. The researcher clearly articulates how concepts are coded and categorised and how the findings emerged (Sandelowski 1986). An overview of coding, category and theme formation is illustrated in Appendix J. Extracts from my diary provide further insight into the conceptual elements of coding, category and theme formation. (Appendix K). According to Hsieh and Shannon (2005), credibility can be established through activities such as prolonged engagement, persistent observation and triangulation; therefore, I did not rush data collection. I spread data collection over an eight-month period and data analysis consisted of prolonged and persistent engagement with the data over a period of eighteen months.

The second criterion as identified by Sandelowski (1986) is applicability or fittingness, referring to the extent to which the study's findings fit contexts outside the study. Based on the epistemological and ontological underpinnings of this study, there is no attempt to generalise or theorise the findings of this qualitative descriptive study; however, the findings are presented using themes and discussed in the context of other relevant literatures, including contemporary policy.

The third and final criterion identified by Sandelowski (1986) is consistency or auditability, relating to the extent to which I articulated my actions and decisions and the possibility of another researcher clearly following my decision trail. An audit trail illustrating category development is provided (Appendix L). A panel of experts cannot check codes or categories, since there are multiple interpretations of reality and there will be no consensus. I reiterate that I deemed data collection and analysis a moral obligation; hence, I interpreted the true perspectives of the participants as described in the interview data. I was honest and open during data collection and analysis. I critically examined my preconceptions throughout the entire process as detailed in the limitations section. Whilst I acknowledge that I made decisions regarding what was more important or less important in the data; I trust that the findings represent participants' perspectives of their understandings of evidence-based practice.

5.10 Summary and conclusion

The aim of this study was to explore mid-level and frontline nurse managers' understandings of evidence-based practice. The study was conducted in Acute Hospitals (n=3) in an identified Health Service Executive Region in Ireland, following approval from the Regional Ethics Committee. Unstructured interviews (n=23) were conducted in participants' offices, providing useful insights into the current clinical environment for evidence-based practice.

Conventional content analysis was utilised to code and categorise raw data, with spider diagrams, thought mapping, and memos recorded in my reflective diary, assisting the process of interpretation. I deemed data collection, analysis and interpretation a moral obligation; therefore, I present balanced, fair and honest accounts of participants' perceptions of evidence-based practice.

CHAPTER SIX: PRESENTATION OF THE FINDINGS

6.1 Introduction

Having analysed the data using conventional content analysis, this chapter presents the findings using three main themes, '*Nurse Managers Perceptions of Evidence-Based Practice (EBP)', 'Nurse Managers Views on Enablers and Barriers to EBP',* and '*Nurse Managers Opinions on making EBP a Reality'.* Each theme consists of categories, which represent participants' perspectives of evidence-based practice.

6.2 Theme One: Nurse managers' perceptions of Evidence-Based Practice (EBP).

Whilst the roles and responsibilities of mid-level and frontline nurse managers (CNM's) differed, similar views of what constituted EBP emerged from the analysis. Participants' understanding of EBP is best represented using four categories entitled *'Knowing the patient, 'Governance',* '*Developing, Implementing and Evaluating Best Practice'* and '*Service user involvement'*. *'Knowing the Patient*' enabled EBP when nurses utilised effective communication to develop meaningful relationships with patients and their families, which informed clinical decision-making. *'Governance'* related to EBP in terms of monitoring clinical practice. '*Developing, Implementing and Evaluating Best Practice'* linked the development, implementation and audit of Policies, Procedures, Protocols and Guidelines (PPPGs) to EBP. '*Service user involvement'* was perceived as fundamental to EBP when service users were involved in decision-making at both strategic and clinical levels.

6.2.1 'Knowing the patient' enables Evidence-Based Practice

It was frontline nurse managers' accounts of 'communication skills', and their 'abilities and willingness' to form 'meaningful nurse-patient/family relationships' that linked 'knowing the patient' to evidence-based practice. For CNMs, 'knowing the patient' necessitated skilled communication with the patient, family, and members of the multidisciplinary team. CNM's communication skills were learned and perfected over time, enabling collation of information, which formed the basis for evidence-based decisions. CNMs deemed 'talking', 'listening', and 'observing' patients as essential to EBP as 'knowing each patient' provided them with the necessary information to tailor interventions towards each patient's unique needs.

> CNM2 (No. 9): I make it my business every day to go out and talk to the patients. Then when it comes to the doctors' rounds, I know from the patients' reactions who I need to go back to. It might be to listen to their worries but mostly they don't understand what the consultant has said so I have to explain, and this is regular.

> CNM2 (No.5): Straight after report, I go out and see every patient. I have to, because if someone stops me in the corridor, I have to be able to answer that person's questions. And I have to be able to pull it altogether for the patient. And that includes blood tests, procedures, going home, who's at home, the lot because when someone asks, I have to know

> CNM2 (No.3): Nothing is difficult when I know the patients. It doesn't matter who asks me: the consultant, physio, the family, the patient, whoever, I don't mind

Participants' accounts of 'knowing the patient' also focused on an appreciation and awareness of patients' vulnerabilities and worries. The emotional element of decision-making was highlighted by CNMs when they described how patients' physical symptoms masked emotional turmoil. According to Maxwell Smith (2010) no amount of clinical experience can inform nurses of the unique worries and torment which some patients conceal; however, by being 'attentively present to the person and family' nurses can gain a deep understanding of each person's unique needs. In an attempt to elaborate on the emotional component of evidence-based decision-making, one CNM described a young patient's outburst of emotion prior to

having an ultrasound for abdominal pain. As the CNM prepared the patient for a medical procedure, the patient revealed she was pregnant. Although the patient felt comfortable with the CNM and shared this sensitive information, the CNM 'couldn't believe' this essential information had now emerged.

> CNM2 (No.10): I had a situation here a few weeks ago where I was preparing a fifteen-year-old girl for ultrasound. She was on the trolley and I was just going through the checklist. I didn't suspect for one minute that she might be pregnant. She'd said she wasn't and I was thinking cyst or appendix. Then she just said it… I'm pregnant…. I couldn't believe it

Participants' perceptions of EBP echoed recent publications from both the Health Services Executive (HSE) and the Health Information and Quality Authority (HIQA) regarding the creation of a culture of caring, kindness and communication in their respective units. According to the Health Services Executive (HSE) 'an environment of trust, openness, respect and caring among managers, clinicians, staff and patients' contributes to improved patient outcomes (HSE 2011, p.4). Patients should be treated with consideration and respect based on a culture of kindness, which incorporates active listening and communication (HIQA 2012a). One CNM described EBP in terms of caring for a patient who became emotional following a procedure. This patient had concealed his emotional torment as he coped with bereavement from suicide in his family. This information equipped the CNM to inform her decision-making and tailor her interventions to this patient's specific needs. The CNM proceeded to describe the services that she sourced for this patient, reiterating the need to listen attentively to patients' personal stories in order to gain insight into their health and personal care needs.

> CNM2 (No. 9): It's just so important to listen to the patient. We had a man here recently who came in with a suspected duodenal ulcer. After his scope he became very emotional and he couldn't stop crying. He proceeded to tell me about bereavement in the family from suicide and he was distraught, he just cried and cried…

Another CNM utilised effective communication skills to gain further knowledge and understanding of the patient's perspective. Information from this patient provided

the CNM with a deeper level of understanding regarding effective interventions for this patient when she realised the therapeutic effect of holding the patient's hand during a procedure. Although holding the patient's hand was a routine nursing practice in this department, the patient's perspective informed the CNM of the value of this intervention. Interventions must be tailored to the patient's perspective in order to achieve EBP.

> CNM2 (No.7): Little things matter like a patient saying to me yesterday – 'That made a difference', and I thought she meant the top up sedation and when I said 'That's great, if you feel discomfort we can give you more through this drip and she said 'no-you holding my hand'.

In an attempt to achieve EBP, participants advised colleagues and nursing students to treat patients as a member of one's own family.

> ADON (No.1): I challenge nurses to think of patients as one of their family. Think of someone who is close to you and challenge yourself and ask yourself would you do this differently if you thought there would be a better outcome

As I analysed participants' advice to treat patients as a member of one's own family, I reflected on recent nursing models published by Irish nurse theorists. Meehan (2012, p.2913) recently published 'Careful Nursing' as a philosophy and professional practice model to guide contemporary nursing practice based on fostering respect for the innate dignity and worth of all persons. The philosophical assumptions underpinning 'Careful Nursing' include the 'benevolent affection of one human person for another' (Meehan 2012, p.2910). Likewise, McCarthy & Landers (2010) underpin their 'Model of Personhood for Irish Nursing' with 'soul friend', 'spirit', 'love', and 'hope'. Whilst participants in my study did not directly refer to 'love' or 'benevolent affection', participants challenged nurses to form close relationships and truly know their patients.

> CNM (No. 6): I always say to the students, treat every patient as your father, your mother, brother, sister, husband or wife and you won't go wrong with that approach.

Having returned to participants (n=4) to seek further understanding of what they meant by 'close nurse-patient relationships', both mid-level and frontline nurse managers agreed that nurses must engage in meaningfully relationships with patients in order to achieve EBP. Participants acknowledged that knowing the patient at this level was difficult, as nurses balanced 'not getting too attached' with 'close and meaningful' to understand each patient's needs. CNMs acknowledged that EBP is not being 'touchy feely' with patients, rather nurses developed and utilised skills to tailor appropriate evidence based interventions.

> CNM2 (No.1) It's a bit too touchy feely for me. Appropriate and meaningful yes but there is a professional boundary. As a nurse you can't afford to get too attached to patients, as you must be the advocate and you must be professional. But I agree you do get the best out of it when you know the patient and you know the family, it comes together. Things run smoothly when you know the patient and the family. But stay objective. You have to maintain some distance to stay objective. It's getting the balance and if you get too close to the patient or the family, then you can't be objective.

Acknowledging that the majority of nurses endeavoured to know their patients, CNMs admitted that nurses struggled to achieve this aspect of EBP as the process 'takes time and effort'.

> CNM2 (No: 5) I found your section on 'Knowing the Patient' encouraging because I think, as a profession, nurses want to get this right and we are trying really hard but it is not easy. It takes time and effort to develop the ability to help patients to make sense of things.

Mid-level nurse managers emphasised the necessity of 'knowing the patient' in achieving EBP, without acknowledgement of the associated challenges in getting to know each patient. From their perspectives nurses, including agency nurses, must know their patients.

> ADON (No: 5) There's no excuse why nurses don't know the patients and their families.

Knowing the patient involves communication with family members; yet, from participants' perspectives there were many variables that influence family

involvement in evidence based-decision making. 'Patients, carers and family members must be at the centre of all that is done in the Irish health service' (Government of Ireland 2008, p.3). It seems straightforward and logical; however, participants acknowledged that involving patients and families could not be assumed. According to participants, some nurses felt threatened by family involvement and this was related to nurses' lack of experience, knowledge or confidence to answer questions from the family. There were patients and families who preferred not to be involved. There were families who became overly involved. In addition, there were patients and families whose concerns were not addressed by healthcare professionals. According to mid-level nurse managers, it was simply a matter of nurses sitting down with patients and families and answering their queries. CNMs provided further insights into the reality of evidence-based clinical practice. Variables such as limited time with patients and families, nurses' clinical experience and knowledge, agency staff who didn't know either the patient or family, and uncertainty regarding information that each patient required, influenced the extent to which patients and families were involved in evidence-based decision making.

> ADON (No.6): The nurse should be able to sit down and talk to the patient, answer questions, include the family, answer the family's questions and not feel threatened when a family member asks a question. Nurses should be involving the family but nurses don't want to take this on.

> CNM (No. 2): From the time of admission we try and get families involved because we need to work with them especially with the new discharge policy. But there are times when families don't want to know and there are also times when inexperienced staff are on duty and they miss the opportunity during admission. It is very difficult when the family aren't involved from the beginning.

> CNM (No. 6): For the most part we work very well with families. But you will also have situations and it gets very complicated and there are families who don't want to be involved and there are families who take over the place. It doesn't help when you have agency staff that don't know the patient or the family.

Participants considered it necessary that nurses find time to engage in evidence-based decision making by 'knowing the patient'. According to HIQA (2012a), good communication and the provision of adequate information enables patients to make informed decisions about their health; yet, both mid-level and front-line nurse managers considered it necessary to consistently prompt nurses to 'know' their patients.

> DNM (No.2): You cannot policy all practice. Nurses must know about the patients in their care. Even in busy departments it only takes five minutes to get to know the patient, but it can be a challenge to get nurses to do this.

> CNM2 (No.4): All our patients feel vulnerable but if the nurse takes the time she will get to know where they are coming from.

According to participants, achieving EBP was hindered by patients' shorter length of stay in acute hospitals. There was an expectation that nurses completed prompt and astute nursing assessments to accurately determine each patient's unique needs. Otherwise, nurses missed the opportunity to 'know the patient', which impacted on nurses capacities to make evidence based decisions from the patient's perspective.

> CNM2 (No. 10): You have a very small timeframe to gel with the patient now. It is so easy to miss the window of opportunity; it is a quick turnaround so you don't have days to get to know the person.

In summary, 'knowing the patient' contributed to evidence-based practice when nurses developed and utilised astute assessment and communication skills, which informed evidence, based decisions from the patient's perspective. Each patient has unique health and social care needs; therefore, evidence based decision-making necessitates skilled nurses who are willing to take on the challenges associated with truly 'knowing the patient'.

6.2.2 Governance and Evidence-Based Practice

According to the HSE (2009a, 2012), the achievement of good clinical outcomes for patients, which incorporates evidence-based practice, is dependant on good clinical governance. Clinical governance 'is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver' (HSE 2012, p.1). Both mid-level and frontline nurse managers, in this study, expressed differing views on 'governance' as a component of EBP in terms of 'monitoring nursing practices', 'mentoring, supervising and managing staff', and 'investigating clinical incidences'. For mid-level nurse managers 'monitoring' nursing practices was central to EBP as they described spending time on the wards observing other nurses' practices. Mid-level nurse managers considered themselves gatekeepers of standards as they discussed evidence-based clinical practices with nursing staff.

> ADON (No. 5): I must spend time in the clinical areas every single day. You have to be seen, it is the only way that you know what is happening over there.

> ADON (No.9): You spot things the minute you scan the ward and I often see crazy things like IV fluids disconnected or drugs left on lockers.

> ADON (No.10): I do 'walkabouts' every day. You have to in order to see for yourself what is happening. For example: IV drug administration, that is a real bone of contention.. no matter how many times I remind nurses of the policy and it is there to protect them and the patients, staff don't adhere to the policy. As a nurse manger I must keep going back again and again and sometimes I have serious discussions with staff regarding their practices.

Having outlined their responsibilities in terms of observing and discussing best practices with nurses, many mid-level nurse managers subsequently delegated accountability for monitoring care standards to CNMs. Therefore in practice, mid-level nurse managers relied on CNMs to monitor use of evidence in clinical practice.

> ADON (No. 3): The CNM2 should be monitoring the nurses on her unit and making sure that practices are being done correctly. She should be monitoring and supporting the nurses and that does not always happen. To me this is where evidence-based practice starts.

ADON (No.8): The CNM2 ensures that evidence-based practice is happening in the unit.

The word 'clinical' in the nurse manager's title denoted a clinical remit with associated duties and responsibilities whether working as a CNM2 or CNM3. Some specialist departments employed CNM3s who retained clinical and managerial remits. For the CNM3, wearing the uniform symbolised EBP in terms of leading, mentoring, and providing 'hands-on' support for staff in the clinical setting.

CNM3 (No 1): I don't wear a suit; I wear a uniform because I don't sit in an office all day. I am out on the floor doing the caring, the teaching, the supporting, the mentoring. I feel I am leading and they don't even know I am leading.

CNM2s substantially increased their clinical responsibilities as a result of staff shortages in the current environment. Similar to the CNM3, the consistent presence of the CNM2 from Monday to Friday enabled her to know the patients and facilitate continuity of care.

CNM2 (No. 8): I could do a drug round three times a week. It is important because I am part of the reality of practice.

CNM2 (No.4): The CNM2 works Mon-Fri and is there every day whereas staff work long days, so they are here today and gone tomorrow. You have to know what is going on, so you have to be out there.

Frontline nurse managers retained their clinical skills and competencies, which contributed to EBP; nevertheless, as I reflected on participants' accounts of the extent of their clinical nursing duties, I was concerned with their lack of reference to mentoring, supervising, or managing staff. In fact, one got the sense that the CNM2 had replaced the senior staff nurse in general medical and surgical wards; yet, the CNM2 retained responsibility for managing her unit.

CNM2 (No.5): My clinical role is at the forefront at the minute. My role is to be out there and hit the ground running helping and supporting staff. By the time Friday comes there is very little I don't know.

I sought further clarification from mid-level nurse managers regarding the CNM2s roles and responsibilities in the context of clinical governance and EBP. One mid-level nurse manager acknowledged that CNMs in her hospital were never supernumerary; consequently, in her view, CNMs continued to effectively balance their responsibilities to enable EBP.

> ADON (No.3): Our CNMs were never supernumerary. They always had clinical caseloads not like other hospitals. It's not a problem for them as they've always managed to balance clinical with management.

Governance, as a component of EBP, re-emerged when participants articulated their roles and responsibilities regarding dealing with clinical incidents. As layers of accountability were unravelled, differences emerged regarding answerability. Ultimately, the CNM explained to senior management the circumstances that led to the incident, whereas mid-level nurse managers linked clinical incidences directly to policies and procedures. Mid-level nurse managers linked clinical incidents to staff not adhering to policy and subsequently aimed to establish why staff did not adhere to evidence-based policy.

> ADON (No.7): Incidences around medication management usually means that the policy wasn't adhered to.
>
> ADON (No.4): When there is an incident such a patient falls, I will go and check the documentation that is evidence based, and I will check if there was a falls risk completed and if it hasn't been done, I will be asking why.

The HSE (2008) stipulate that investigation of incidents must take a systems/root cause analysis approach. Systems analysis establishes what happened, how it happened and why it happened (HSE 2009b), rather than focusing on the actions of the practitioner in relation to adherence to policy. Participants explained that incidents sometimes occurred when there were no policies or guidelines in place;

hence, it was the responsibility of the mid-level nurse manager to retrospectively devise a policy to guide EBP.

> ADON (No. 9) Development of policies, procedures and guidelines can be in relation to a serious incident. The incident form lands on my desk and then I get a phone call to initiate the policy.

> ADON (No. 2) Policies are developed following incidents to formalise practice for example we had a patient admitted with diarrhoea and chest pain. She was given a single room because of the diarrhoea. She later collapsed because of an MI but the ECG that she had taken earlier that day had not been reviewed…Her treatment was delayed because of this but luckily everything was ok. We subsequently developed a policy and procedure so that the person who records the ECG signs it and this person is responsible for having the ECG reviewed and signed by a doctor.

In 2009, the HSE published a toolkit of documentation to support incident management, incorporating a hierarchy of controls to guide staff regarding risk reduction strategies (HSE 2009b). Elimination of the hazard is the strongest control with introduction of new policies, procedures, and guidelines at the bottom of the hierarchy; yet, mid-level nurse managers continued to develop policy as a priority risk reduction strategy.

In contrast to mid-level nurse managers, CNMs considered themselves accountable for explaining the factors that contributed to the clinical incident. While the stress of an official investigation affected all staff, the CNM was the person who explained what happened, how it happened, and why it happened to the investigating team.

> CNM2 (No.3): Every nurse is responsible and accountable but ultimately it comes back to me.

> CNM2 (No.2): We have had incidents around particular nursing practices and when there is an official investigation, it certainly gets people thinking. But at the end of the day it comes back to the CNM because nurses don't want to take responsibility for their actions.

> CNM2 (No.6): I have no help really. Nursing staff are afraid of evidence-based practice and they take a step back. At the end of the day I am the one who has to track back and see what happened and why it happened.

Following the initial investigation, the mid-level nurse manager arranged what they termed a 'desktop review', which involved investigating what happened and why it happened.

> ADON (No.8): I lead out on desktop reviews. I review all the documentation and I meet with all staff that was involved. We look at what happened, what went wrong, was it our fault, and what can we learn from this to prevent the same thing happening again. It is formal and there are minutes taken and there is always a change in practice as a result.

According to the HSE system analysis involves wider examination of aspects of care delivery, including communication within the team and the ability of the team to work together to deliver safe care (HSE 2009b). CNMs considered 'desktop reviews' as contributing to EBP as this forum brought together key members of the team to formally discuss clinical practice with a view to improving patient care. Unfortunately, as identified by a participant, the review only takes place after the incident has occurred. It does, however, pave the way for better practice based on evidence.

> CNM2 (No.8): Desktop reviews are a great way of getting the consultant, nurses, the DNM and myself to sit down and discuss clinical practice and we review care and balance risks with benefits. Unfortunately they only happen because there has been an incident and we've been asked to review it.

In summary, EBP necessitated good clinical governance, which included monitoring nursing practices, mentoring, supervising and managing staff, and investigating clinical incidences. The roles and responsibilities of mid-level and frontline nurse managers for the quality, safety and satisfaction of patients differed. CNMs were responsible for monitoring patient care standards in their respective units where as mid-level managers took less responsibility at clinical level. CNM2s accounts illustrated the extent of their clinical nursing duties with less emphasis on mentoring or monitoring standards of practice; therefore, evidence-based practice may be compromised. Governance in relation to management of incidents reiterated distinctions between nurse managers' roles and responsibilities. Ultimately the CNM justified to the investigating team what happened, how it happened and why it

happened, whereas mid-level managers establish if staff adhered to evidence-based policy.

6.2.3 Developing, Implementing and Evaluating Best Practice

Developing, implementing and evaluating best practice directly links the development, implementation and audit of Policies, Procedures, Protocols and Guidelines (PPPGs) to EBP. According to the Health Services Executive (2009c, p.6), 'PPPGs represent a statement reflecting an expected standard of care and could be introduced in law as evidence of the standard of care expected. During interviews, no prompting on PPPGs was required as participants articulated their views on the 'development', 'implementation' and 'evaluation' of best practice policies and guidelines. From the outset it was evident that participants had polarised views on the value of PPPGs to EBP. Some participants stipulated that all nursing practices be based on PPPGs, whereas others considered PPPGs as paper exercises that did not reflect the reality of clinical practice.

> ADON (No.8): PPGs are there to standardise care but they are not the bible. They have a purpose and they are important as they reassure staff that they are doing the right thing.

> ADON (No.1): The majority of PPGs are paper exercises and they are not implemented.

> CNM3 (No.2): In the absence of evidence the guideline standardises practice because everyone will have a different opinion.

> CNM2 (No.1): Staff want guidance and standarisation and they make regular suggestions that they want a policy to guide a particular practice.

Clinical guidelines support evidence-based practice; however, there are concerns regarding their quality and implementation (Government of Ireland 2008). Without exception, all participants identified PPPGs as a component of EBP; yet, some nurse managers considered PPPGs as potentially restricting, unrealistic and rarely used to

guide clinical practice. Undeniably, there were folders of policies stacked high in each participant's office; however, the extent to which these policies informed and guided clinical practice was not confirmed. Mid-level nurse managers were adamant that PPPGs represented the expected standards of care; yet, they admitted that staff were not familiar with the PPPGs and were therefore not adhering to these standards of care.

> ADON (No.5): To be honest I don't think too much of PPPGs because there are so many of them and staff don't even know where to find them a lot of the time.

> ADON (No.6): There are folders and folders of PPPGs out there, and when I go out to check if they have a policy on X,Y or Z, the staff cringe and nobody knows where to find it, and generally speaking we don't find it and I end up coming back to the computer and printing it off the intranet. I go back out and make a big deal of it for a week or a few weeks, and then it all dies down until the next fire starts and off we go again.

Some mid-level nurse managers supported an argument for not basing practice on policy and procedure. In particular, participants believed that patients' individual needs could not be anticipated or prescribed.

> ADON (No.2): You cannot policy all practice. The environment must be open for people to raise concerns.

> ADON (No.4): When you are dealing with people and varying human responses, it is very difficult to policy for variations, as one size does not fit all. If the policy doesn't work, I ignore it and revert back to my own clinical experience.

Other participants considered PPPGs to be overly wordy and cumbersome, incorporating numerous pages outlining roles and responsibilities. The actual standard or procedure was difficult to access within the document. Subsequently, PPPGs were seldom referred to when they were attempting to make evidence based clinical decisions.

> CNM2 (No.4): There is too much paperwork associated with PPGs. When they are issued we get pages and pages on roles and responsibilities, scope, definitions and it goes on. Staff just need to know what is important for me, do I need to change or continue on as I have been doing.

Hospitals throughout the world engage in the development of policies and procedures; yet, many nurse managers in this study worked independently of other departments and services to devise PPPGs. The National Clinical Effectiveness Committee (NCEC) established in 2010 is currently working on the development of quality assured national guidelines; but, in the interim participants had not managed to establish a system of streamlining development and refinement of PPPGs to avoid duplication.

> CNM2 (No.10): Whilst the equipment for say suctioning may vary, the procedure should be the same in Cork, Dublin and New York. But we all re-invent the wheel and write policies and it is such a waste of valuable time.

Participants' accounts of the processes involved in the development and implementation of PPPGs also differed, with some mid-level nurse managers accepting responsibility for development, whereas others allocated this work to CNMs.

> ADON (No.9): DNMs are the link between clinical practice and the quality governance structure because we get communication from the quality governance committee about the development and implementation of policy.
>
> ADON (No.1): I am not the clinical expert; therefore I afford the experts the respect of writing the PPG.
>
> ADON (No.8): As a DNM, I am involved in the development of guidelines. I link with colleagues in other hospitals and we use literature and other guidelines such as NICE to develop our PPGs.

Although there is a standardarised template to guide PPPG development (Health Services Executive 2009c), participants' accounts of the actual development process varied considerably. Many mid-level nurse managers and CNM3s sourced and appraised literature to inform PPPG development, consulting with key stakeholders such as CNMs, physicians, staff nurses or allied health professionals. CNM2s tended not to have time for PPPG development in the current environment; yet, some mid-level nurse managers delegated this responsibility to the CNM. Subsequently the

process of PPPG development was delayed or even shelved, as the CNMs priority in the current environment was 'hands on' patient care at the expense of standard setting and EBP. Nevertheless, CNMs remained accountable for the standards of care in their respective units.

> ADON (No.5): We are so short staffed and CNMs are so busy that a lot of this work falls on me to do. I work with the CNMs.

> ADON (No. 3): It is the responsibility of the CNM2 to update the PPGs. As a DNM I am responsible to make sure the PPGs are available, but it is the responsibility of the CNM2 to make sure they are done and that they are working okay.

The PPPG development process was complex and lengthy, necessitating effective use of interpersonal and facilitation skills. Achieving consensus among professionals who have expert knowledge and experience in any given area was challenging. The process was further prolonged when different disciplines failed to provide feedback. Although it was difficult to bring people together at a meeting, participants considered this collaboration essential to advance the process of PPPG development.

> ADON (No.6): It's about getting everyone around the table, engaging with people and getting their feedback. If you just send the PPPG out for feedback, you will get nothing back. If you don't get a meeting together, it is a disaster.

> ADON (No. 9): I spend a lot of my time chasing feedback and it is very difficult to get people together.

Both mid-level nurse managers and CNMs agreed that it was important that the person or persons developing the policy and procedure had the requisite skills and knowledge to source and appraise the evidence whilst being clinically competent to perform the procedure. In fact, participants considered it dangerous when the person writing the policy was not familiar with the procedure.

> CNM2 (No. 7): The author or authors of the procedure must be familiar with the practice. There is a skill set which the author must meet including the ability to source and appraise the evidence including research, and be clinically competent to carry out the procedure.

> CNM2 (No.8): I always worry about people writing guidelines who aren't familiar with the practice. It is very easy to make it complicated and to be honest it is very dangerous also.

> ADON (No. 5): You need the specialists involved. They provide the practicalities that you won't get in the books.

The complexity of PPPG development in the context of EBP was further exemplified when participants acknowledged that many nursing practices were not supported by research. Nurse managers reverted to other sources of evidence including colleagues, past experiences, intuition, and experts to inform the content of the PPPG. In the absence of any evidence, nurse managers sometimes decided to trial the nursing practice and monitor the outcome.

> CNM3 (No.2): Evidence based practice is practice based on research. Some nurses do procedures which may not be based on research but that doesn't say it is not the right way to do it and it is not evidence-based.

> ADON (No.7): There are a lot of grey areas whereby there is no research or evidence to inform the practice. Sometimes you rely on instincts or you would contact a colleague. We have a close network to inform different queries and what has worked in other areas. At the end of the day instinct prevails and you may decide to trial a practice and see how it goes by monitoring the outcome.

> ADON (No.2): Its not straightforward black and white. Trials don't solve everything. Sometimes the evidence is not there and it is a case of trial and error.

Mid-level nurse managers accepted responsibility for reading PPPGs in advance of 'sign off' by the Director of Nursing.

> ADON (No.10): The ADON reads all PPGs before they are signed off by the Director.

> CNM (No. 4): The Director of Nursing signs it off, but it is the person who writes it who makes sure it is accurate.

> CNM (No. 2): The Practice Development Co-ordinator develops most of the PPGs and the Director signs them off.

According to the HSE (2009c, p.10), 'a three-step formal process is required to sign off a PPPG in advance of final approval and sign off'. The first step includes

consultation with individuals from within or outside the organisation who provide assurance regarding the content of the PPPG. The second step involves circulation of the PPPG to all managers who will implement the PPPG, and the third step is 'sign off' by the Chair of the development group who then forwards the PPPG to the 'Core Management Committee' for approval (HSE 2009c: 11). However, these steps were not evident from participants' responses as Directors of Nursing 'signed off' PPPGs without validation of the content by individuals from either inside or outside the organisation. Whilst the development of PPPGs is integral to EBP, ensuring that they are user-friendly in the clinical setting is paramount to developing an evidence-based culture in the delivery of care.

In the current environment there was no formal education to support implementation of PPPGs; yet, the HSE stipulate the development of an 'Implementation Plan' for each PPPG (HSE 2009c). The 'Implementation Plan' includes assignment of a named person responsible for implementation, identification of training needs, realistic resources required to implement, and the most effective method to communicate the PPPG to staff (HSE 2009c: 10). Participants made no reference to 'Implementation Plans'; therefore, in practice once the PPPG was signed off, it was the responsibility of the CNM to ensure staff had access to this evidence-based information. Participants utilised various modes of communication to ensure staff were made aware of the existence of the PPPG including verbal, written and electronic. However, CNMs accounts illustrated that they struggled with reading and filing these documents.

> ADON (No.1): To get the policy into practice, ideally there is education but this is not always possible. Simple things like emailing the link to where the guideline can be found is useful, and summarising the changes required.

CNM2 (No.5): I flag it during handover, highlighting the key points.

CNM2 (No.7): I use the communication book to inform staff.

CNM2 (No. 9): I don't know where to go with PPGs. They are coming to me by email, they are being dropped off to me and I don't even have time to read them. In fact if you asked me this minute for a particular PPG, I wouldn't know where to start looking.

'All staff members must sign a signature sheet to confirm they have read, understand and agree to adhere to the PPPG' (HSE 2009c: 12). Mid-level managers welcomed this relatively new practice as this declaration placed the onus on each individual practitioner to adhere to the PPPG, ensuring their practices were based on evidence within the policy or guideline.

ADON (No.1): Nurses must sign that they have read the PPG, this is new that they have to sign that they have read them, and it's a good thing.

ADON (No.5): We get the staff to sign a signature sheet stating they have read the PPG and agree with it, and we attach it to the master copy. When staff have read and signed it, basically it is up to themselves to be accountable for their practices and what they are doing.

Interestingly, CNMs were less convinced that reading and signing a declaration of adherence led to compliance with the PPPG, and perceived this exercise as simply a strategy to protect the organisation. CNMs were based in the reality of practice in these busy units. They believed that PPPGs did not guide staff in terms of care delivery. According to CNMs, PPPGs have the potential to contribute to evidence-based practice when implementation was supported with structured education, which involved time, commitment, and engaged staff. In practice, however, implementation of PPPGs was not priority as other demands on CNMs and staff took precedence, reducing the value of PPPGs to mere paper exercises.

CNM2 (No.1): The practical application of EBP is not supported; the writing of PPPGs is an exercise in ensuring the organisation has legal cover in the event of an incident. They are not there to support staff in terms of the practice they are delivering. EBP can only happen when you have a group of people that are committed to rolling it out in a fashion that engages staff and to do this you need time, you need resources and you need people. Right now it is at the bottom of a long pecking order of demands that are placed on CNMs and staff on a daily basis, and if it is not facilitated in a structured way, then it is effectively a paper exercise.

Having acknowledged the challenges associated with PPPG implementation, CNMs described their endeavours to monitor EBP by auditing adherence. Care bundles are defined as 'a number of related evidence-based interventions, which when followed consistently for every patient each time care is delivered, result in improved patient outcomes (HIQA 2012a, p.140). CNMs used care bundles to guide the audit of certain policies and procedures such as 'Care of a peripheral venous cannula'. 'Clinical audit seeks to improve patient care through the systematic review of care against explicit criteria' (HSE 2012, p.13) and CNM2s endeavoured to conduct clinical audits. Participants described how audit findings contributed to EBP by substantiating their concerns with data from the audit, which were subsequently acted upon to improve patient care.

> CNM2 (No.4): I audit the venous cannula care bundles and I am involved in the hygiene audits.

> CNM2 (No.5): The audit I am doing at the moment is foetal heart monitoring and the audit tool is from the guideline. Audit substantiates what we thought already and we have changed practice for the better as a result of audit. We felt that babies post caesarean section came back to the unit cold so we did the audit and yes it supported what we thought. The practice is changed now and babies are wrapped much better and they wear hats.

In summary, this category focused on the development and use of PPPGs in supporting and guiding EBP. Mid-level and frontline nurse managers had differing opinions regarding the extent to which PPPGs supported nursing practice. CNMs considered PPPGs as paper exercises that protect the organisation in the event of an incident whereas mid-level nurse managers described PPPGs in terms of expected standards of patient care. Although implementation of PPPGs was unstructured and haphazard, CNMs described EBP in terms of their endeavours to audit and improve patient care.

6.2.4 Service-user involvement and Evidence-Based Practice

Participants discussed service-user involvement in terms of patients being involved in 'decisions about their own care at clinical level', and also at 'strategic level in relation to policy development'. According to the DoH&C & HSE (2008) service users contribute to local health service delivery in addition to contributing to the development of strategic national health policies. Service-user participation at strategic level including the planning, design and delivery of care and support services can lead to improved outcomes and better health and well-being (HIQA 2012). Participants, of this study, concurred that service users ought to be involved in decision-making as a necessary component of EBP; however, this was a relatively new concept and participants admitted they were unsure how to facilitate service user involvement in decision-making at strategy level. Service user involvement at strategy level was currently more of an aspiration than a practical reality. Participants requested assistance to enable them to engage in collaborative decision-making with service users regarding service development.

> CNM2 (No.8): I would like to involve patients so that we can truly improve the service and make it more user friendly but how do you do this?

> CNM3 (No.3):I like the idea, but at a practical level I don't know how it could be done. The ideological side of my head sees how patient involvement would be very beneficial, I would like someone to show me how it could be done.

'Open dialogue, trust and mutual respect are key ingredients of successful service user involvement' (HSE 2008, p.11). Participants were hesitant to engage in open discussions with key stakeholders at decision-making forums when service users were present. Participants feared there might be consequences when service users were involved. They expressed concerns around exposing weaknesses in the organisation and frightening patients when they were made aware of problems such as staffing issues.

ADON (No.7): We wouldn't like to expose our weaknesses and show up the organisation.

ADON (No.1): The last thing we want to do is to frighten patients when they realise we don't have enough staff.

Participants perceived that the Irish health service was unprepared for service user involvement, calling for current decision-making processes to be reviewed in advance of seeking service users' perspectives.

ADON (No.9): Get our own house in order and then invite the patients.

CNM2 (No.5): It is very difficult. To be honest do you actually want someone to be there listening to the issues and problems that we have before we actually get them somewhat sorted.

ADON (No.3): We are trying not to portray ourselves in a bad light and yet we are trying to give information in a transparent way.

Nurse managers, have traditionally dominated policy development and subsequent service delivery; hence, there may be an element of hesitancy regarding relinquishment of power and control on the part of professionals. Trust was identified by participants as a critical success factor to enable nurse managers, professionals and service user representatives to perform and work together, based on recognition of each member's contribution, shared decision-making, and mutual respect. Participants endeavoured to retain control of decision-making by choosing when and if service users were to be involved in policy development.

ADON (No.7): Choosing the service user to be involved in policy development is important, as you want someone who is knowledgeable and who will give a balanced view.

CNM2 (No. 8): You need to trust this person implicitly to make sure that what is discussed does not go outside the meeting.

Despite participants' apprehension, there was evidence that service users were involved in policy development, which contributed to EBP. Participants articulated how they involved patients and families in policy development and it was

encouraging that matters such as waiting times and parking were adapted to improve patients' experiences.

> ADON (No.9): We developed a policy on caring for the patient who is confused and we held a focus group with patients and families to get their views. I found it difficult to manage as some people wanted to complain about the service rather than contribute to improving it. But at the end of the day we got the detail needed to make it work. And we re-organised the anti-coagulant service because things like parking and waiting times were most important to patients and their families and that's what makes the difference.

> CNM (No.4): Patients with diabetes come into hospital and it is policy now that they do their own glucose monitoring and administer their own insulins as they know best.

Service user involvement at clinical level differed in the sense that service-users contributed to decisions regarding their own care. According to the DoH&C & HSE 'service user involvement contributes to safer, more accessible, and improved quality of care whereby patients are involved in their own care as partners with health professionals' (DoH&C & HSE 2008, p.15). Participants explained that patients had become more vocal and confident in asserting their care preferences. Patients attending specialist units were most proactive in managing their care. These patients differed, as they informed the medical and nursing staff of their care needs. The level of patient involvement in clinical decision-making depended on the patient's knowledge of his or her condition. Patients who attended Clinical Nurse Specialists (CNSs) were considered knowledgeable. Interestingly, the SCAPE study, which evaluated the role of the CNS in Ireland, found that the health promotion and education skills of CNSs enhanced patients' knowledge (Begley et al 2010).

> CNM2 (No.1): Patients with heart failure-they tell the consultant what meds to change and what not to change. They tell the consultant, they tell us. Patients with leg ulcers, they are another group that dictate their care and they won't let you touch that dressing until the day it is due to be changed.

> CNM2: (No.2): Patients who attend Clinical Nurse Specialists are very well informed.

In summary, participants endorsed service user involvement at both strategic and clinical levels as contributing to EBP; nevertheless, they expressed real apprehension

related to the transition from entire control over policy and practice to shared decision making with service users. Participants shared examples of service user involvement, yet they yearned further guidance and instruction regarding service user involvement at both strategic and clinical levels.

6.3 Theme Two: Nurse managers' views of enablers and barriers to Evidence-Based Practice (EBP).

Theme two presents participants' accounts of 'enablers and barriers to EBP' which, are discussed under the following five categories: *'Utilising Resources to achieve Evidence-Based Practice, 'National Guidelines', 'Capacity to fulfil Roles and Responsibilities', 'Resistance to Change', and 'The Current Clinical Environment'.*

6.3.1 Utilising resources to achieve Evidence-Based Practice

The Report of the Commission on Patient Safety (Government of Ireland 2008) reiterates the individual responsibility of each member of staff working in the health service to ensure patient safety and quality. Despite working in an environment that placed increasing demands on staff, CNMs believed that nurses strived to achieve EBP by delivering quality safe patient care.

> CNM2 (No. 2) Patient safety comes first for all staff working here.
>
> CNM2 (No. 4): I am so lucky because I work in a unit where everyone puts the patient first.
>
> CNM2 (No.5): 100% of my staff here are passionate about what they do and they want to do it well.

CNMs acknowledged their own knowledge deficits, describing how they worked with experts and other members of the multidisciplinary team to resolve problems, find solutions, and achieve EBP.

> CNM2 (No.4): We have to realise that we are all learning all the time.

> CNM2 (No.7): I am learning too and it is not like I am the ultimate one that makes the decision here. Staff are highly qualified and they are very committed, they will all take responsibility for their own actions and they ask only when they are not sure about something.

> CNM2 (No.2): I am not the perfect human being and I may not be doing it perfectly either, but it is important for me to know what is going on at the bedside.

CNMs shared information with other members of the multidisciplinary team, the patient, and the staff that they managed. CNMs reported working alongside their staff to achieve EBP, endeavouring to create an open environment where staff were not afraid to ask questions.

> CNM2 (No.4): EBP is as much about the team working together as it is about PPGs. It is about collaboration and communication between us. And I feel that the CNM2 has a key role in creating the environment for this to happen.

> CNM2 (No.6): There has to be an open environment where people are not afraid to question and don't for God sake be afraid to say I don't know how to do that - everyone is expert in something but no one is expert in everything and I don't know everything either.

Both CNM3s and CNM2s had clinical roles and responsibilities, and as leaders they worked to achieve EBP at the bedside. CNM3 posts were limited to specialist units where they had the support of a CNM2; therefore, CNM3s achieved EBP by avoiding complacency with the introduction and monitoring of new practices.

> CNM3 (No.1): As a CNM3, I would be about 50/50. We have introduced a number of new care pathways and I want to see how they are working. It is important that we don't get complacent and I also need to know what I need to audit.

Participants in specialist areas acknowledged that established links with other specialist departments enabled them to access information, including research.

Participants provided examples of resources that enhanced availability to research, including librarians visiting units to supply relevant nursing journals. Resource boxes were available in some units where journals were stored, making literature and research readily accessible to all staff. Likewise, all CNMs received regular email alerts with links to the latest editions of contemporary nursing journals attached; therefore, nurse managers in this study had access to full text journal articles without having to go to the library.

> ADON (No.10): Nurses don't have time to access information during their shifts, and they certainly don't have time to go to the library. Therefore the Librarian goes to each unit and places articles of interest in a resource box. I have never seen a nurse googling a health topic during a day shift… occasionally on night duty.

Some participants considered information provided by sales representatives (Reps) as a valuable resource that provided them with research to support various products, enhancing their knowledge and thus contributing to EBP.

> CNM2 (No.3): Reps guide us quite a lot. I know they are trying to plug their own product but I always look for research to back up the product.

> CNM3 (No.2): Reps send us on study days and they also provide on-site training and support.

While the benefits of study days and on-site training may well contribute to EBP, there is no real evidence in these data that participants were aware of product information, which could be biased towards selling the product. Although there was reference to a CNM2 requesting research to support the product, there is no evidence of established processes to appraise the evidence presented by 'Reps' or an awareness of potential bias in the information they provide.

6.3.2 National Guidelines

Both mid-level and frontline nurse managers concurred that clinical guidelines, signed off at national level, contributed to EBP. 'Clinical guidelines are systematically developed statements, based on a thorough evaluation of the evidence, to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances, across the entire clinical spectrum' (National Clinical Effectiveness Committee (NCEC) 2012, p.7). Mid-level nurse managers, in particular, supported the use of national guidelines, as they perceived that these documents would contribute to EBP by standardising nursing practices.

> ADON (No.9): National Guidelines are the only way forward as there need to be standardisation for practices such as IV drug administration, phlebotomy, suctioning, catheterisation… There may be slight changes needed locally but patients would be guaranteed that every hospital in the country is basing their practices on up to date policies and guidelines.

Participants recognised that development of national guidelines necessitated consideration of a number of factors, including appropriate representation of key stakeholders on the development group. The clinical guideline development group, in their view, should consist of committed individuals with expertise in the area, incorporating all members of the multidisciplinary team and the service-user.

> ADON (No. 7): It will be difficult. It is difficult enough to get agreement regionally. But the key is to get a group of committed experts to do the national policies and procedures. Say for example palliative care you need a lead clinician, a lead nurse, pharmacist, psychologist.. and of course patients and their families.

Both mid-level nurse managers and CNMs insisted that national guidelines should reflect the reality of clinical practice. From participants' perspectives, it was imperative that the groups developing these guidelines ensured the content was applicable to clinical practise.

> ADON (No.1): The policy should be appropriate to the service we provide. If I want to use the policy on caring for the homeless person, I must do so between 09.30 hrs and 17.30 hrs (Monday-Friday). If I go to use the policy outside these hours, the policy will not inform the care I deliver because the services referred to in the policy are not available.

Once national guidelines are available, it is imperative that staff can access these guidelines with ease. Participants described current difficulties associated with accessing information, including convoluted steps to navigate the intra-net.

> CNM2 (No.10): We'd only access policies and guidelines for something unusual like maybe an infusion. There are folders and folders of information up there but no doubt I won't find the instructions I need in any of them. And the computer doesn't help. Surely it could be set up so that I can get information quickly.

Participants proposed national online sites or hubs as means of facilitating speedy access to national guidelines, which would support EBP. By directly accessing a hub, staff could avoid the complexities associated with searching the intra-net.

> ADON (No.8): It would be great if we could access national hubs such as 'Orthopaedic Hub' or 'Maternity Hub' or 'General Surgery Hub', and we would all be able to access national guidelines in these hubs.

In summary, the recent establishment of the National Clinical Effectiveness Committee (NCEC) in 2010, as part of the Patient Safety First initiative in Ireland, will result in a 'framework for national endorsement of clinical guidelines and audit to optimise patient care' (NCEC 2012, p.5). Appropriate representation including clinical experts will, according to participants, ensure national clinical guidelines contribute to evidence-based practice.

6.3.3 Capacity to fulfil roles and responsibilities

Having identified governance as central to EBP, participants illustrated that daily monitoring of clinical practice was fundamental to EBP; however, mid-level nurse managers suggested that they had limited capacity to monitor standards, as in their view, they were not clinical experts.

> ADON (No. 3): I can't know everything, I am not the expert

Mid-level nurse managers had responsibility for a number of units; however, these nurse managers did not have a clinical role and did not engage in direct patient care. Subsequently they relied on CNMs to monitor nurses' practices, acknowledging the CNMs' capacity to deliver evidence based nursing care.

> ADON (No.1): I support the CNM2. The CNM must be clinically competent. She needs to be able to do a drug round, insert a catheter, remove a suture, prepare a patient for theatre, she should not be stuck in the office doing paper work. Doing off-duty and ordering stores takes up an awful lot of time for the CNM.

Mid-level nurse managers visited their units daily and availability of the line manager was in itself a support for CNMs. Unfortunately most mid-level nurse managers had offices in administration departments or buildings some distance away from their clinical areas, whereas mid-level nurse managers with offices nearer the clinical area were more accessible.

> ADON (No.6) I am located here right on the frontline, people describe my office as like a bus stop because they are in and out all the time. I am out there in a flash when something comes up and my role involves an awful lot of problem solving. I try and leave it to the CNMs to sort out but if they hit a brick wall I am called in.

Although mid-level nurse managers sourced evidence to support change in clinical practice, limited clinical expertise in the area, in their view, undermined their capacity to progress the change. There was a sense of frustration among mid-level nurse managers that the evidence they provided, which was based on detailed researching and sourcing of information, was not valued. Yet, information presented by Clinical Nurse Specialists was accepted and utilised without the necessary supporting evidence.

> ADON (No. 10): It's difficult to question if it's not your area. I devised a clinical care pathway, which I spent a lot of time researching including getting evidence from specialists in America. A Clinical Nurse Specialist developed the same pathway and it is not clear where the evidence came from, yet it was accepted and adapted. But this is not my area so I am not confident to question this.

It was unclear from these data why mid-level nurse managers and Clinical Nurse Specialists developed clinical pathways independently of each other, as the clinical

expertise of the Clinical Nurse Specialist should have complemented the research skills of the nurse manager, resulting in evidence based clinical care pathway. Subsequently the nurse manager was aggrieved that the research, which she completed, was not included in the care pathway.

Overall, these data illustrated that mid-level nurse managers perceived themselves as the link between senior management team and frontline staff, including CNMs. Whilst mid-level nurse managers described their input into policy development and subsequent EBP, they also expressed discontentment with their limited capacity to fulfil their roles and responsibilities. Mid-level nurse managers were responsible for ensuring safe staffing levels; yet, they did not have the capacity to hire staff. Although mid-level nurse managers work at a senior level, they perceived themselves as having limited decision-making powers. There was a real sense of disillusionment among mid-level nurse managers, which limited their capacity to achieve EBP.

> ADON (No.5): As a Divisional Nurse Manager, you are jack-of-all-trades and master of none. I am involved in audit and I do a bit of everything really. Yesterday I ended up in nursing administration because we needed to redeploy someone out of there.

> ADON (No.6): Your hands are tied. We are very short staffed and we can't hire anyone. We are told not to use agency nurses. It just doesn't make sense at all.

6.3.4 Resistance to change

CNMs acknowledged that maintenance of EBP, including introducing new ways of working, was difficult as staff members resisted change. It took perseverance to get new practices embedded. The Health Service Executive (2009c) states that PPPGs are an essential tool to improve the quality of healthcare provision; yet, according to participants, staff resisted change and did not adhere to best practice stipulated in PPPGs. According to CNMs, nursing staff found it difficult to adapt to new ways of

practising; therefore, they reverted back to the familiarity of outdated practices. CNMs considered it their responsibility to drive EBP by consistently monitoring new practices and exhaustingly repeating and reinforcing the procedure to familiarise staff with the practice.

> CNM2 (No.5): One of the slowest learning elements of my transition to working as a CNM2 was the necessity to keep repeating myself. I could write a policy and have all the supporting documentation. But if I am not reinforcing it again and again and again... there will be slippage on it for example 'Wearing of goggles is for the individual's own protection but every so often I will have to bang on again about wearing them and it will work for a while and then the practice slips again… it hasn't embedded into their practice.

When an outdated nursing practice was witnessed, it was the CNM who spoke with the staff member and highlighted practice that was unacceptable. But undoubtedly staff still reverted back to the old way of doing things because it was familiar, convenient, or saved time. According to participants, it was imperative that all staff adopted best practice; otherwise, change was not successful. One CNM described how it took just one staff member to periodically revert to the outdated practice and all staff followed suit.

> CNM2 (No.2): Maybe it is human nature but they revert back to bad practices. Even when the policy and procedure clearly states that the nurse is not to do a particular practice, some nurses continue to do it. Therefore you have to be out there and witness the malpractice and draw it to the attention of the nurse. They have every rationale for doing it this way and this is because people don't want to be wrong. It is not easy because they wont take it lying down even though they are clearly in the wrong. At the end of the day it comes back to the CNM2.

> CNM2 (No.10): It only takes one person to keep repeating the bad habit and that's it, the other staff will revert back and do it also. Say for example now, a simple thing like keeping that medication press locked. I say it every single day and look it is open. Its convenient and it saves time not having to ask me for the keys but the policy says all medication must be locked away.

CNMs used various approaches to entice and motivate staff to engage in developing their nursing practices. The new Nurses and Midwives Act was considered helpful as it placed the onus on the registered nurse to demonstrate his or her competence; therefore, CNMs cited the Act to encourage staff to review their nursing practices.

> CNM2 (No.3): I try to get staff interested in a particular area and encourage them to work on the documentation say for example suctioning or wound care. I have to use a bit of coercion now with

> the pending Nurses Bill and I am using it as a stick to get people involved. And remember it is in our contract that we have to keep up to date.

Overall, from participants' accounts, it was CNMs rather than mid-level nurse managers who persisted with change initiatives in their efforts to achieve EBP in their respective units. However it was difficult to embed new practices as staff resisted change, reverting back to familiar ways of working.

6.3.5 The current clinical environment

The current clinical environment, as articulated by participants, was not conducive to EBP due to staff shortages. The CNM was torn between delivering patient care, maintaining best practice standards and striving to improve nursing practices. Having spent time interviewing participants, I witnessed CNMs visible exhaustion as they described daily challenges, which included co-ordinating whatever staff were available on a given shift, assisting staff to deliver patient care and managing the unit. In fact, CNMs reported that they felt guilty when they left the clinical area to complete administrative responsibilities in their offices. Terms like 'hitting the ground running' and 'constant toss up' were terms used by CNM2s to describe their work. Therefore, EBP enabling elements associated with the clinical role of the CNM2, discussed earlier, were considered in the context of managerial elements, which were relinquished. CNM2s admitted that hadn't time to read their emails.

> CNM2 (No. 7): I always feel guilty now when I come into the office to read my emails because if there is a problem out there or an issue which delays patients it is up to me to sort it out. The majority of my role at the minute is clinical and I am out there supporting staff.

CNMs described how they had no influence over staffing levels on their units and there were less staff to deliver patient care. CNMs coped as best they could in the

current environment as they juggled their responsibilities to ensure safe patient care was delivered.

> CNM2 (No. 2): Where you previously had five nurses, you are lucky to have four, more likely three so what do you do.. it is a constant toss up now.

With the onus on coping in the current circumstances, it was understandable that motivation for change among staff was stifled. Once again it rested with the CNM to generate enthusiasm among staff to achieve EBP. Frontline nurses managers were visibly frustrated when they described their struggles to motivate staff to engage in EBP. One participant's symbolic description of applying her motivation face in advance of engaging with her staff illustrated the effort that was required by CNMs. 'Putting on the motivation face' was deliberate and required effort by this CNM, implying that application of the motivation face masked another reality, which was not so motivated about EBP; rather, she struggled to balance challenges in the current environment.

> CNM2 (No. 2): As a manager you have to put your motivation face on and try and move people along but it is extremely difficult at the moment. The majority of staff want to come in at 8 o'clock, do their work and go home at half 8 that evening and they don't want to hear about changing practice or auditing.

CNMs themselves regularly planned to engage in EBP but despite their best intentions, plans were ambushed as priorities changed and patients' daily care needs took precedence.

> CNM (No.3): A lot of this is left to me and I never seem to have the time. The moratorium and recruitment embargo has impacted on us big time and it limits us in terms of examining our practices. I might have someone pinpointed to review a particular guideline and then nursing admin will ring and they are short in an area and we have to send a nurse. Revision of the guideline goes out the window.

> CNM2 (No.5): I had planned to audit ten charts this week, and I haven't got to one yet, it's just too busy and when its busy, standards slip.

No doubt the busyness of the current environment impacted on nurses' willingness to engage beyond the fundamentals of caring for their patients. Both mid-level and frontline nurse managers agreed that staff nurses were just too busy to engage in policy development. In fact many CNM2s stated that their own involvement in policy development tended to occur outside their normal working day.

> ADON (No. 6): Nurses have the intranet on their units but they don't have time to look at it, honest to God they don't have time. They are flying there all day every day and they have to fly to get the work done because there are admissions and discharges in the middle of everything, it is constant and it is relentless and then if someone is out sick, they are left short.

> ADON (No.7): The first thing you will hear is no, we are too busy and we can't take on anything else. So you have to quantify it down to how long it will actually take and simplify the process and keep re-iterating that this will have a better outcome for the patient…

> CNM2 (No.4): As a CNM, I don't develop PPGs. They come from above but I am involved in reviewing and revising them. I can't take on development of PPGs, I just wouldn't have time.

> CNM2 (No.6): PPGs falls back to me unfortunately and with the best will in the world, I would like to get them done in a timely fashion, but that is not the case at the minute.

> CNM2 (No.5): I look up information at home and I do drafts at home.

In summary, CNMs described how they led their teams through challenging times as they coped with staff shortages and increased clinical caseloads. They endeavoured to motivate staff to engage in EBP but this was difficult due to lack of time and resistance to change. Mid-level managers were less confident of their abilities to make EBP a reality, as they felt disempowered to fulfil their roles and responsibilities.

6.4 Theme Three: Nurse managers' opinions on making Evidence-Based Practice (EBP) a reality.

Mid-level and frontline nurse managers concurred that they needed support to make EBP a reality in nursing. Having identified enablers and barriers to EBP, participants

proposed tangible and realistic ways to enhance EBP and improve patient care. Participants identified *'Facilitating Nurses to Question Clinical Practices', 'Promoting Student Nurses contribution to EBP'*, and *'Enhancing Nurses' Confidence to speak as part of the Multidisciplinary Team'* as contributing to making EBP a reality.

6.4.1 Facilitating nurses to question clinical practices

Both mid-level and frontline nurses managers agreed that EBP involved changing the tradition of not questioning clinical practices to an environment whereby practitioners were critical thinkers who constantly questioned clinical practices. Acknowledging that questioning practice was relatively new to Irish nurses, participants were adamant that questioning was central to EBP.

> ADON (No.1): I trained in Ireland in the 70s and I learned everything off by heart, signs and symptoms, treatments, pre and post op care and I did not question anything and no one questioned if what we did was in the interest of the patient.

Participants conceded that nurses worked tirelessly to deliver patient care on a daily basis; however, their efforts were considered insufficient without reflection on the effectiveness of their interventions. Participants advised nurses to reflect on, and question their practices as opposed to caring without consideration of the outcome for patients and their families. Reflection enables practitioners to take the time to step back and ponder the meaning of situations in order to gain 'situational awareness and understanding' (Higgins 2011, p.583).

> ADON (No.1) Staff don't ask questions. Now they are to the pin of their collars and their main focus is to just get the job done. They need to stand back, find time and reflect on what they are doing.

Nonetheless, there was evidence in the data of questioning occurring in specialist areas where nurses did request evidence to support changing practices. Specialist

areas differed from general medical and surgical units. This was probably related to nurses' knowledge. Many nurses working in specialist units had completed higher diplomas in the speciality and were confident to question practices. Furthermore, nurses working in specialist units cared for smaller cohorts of patients; therefore, they had time to get to know their patients' individual needs and wishes. In addition, one CNM of a specialist unit referred to 'busy times with occasional lulls'; therefore, there was time to question, unlike general units where 'it was a constant toss up' to meet patients fundamental care needs.

> CNM3 (No.2): Staff want to see the evidence and they will not introduce anything new unless I am able to demonstrate there is a good reason for changing. Here you are questioned to an inch of your life and they won't just question me, they will question SHOs, registrars and the consultant.

One wondered if questioning related to new procedures or drugs rather than 'routine practices' that were rarely considered. Participants' responses indicated that nurses, even those working in specialist areas, became over familiar and complacent about nursing routines that they learned during their nurse training. Nurses, in their view, needed to constantly question all clinical practices in an effort to achieve EBP.

> CNM2 (No.5) Nurses are so used to doing the everyday practices that they don't think twice about it. Normal ordinary practices are done the way we learned them in nursing school all those years ago and it is only when something out of the ordinary happens that we start looking for evidence. And then it's too late because something has happened.

6.4.2 Promoting nursing students' contribution to Evidence Based Practice

Both mid-level and frontline nurse managers purported that nursing students contributed to making EBP a reality when they were enabled and encouraged to ask questions and appraise practice. Nursing students completed case studies during their placements and staff learned from these presentations.

> ADON (No. 9) Students do case studies and they might review a policy or guideline. I try to attend as many as possible because it encourages the student to question clinical practice and we all learn from these presentations.

Yet, with the exception of scheduled learning activities, nursing students rarely questioned practices during their placements, tending to blend into the environment and adapting its associated ways and routines whether they were evidence based or not. From participants' perspectives, the move to an all-graduate profession had not influenced EBP, as nursing students did not link theory with practice during their clinical placements. In their view, nursing students accepted the nursing practices, which they observed in the clinical area, without questioning.

> ADON (No.7) I have seen an awful lot of our own diploma nurses adopt bad practices that they have learned from senior nurses here. And I have had to challenge them on this. They are taught evidence-based practice in the university but it is not easy when they come here.

> ADON (No.5) I think student nurses just go with the flow and it would be very seldom that they would ask questions. I don't notice any difference in patient care since we moved nursing into the college.

Nursing students adopted the task-orientated routines that continued to guide nursing practice in many units. Despite participants' earlier accounts of knowing each patient's unique personal and emotional needs, CNMs admitted it was easier to continue the task culture rather than try changing routines.

> CNM2 (No.2) We talk about this theory practice gap but when the students or interns come into the clinical environment they just seem to blend and they never ask why. If you say we'll wash all the patients first and then we'll do the obs, they will just follow suit. I can't understand why students go through four years of training and successfully complete their degrees with the latest research but they don't translate it here. Mind you, I have also blended into the task culture since I took up post here because it is easier than trying to change routines.

Despite accepting and adopting the routines of their clinical placements, nursing students subsequently expressed their concerns to Clinical Placement Co-ordinators or directly back to lecturers in the university. CNMs received feedback reports from the university highlighting areas for improvement; nevertheless, there was no evidence that this information subsequently contributed to EBP.

> CNM2 (No.4) Students bring a wealth of knowledge. But they tend to voice their feedback through their CPC or back to the college. We get a yearly report from the college and yes there would be information there about improving our practices say for example our routines where we all pile into a ward to get the tasks done and this is not what the theory would say about patient allocation.

CNMs acknowledged that questioning nursing practices by nursing students, interns, or newly qualified graduates was not encouraged; rather, critical thinking was 'knocked out of them'. Since questioning of clinical practices or routines provoked conflict, nursing students suppressed their views in exchange for acceptance by the team. Participants suggested that nurse lecturers support nurse managers in making EBP a reality by engaging with staff nurses and managers and assisting them with applying theory to practice.

> CNM (No.1) Graduate nurses come out of college as critical thinkers but going out there as a critical thinker and willingness to challenge is not easy. It is knocked out of them because they are not allowed to practice the way they are taught. I had to intervene recently over a care plan that an intern wrote. The staff nurse wanted her to re-write it and she was in tears. To be honest we need help with all this. The lecturers from the university should be out here.

> CNM (No. 4) Nurse educators need to see what is happening on the ground.

> CNM (No.6) Nurse lecturers are in the ideal position to source the evidence and adapt it in consultation with clinical staff to what would work in clinical practice, marry the two and it would be an ideal world.

Many newly qualified graduates worked as agency staff, replacing experienced nurses who had recently retired. The loss of these experienced senior nurses meant there was very little support for newly qualified graduates, and participants stated that the current skill mix impacted negatively on EBP. Participants expressed concern for newly qualified nurses, as nurse mangers did not have time to mentor and support them. Mentorship and supervision, in their view, was required to enable nurses to deliver EBP.

> CNM2 (No.2) The senior nurses who recently retired are replaced by our newly qualified nurses who are working as agency. Yesterday I had two agency nurses, one student nurse and two healthcare assistants. Now this is not good skill mix. The agency nurses couldn't do the IVs, the meds, the VAC dressing and whilst they did their best and I did my best, its just not good enough.

> CNM2 (No. 8) Newly qualified nurses need further support. You can't just let them off and expect them to develop. There must be appropriate supervision and mentorship so they can develop skills. At the minute, this is not happening and it's impacting on patient care.

Participants acknowledged that nursing students possessed a wealth of theoretical knowledge that could contribute to EBP; however, the clinical environment didn't support learning and change. Factors such as inadequate mentorship of newly qualified nurses, suppression of nursing students' critical thinking and questioning skills in exchange for acceptance by the team, and limited the capacity of the CNM2 to support a conducive learning environment for student and graduate nurses inhibited EBP. As a result, the capacity of nursing students and newly qualified graduate nurses, to contribute positively to EBP in the clinical setting, was not fully exploited.

6.4.3 Enhancing nurses' confidence to speak as part of the multidisciplinary team

Confidence was considered central to EBP, enabling nurse managers and nurses to openly assert their views regarding patient care to the multidisciplinary team. Acknowledging that nurses traditionally did not question other members of the team and critical thinking and questioning was knocked out of student and graduate nurses, there was a sense among participants that nurses are generally more confident to speak up and give their opinions regarding patient care. Engaging in continuing education was identified as contributing to enhanced confidence among nurses.

> CNM (No.5): I feel empowered and confident since I went back to college because I know how to look up research and to appraise it. I won't go on what the Consultant says or some adhoc evidence.

> CNM (No.7): Nurses are more confident speaking up and doctors recognise that nurses are educated. You will still meet the cocky guy who won't take it initially, but he will learn and they all learn that we are in this together.

Confidence to contribute to multidisciplinary decision-making was further enhanced when members of the multi-disciplinary team understood and respected each other's contribution to patient care. Communication skills and respect were considered key tenets of an effective working relationship and cross discipline education was recommended to enable understanding among healthcare professionals and enhance EBP.

> ADON (No.9): I think it comes down to how we are educated and I do think that maybe in colleges there should be more cross discipline sessions or modules say for example in communication, and there needs to be an understanding of other professionals roles. It is sometimes as simple as communication, understanding and respect of other people's roles.

> ADON (No.10): I think the working relationship with medical staff has improved. In the past the consultant would not have listened to the nurse but whether it is my advancing years or advancing knowledge but I would say I am more confident and it doesn't necessarily mean I am right.

Participants described how the working relationship between medical consultants and nurse managers had improved. Consultants were more willing to listen to the views of other members of the team. Nurse managers endeavoured to include the views of all members of the multidisciplinary team in decision-making without being influenced by the personal preferences of any profession.

> CNM2 (No.3): Only the other day I said to the consultant- go away from me, we are not going back down this road, the decision has been made, everyone was asked for their input so we can't take personal preferences at this stage.

> ADON (No.6): I remember when evidence-based practice was based on what the consultant said. I wanted to introduce new leg ulcer dressings but the consultant wouldn't even listen to me. Nurses are much better now at speaking up and I think the new education system gives nurses confidence in themselves. Confidence was dragged out of us and we were definitely not to be assertive, and most definitely not to question. We were told to just get on with it.

Despite enhanced working relationships, coupled with CNMs efforts to value every member's contribution, participants' accounts illustrated that the medical profession retained a level of authority regarding decision-making. Although it was not evident in the data, the level of power and authority, which the medical profession retained may be related to cultural and historical influences, or as was suggested, may be

attributed to personality. There was also reference to the current generation of consultants who were willing to listen, which enabled other members of the team to contribute to clinical decisions.

> CNM3 (No.1): Practice depends on what the consultant likes rather than what the research says. If the doctors like something like say a venous cannula or bung, they will get it. That's the medical profession; it's what is convenient and what they like.
>
> ADON (No.8): A lot of it is personality but relationships have improved down through the years.
>
> CNM2 (No.4): In fairness the consultants work with us and they don't take it over completely. I think the consultants who have come in the last few years are more willing to listen.

From participants' perspectives, Clinical Nurse Specialists (CNSs) and Advanced Nurse Practitioners (ANPs) were confident members of the multidisciplinary whose professional input was respected by all members of the team, including the medical profession. Participants believed that the medical profession engaged in more meaningful dialogue and discussion with ANPs and CNSs regarding patient care whereas doctors, in their view, were less likely to listen to the professional opinion of the staff nurse. The SCAPE study illustrates very strong evidence that Advanced Practice and Clinical Specialist nurses improve communication across the multidisciplinary team with reference to 'mutual understanding between health professions and team members' (Begley et al. 2010: 32). In the context of this study's findings, participants acknowledged the mutual understanding between CNS/ANP and medical consultants, which realised into an effective working relationship based on mutual respect. However, in their view, nursing staff were not afforded the same respect by medical consultants, thus limiting staff nurses abilities to engage in meaningful discussions regarding patient care and apply changes to conform with evidence based practice.

> ADON (No.1): CNSs and ANPs work are part of the team and they challenge each other and work together. At ward level it is different and we don't have that kind of working relationship. Doctors don't mind a CNS challenging them but they don't like the staff nurse questioning them.
>
> CNM2 (No.8): Doctors accept questioning from Clinical Nurse Specialists and Advanced Nurse Practitioners but not from the nurses on the ground.

Participants expressed no resentment towards Clinical Nurse Specialists (CNSs) or Advanced Nurse Practitioners (ANPs); on the contrary, these nurse managers valued the expertise of ANPs and CNSs.

> CNM (No.2): Clinical Nurse Specialists and Advanced Nurse Practitioners are excellent resources.
>
> CNM (No.4): Healthcare Risk Management support us. We have a clinical audit facilitator who helps with audits.
>
> CNM (No.6): Infection Prevention and Control Nurse Specialists help us with evidence-based practice.

6.5 Summary and Conclusion

This chapter presented the study's findings under three main themes, which illustrated participants' perspectives of evidence-based practice: '*Nurse Managers Perceptions of Evidence-Based Practice (EBP)', 'Nurse Managers Views on Enablers and Barriers to EBP',* and '*Nurse Managers Opinions on making EBP a Reality'*.

Nurse managers' perceptions of EBP included 'knowing the patient', which involved development of meaningful nurse-patient relationships. As 'knowing' required astute assessment and communication skills, participants highlighted the need to prompt and support nurses with this element of evidence-based decision-making. As regards governance, frontline nurse managers were responsible for monitoring patient care standards in their respective units, whereas mid-level nurse managers were responsible for development of policies and guidelines to guide care standards. Mid-level nurse managers accepted accountability for ensuring evidence was available; however, responsibility for ensuring evidence was applied in practice clearly rested with the CNM2. Development, implementation and evaluation of local policies and guidelines highlighted anomalies as participants' perspectives differed

regarding the extent to which these policies and guidelines informed clinical practice. Participants identified services user involvement as a fundamental element of EBP; however, they identified the need for further guidance and instruction to enable service user involvement at both strategic and clinical level.

Theme two presents participants accounts on enablers and barriers to Evidence-Based Practice. Resources, including staff motivation, willingness to learn and availability of resources were facilitators of EBP. Appropriate representation on national committees for the development of national guidelines was identified as an enabler of EBP. Limited capacity to fulfil roles and responsibilities was identified as a barrier to achieve EBP. Another barrier to EBP as described by participants related to staff resisting changes to routine practices. The current clinical environment with associated staff shortages and increased workloads emerged also as a major barrier to EBP.

Theme three, 'nurse managers' opinions on making Evidence-Based Practice a reality', included facilitating nurses to question clinical practice and confidently contribute to evidence-based decision-making. Participants' recommendations for making EBP a reality included facilitating nurses to reflect on, and value their contributions to patient care as members of the multidisciplinary team whereby nurses felt confident to speak up and question other members of the team. Nursing students and new graduates were perceived as possessing a wealth of knowledge, which could contribute to EBP; however, they needed encouragement and support to question practices, which they observed in the clinical setting.

In conclusion, participants described EBP in terms of communication, caring and knowing the patient in addition to the development and implementation of policies,

procedures, protocols and guidelines, to include service user involvement. Whilst enablers of EBP included availability of national guidelines, staff commitment and resources such as access to information, participants highlighted lack of time, staff shortages, coupled with staff resistance to change as barriers to EBP. To make EBP a reality, participants advocated that continuous questioning and review of nursing practices be encouraged. The knowledge of nursing students and graduates was identified as a key source of information that should be exploited. All participants acknowledged that collaborative and open discussion among the multidisciplinary team as paramount to EBP. A culture of open discussion and continuous questioning would nurture the development and provision of patient care that is truly evidence based. The next chapter considers these findings in the context of contemporary literature.

CHAPTER SEVEN: DISCUSSION, RECOMMENDATIONS AND CONCLUSION

7.1 Introduction

The development of a healthcare system whereby service users receive high quality safe care, based on best available evidence, is priority in Ireland (HSE 2012). Despite drastic cuts in healthcare funding in recent years, the HSE is adamant that standards of care will not be compromised, reiterating that 'quality and patient safety is the responsibility of all staff from frontline to senior management level' (HSE 2012, p. 17). Healthcare in Ireland must reflect 'national and international evidence of what is known to achieve best outcomes for service-users' (HIQA 2012, p.42). A core competency for frontline, mid-level, and top-level nurse managers in Ireland is the promotion of evidence-based decision-making, which incorporates using a wide range of information sources (Rush, McCarthy and Cronin 2000). Evidence-based practice is defined as:

> a paradigm and life-long problem solving approach to clinical decision making that involves the conscientious use of best available evidence (including a systematic search for and critical appraisal of the most relevant evidence to answer a clinical question) with one's own clinical expertise and patient values and preferences to improve outcomes for individuals, groups, communities and systems (Melynk and Fineout-Overholt 2011, p.575).

This research study describes mid-level and frontline nurse managers' understandings of evidence-based practice in the context of their daily decision-making. This chapter discusses the study's findings in the context of contemporary literature with a view to formulating recommendations for practice. Data, in the previous chapter, presented in themes and categories, underpin this discussion, which focuses on 'enabling nurses to know their patients', 'achieving positive patient outcomes through effective clinical governance' and 'insights into barriers that inhibit evidence-based practice'.

7.2 Enabling nurses to know their patients

Participants in this study described evidence-based practice in acute hospital services (n=3) as complex; influenced by CNMs who were torn between delivering patient care and improving nursing practices, and mid-level nurse managers who perceived themselves as having limited capacity to fulfil their roles and responsibilities. Acknowledging that patients spend less time in acute hospitals, participants' accounts indicated that nurses must perfect their skills in truly 'knowing the patient'. CNMs described how they developed their skills over the years, enabling them to communicate effectively with patients, the multidisciplinary team and the family. One CNM described her morning routine as 'making it her business to see each patient', which enabled her to know each patient's unique needs, preferences and values, which ultimately informed her decision-making.

According to Chan et al (2011) nurses must value their short informal conversations with patients, which contribute to quality communication, knowing their patients, relationship building and ultimately EBP. Another CNM described how she learned the skill of 'knowing the patient' in response to information requested by a particular medical consultant during ward rounds. Although Buchanan-Barker & Barker (2005) would possibly consider the provision of this information to the medical profession as reinforcing the role of the nurse as handmaiden, participants of this study considered this as EBP in the context of making accurate information available to inform clinical decision-making. Melynk & Fineout-Overholt (2011) define EBP as a problem solving approach to decision-making that incorporates patients' values and preferences in the context of best available evidence. Participants' accounts of EBP illustrate that knowledge of patients' values and preferences alone may not achieve EBP unless the nurse truly knows the patient and his or her family in order to

initiate evidence-based decision-making. Truly knowing the patient incorporates knowledge of the patients' psychological, emotional and physical symptoms.

Participants' accounts illustrated that patients' psychological and emotional torment were often masked by physical symptoms, which, in their view, were revealed through close and meaningful nurse patient relationships. Galvin & Todres (2011, p.523) define caring as 'embodied relational understanding', whereby nurses are mindful of responding sensitively to each individual patient's situation. Participants illustrated the therapeutic effects of 'listening attentively', 'observing patients' reactions' and 'holding a patient's hand', which contributed to evidence-based practice in the context of truly knowing the patient and delivery of appropriate therapeutic interventions. Likewise, Bundgaard et al (2011, p.2287), in their ethnographic study in Denmark, conclude that 'deliberate use of communication and sensing' enhanced knowing the patient. Communication is defined in terms of 'listening, small-talking, observing, feeling and asking questions' whereas sensing takes the form of the nurse using her eyes, ears and physical touch' (Bundgaard et al 2011, p.2286). Hence, as outlined by participants in my study, nurses must perfect their communication skills to elicit necessary patient information in short time frames to engage in evidence based decision-making.

Mid-level managers considered it inexcusable that nurses, including agency nurses, would not know their patients; however, CNMs admitted that nurses needed prompting and support to know their patients. One factor that hindered nurses' capacity to know their patients was 'the busyness of the ward environment'. Lack of time is consistently identified by nurses as inhibiting person-centred care (Bolster & Manias 2010, Hinno, Partanen and Vehvilainen-Julkunen 2011, IOM 2011);

however, the Health Information and Quality Authority (HIQA) in Ireland cite 'Person-Centred Care and Support' as a National Standard for implementation by health care providers (HIQA 2012:19). Person-centred care incorporates 'advocating for the needs of service-users, protecting their rights, respecting their values, preferences and diversity and actively involving service-users in the provision of care' (HIQA 2012, p.19). As outlined in my study, nurses must truly know their patients to enable them to advocate, protect, respect and promote patient preferences in order to achieve person-centred care.

Lehuluante, Nilsson and Edvardsson (2012) found that nurses' work satisfaction is significantly associated with person-centred care, which incorporates physical and psychosocial care whilst enabling patients to maintain contact with family members. Both mid-level and frontline nurse managers in my study considered family involvement in patient care as contributing to EBP; nonetheless, differences emerged regarding the complexities associated with family centred care. Mid-level nurse managers considered family involvement as simply a matter of sitting down with the family and answering their questions. Research indicates that the single most important need for families is to 'have questions answered honestly' (Obringer, Hilgenberg and Booker 2012, p.1656). However, CNMs identified situational factors, which influenced the nurse's ability to answer questions from the family including the extent to which the nurse knew the patient. Similar to CNMs accounts in this study, contemporary research indicates that factors such as staffing levels, availability of time and managerial support determine the extent to which nurses provide effective family centred care (Coyne et al 2011). Hinno, Partanen and Vehvilainen-Julkunen (2011) highlight that care systems must be adapted to enable nurses to spend more time with their patients. The Institute of Medicine (IOM) in

the United States (2011) notes that information technology will change the face of care delivery into the future; however, nursing's body of knowledge related to human caring, must remain central to healthcare delivery. The IOM highlight that current models of care address the nurse's plan of care for the shift, rather than focusing on the interdisciplinary team plan to discharge the patient to the next level of care.

In summary, nurses must incorporate patients' preferences and values in their decision-making, but as participants' accounts reveal in my study, this must also include truly 'knowing the patient'. Truly knowing the patient provides the nurse with knowledge of the patients' psychological, emotional and physical state, which informs and facilitates evidence-based decision-making. Therefore, evidence-based practice necessities nurses spending more time on direct patient care and getting to know the patient. Truly knowing the patient necessitates time, effort, commitment and skill. The current environment of staff shortages focuses on completion of tasks rather than person-centred care.

7.3 Achieving positive patient outcomes through effective clinical governance

The achievement of positive patient outcomes is dependant upon effective clinical governance (HSE 2012). Clinical governance is defined as:

> A system through which service providers are accountable for continuously improving the quality of their clinical practice and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (HSE 2012, p.13)

Although clinical governance is not explicit in this study's findings, participants described many of the principles underpinning effective clinical governance in the context of their descriptions of evidence-based practice.

7.3.1 Patient First

'Patient first' is a guiding principle for good clinical governance, described in terms of a partnership of care between patients, families, carers and healthcare providers in achieving safe quality care (HSE 2012, p.11). Participants provided interesting insights into the challenges associated with involving patients as partners in their own care. Contemporary policy in Ireland and beyond stipulate that service users are meaningfully involved in decision-making regarding their health and social care, treatment, and in the strategic planning and delivery of healthcare services (HSE 2010b, Denis et al 2011, HSE 2012, HIQA 2012). Whilst participants fundamentally agreed that involving patients and their families in all aspects of patient care contributed to EBP, they articulated their fears and hesitations regarding service user involvement at both strategic and clinical levels. Participants feared that they may 'expose weaknesses in the organisation' and they questioned their own abilities to facilitate service-user involvement. Similarly, Forbat, Hubbard and Kearney (2009), using data collected for a previous study in Scotland in 2007, acknowledge that service user involvement is embedded in health policy without due consideration of how the rhetoric should be operationalised, or the implications of truly integrating service-user' perspectives.

Although the HSE (2010b, p.19) promote service user involvement at 'healthcare organisation level', mid-level managers in this study considered shared decision making at this level as premature. Participants described how they themselves struggled with policy formation; hence, they referred to 'getting their own house in order' before involving service-users. Likewise, CNMs described how they endeavoured to engage in shared decision-making with patients; but this was not straightforward, as patients, in their view, had to be knowledgeable in order to make

informed choices. These findings acknowledged that service user involvement was not as simple as policy documents implied; therefore, practitioners required further clarification, guidance and support with this element of EBP. Although the HSE specify that staff receive education and training in patient education and service user involvement (HSE 2010b), there was no evidence in these data that nurse managers were equipped to engage with, or support service user involvement at either clinical or strategic levels.

Intriguingly, participants considered Clinical Nurse Specialists (CNSs) as effectively involving service-users in their own care. From participants' accounts service-users who attended CNSs were well informed, educated, and confident to dictate their care preferences to both medical and nursing staff. CNMs described how patients who attended CNSs confidently voiced their preferences and wishes regarding their care, including titration of their medication. Research evaluating the role of the CNS in Ireland concur that patients who attend CNSs are well informed about their conditions and are more inclined to self manage their illnesses (NCNM 2004, Begley et al. 2010). Shared decision making is defined as a 'process in which patients are encouraged to participate in selecting appropriate treatment options on the basis of best available evidence' (Marshall & Biddy 2011, p.2117). Participants described shared decision-making in terms of patients dictating their care preferences; nonetheless, the re-conceptualisation of roles and responsibilities for both patients and health professionals associated with shared decision-making (Marshall & Biddy 2011), warrants further discussion and investigation. Shared decision-making challenges the belief that professionals know what is best for patients; yet, some professionals still argue that the 'expert does know best' (Ward 2011: 2698); therefore, some health professionals may not support shared decision-making. In

light of participants' responses, it is commendable that shared decision-making is identified as contributing to evidence-based practice; however, the complexities associated with shared decision-making between patients and professionals necessitate further inquiry involving patients and health professionals.

7.3.2 Interdisciplinary collaboration and communication

Interdisciplinary working is another guiding principle for effective clinical governance defined in terms of 'work processes that respect and support the unique contribution of each individual member of a team in the provision of clinical and social care' (HSE 2012, p.11). Inter professional teamwork can potentially improve the quality and safety of patient care through the harmonisation of various perspectives (Denis et al. 2011); however lack of inter-disciplinary and intra-disciplinary communication adversely affects patient outcomes.

Reflecting on the findings of my study, it is remarkable that participants perceived that physicians were more likely to collaborate with Clinical Nurse Specialists rather than staff nurses. Although participants found it difficult to explain their rationale, I interpreted that participants related specialist knowledge and education to effective collaboration with other professionals. Participants clearly linked continuing education to enhanced confidence to speak up as part of the multidisciplinary team. One participant described how she was more assertive and confident to question and contribute to interdisciplinary decision-making since returning to college. Tame (2012) in her qualitative descriptive study in the UK describes how nurses (n=23) who engaged in continuing professional development were more assertive to question doctors decisions related to increased knowledge and confidence.

Participants attributed the historical legacy of traditional nurse training to nurses accepting instructions from their medical colleagues without questioning. According to Bender, Connelly and Brown (2012) interdisciplinary collaboration reduces fragmentation of patient care and improves clinical outcomes; nevertheless, collaboration is complex related to cultural, power, and hierarchical positions, which inhibit egalitarian partnerships. Findings from my study focused on participants' accounts of nurses' contributions to patient care; however, the real benefit of collaborative practice is the empowerment of all members of the team to enhance their abilities to work more effectively together (Orchard 2010). Similar to Fernandez et al. (2010), CNMs described their endeavours to create an environment whereby each member of the team was confident to openly express their concerns and ask questions about patient care. Garon (2012) highlights the nurse manager's role in enabling nurses to speak up in the interest of patient safety. Although participants in my study described nurses as more confident to speak up, and medical consultants as more willing to listen, there is emerging evidence in contemporary literature that healthcare professionals know of risks but deliberately choose not to speak up because they feel it is unsafe to speak about these problems or they are unable to get others to listen (Maxfield et al. 2011, Garon 2012). In light of findings from recent inquires in acute hospitals in Ireland (Government of Ireland 2006, HIQA 2012c), it is imperative that all members of the healthcare team assert their professional views, and are confident to speak up in the interest of evidence-based patient care.

7.3.3 Capacity to fulfil one's roles and responsibilities

Other guiding principles for good clinical governance, which emerged in this study's findings, related to 'Personal Responsibility' and 'Defined Authority' (HSE 2012,

p.11). Combining these two principles for the purpose of discussion enabled exploration of participants' responsibilities in the context of their professional scope to fulfil their roles. Participants highlighted a range of influences that inhibited them from fulfilling their roles and responsibilities as they articulated their frustration and disillusionment with their lack of influence over current circumstances. Mid-level nurse managers considered themselves 'gatekeepers of best practice standards'; yet, 'their hands were tied' as they abided by dictum from senior management.

The Office for Health Management (OHM 2000) described middle managers as 'knowledge integrators' who align the values and policies developed at corporate level with practices at clinical level; however, participants in this study disagreed. In their view, participants have little influence over practice or policy. In fact they perceived their expertise in policy development as not being valued by senior management. Although nurse managers' potential to influence healthcare delivery through involvement in strategy development is well documented (Carney 2006, Currie 2006), participants perceived that they lacked both authority and autonomy to influence standards of care. Reflecting on the recommendations of the Report of the Commission on Nursing (Government of Ireland 1998) which specify the unique responsibilities of nurse managers for maintaining professional standards of care and evidence-based practice, it is concerning that nurses working, as mid-level managers remained vague and inconsistent regarding their roles and responsibilities in relation to achieving best practice. There was no evidence in these findings that 'defined management roles' or 'definite functional roles' as recommended by the Report of the Commission on Nursing (Government of Ireland 1998 p.131) had materialised. Similarly, O'Shea (2008, p.168) in her study to identify the future of nursing and midwifery in Ireland, from the perspectives of key stakeholders (n=115), found a

lack of understanding and support for the key roles of Assistant Director of Nursing and CNM3, with Assistant Directors of Nursing having a 'crisis of identity'.

Currie (2006) argues that middle managers with nursing backgrounds that retain regular contact with the clinical environment are well positioned to inform strategy and policy development. Although the number of CNM3s in this study was limited to three participants, these mid-level managers distinguished themselves as different to Assistant Directors of Nursing. CNM3s identified the wearing of their uniforms as symbolising their efforts to achieve evidence-based practice by 'not sitting in an office all day but by working on the floor caring, teaching supporting and mentoring'. CNM3s seemed to balance their managerial and clinical responsibilities, with support from their CNM2s, without any reference to conflict of roles or identity crisis.

Acknowledging that middle managers in the UK are constrained in 'semiautonomous' positions, influences such as power of the medical profession impact on middle managers decision-making capacities (Currie 2006, p.10). Likewise, Dopson & Fitzgerald (2006) concur that the medical profession retain power and influence; therefore, nurses working as mid – level nurse managers negotiate collaboration between doctors and nurses. Although mid-level nurse managers in my study would undoubtedly settle for 'semiautonomous' rather than 'jack of all trades', it is imperative that these mid-level nurse managers are empowered to accept full individual, managerial, and professional accountability for the quality of nursing and midwifery care in their respective departments, in their quest for evidence-based practice.

Likewise, participants working as front line managers (CNM2s) described their roles and responsibilities in terms of 'hitting the ground running' delivering patient care rather than managing and leading the staff in their respective units. There is a burgeoning literature highlighting the challenges for front-line nurse managers including span of control and role overload (Lee & Cummings 2008, RCN 2009, Bradshaw 2010, McCallin & Frankson 2010). A review of the role of the ward sister in the UK (RCN 2009) highlights the pressures placed on ward sisters with clinical caseloads who are expected to lead, manage and supervise clinical practice standards. Consequently the Royal College Nursing (RCN) recommend that 'all ward sisters be supervisory to shifts, enabling them to maintain care standards, teach clinical practice, role model good professional practice and behaviours, oversee the ward environment, and assume high visibility as nurse leader for the ward' (RCN 2009, p.18). The Department of Health in England is adamant that the traditional linchpin role of the ward sister/charge nurse be reinstated. Immediate steps are being taken to strengthen the role of the front-line nurse manager (ward sister/charge nurse) as the guardian of patient safety by providing them with time to lead and supervise patient care (DoH 2010, DoH 2011).

Reflecting on the findings of my study, the recent attrition of experienced staff nurses who retired from the Irish health service, a moratorium on staff recruitment and pre-registration nurses replacing qualified nurses undoubtedly placed additional pressures on CNM2s to maintain patient care standards. It is essential that the current realities of clinical practice are discussed in the context of enabling the CNM2 to fulfil his/her responsibility to achieve positive patient care outcomes, and ultimately EBP. CNM2s candidly admitted that their input into the development of

policies and guidelines was limited as they prioritised patient care; however, participants unanimously linked policies and guidelines to evidence-based practice.

7.3.4 Development and Implementation of Policies, Procedures, Protocols, Guidelines (PPPGs)

Clinical decisions must be based on best available information, which reflect national and international evidence delivered according to policies, guidelines, protocols and care pathways (HIQA 2012a). In September 2010, the *Patient Safety First* initiative was launched comprising of the National Framework for Clinical Effectiveness, which is overseen by the National Clinical Effectiveness Committee (NCEC). The mission of the NCEC is to provide a framework for the national endorsement of clinical guidelines and audit processes (NCEC 2012). The draft Clinical Guideline Development Manual (NCEC 2012) outlines six comprehensive stages to guideline development, including service user involvement with the process involving the establishment of a multidisciplinary clinical guideline development group, including members who have research and appraisal skills. In theory, the establishment of NCEC will contribute to the availability of best practice standards; however, participants' concerns regarding 'accessibility' and 'applicability' of guidelines warrant further explanation and discussion.

The Framework for Endorsement of National Clinical Guidelines (NCEC 2012) incorporates the National Quality Assurance Criteria for Clinical Guidelines (HIQA 2011), stipulating the inclusion of intended users on the guideline development group (NCEC 2012). In fact, it is anticipated that hospitals and healthcare facilities will submit their guidelines to NCEC for approval and subsequent national distribution and implementation. The mechanisms for streamlining the development of

guidelines for submission to NCEC remains unclear at this time, nonetheless participants in this study were hopeful that availability of national guidelines would standardise evidence-based practice across all hospitals in Ireland. Participants advocated the use of hubs to enable practitioners to access guidelines speedily, without having to navigate convoluted pathways through the intranet. Furthermore, participants referred to packed shelves of folders containing policies and guidelines, which were rarely accessed. These findings resonate with Carthey et al. (2011) who describe familiar time-consuming trawls through multiple websites by practitioners throughout the UK. The establishment of the National Institute for Health and Clinical Excellence (NICE) over ten years ago in the UK led to the development of extensive evidence based guidelines for clinicians; nonetheless, there is scope for further collaboration and cooperation. The 'extraordinary and un-coordinated proliferation of guidelines in the NHS confuses staff, causes inefficiencies and delay, and is becoming a threat to patient safety' (Carthey et al. 2011, p. 3).

Participants in this study concurred that policies and guidelines potentially contribute to evidence-based care; however, responsibility for the development and implementation of policies and guidelines remained unclear. Development and review of local policies and guidelines was not a priority in the current environment for frontline managers; yet, some mid-level nurse managers considered policy development as the responsibility of clinical experts. One CNM2 described how practical skills, such as suctioning a patient, incorporated the same principles irrespective of the environment; yet, there was no mechanism for sharing this procedure between hospitals. The processes for implementing policy and guideline recommendations were equally as haphazard. Participants described lengthy documents that outlined roles and responsibilities with key messages difficult to decipher. The sheer volume of information contained in each policy and guideline

made it unrealistic for staff to understand and comply with key recommendations. Similar to previous research (Rycroft-Malone et al 2009, Mickan, Burls and Glasziou 2011) participants agreed that clinicians rarely referred to policy or guidelines to inform their clinical practice. One CNM2 candidly admitted that the policy was read when something went wrong. Likewise, Mickan, Burls and Glasziou (2011) explored physicians' use of clinical guidelines, concluding that physicians did not adhere to clinical guideline recommendations up to two-thirds of the time.

The National Standards for Safer Better Healthcare stipulates that 'healthcare is delivered according to policies, guidelines, protocols and care pathways that are based on best available national and international evidence' (HIQA 2012a: 42). Both mid-level and frontline nurse managers described inconsistencies regarding the development and use of policy and guidelines at clinical level. The development of national guidelines is currently in its infancy; however, it is imperative that systems for adapting national guidelines for use and implementation at local level must be established at the outset. Otherwise, the information overload that currently exists in the UK (Carthey et al. 2011) will be mirrored here in Ireland. Whilst participants perceived that availability of national guidelines would enable EBP, it is CNMs who will be challenged to ensure that standards set in national guidelines are adapted locally and applied to guide clinical practice. CNMs will undoubtedly need support and help to achieve these national standards. Policies and guidelines contribute to evidence-based practice; nevertheless, the reality of diffuse accountability regarding the development and dissemination of PPPGs as described by participants, must be addressed nationally.

7.4 Insights into barriers that inhibit evidence-based practice

7.4.1 Non adherence to best practice standards

Mid-level nurse managers linked evidence-based practice to policies and guidelines; therefore, errors and clinical incidents, in their view, usually meant that policy was not adhered to. Mid-level nurse managers acknowledged that nurses did not have time to read policies and guidelines; yet, participants did not consider other factors that might influence nurses' use of policies and guidelines. Dougherty, Sque and Crouch (2012) recently conducted an ethnographic study in the UK to explore nurses' decision-making (n=20) during intravenous drug administration. Nurses stated they did not check the name, date of birth, and allergy status for each patient as per hospital policy because they 'knew the patients' (Dougherty, Sque and Crouch 2012). 'Knowing the patient' from these nurses' perspectives abdicated them from their legal and professional obligations to adhere to hospital policy. In light of Dougherty's findings, participants' accounts of 'knowing the patient' in my study does not abdicate nurses from formally checking patients identities prior to administration of medication, as per hospital policy. Dougherty, Sque and Crouch (2012) research is interesting as Dougherty herself endeavours to gain insight into nurses' behaviours, acknowledging that availability of hospital policies and supporting education does not ensure evidence-based practice.

CNMs provided further insights into non-adherence to standards, including the necessity to constantly monitor and reinforce best practice. CNMs described how complacency in maintaining care standards led to deviations from established best practice, which ultimately resulted in omissions or errors. One CNM described her continuous efforts to ensure that medication was not left on patients' lockers; yet, nurses continued to compromise patient safety by being complacent and not adhering

to hospital policy. An article by Prielipp et al. (2010, p.1499) explores 'the normalisation of deviance', which they define as the gradual erosion of best practice as a result of the acceptance and tolerance of small incremental deviations from the standard. Discussed in the context of aeronautical science and the launch of the Challenger shuttle into space in 1986, Prielipp et al. (2010) convincingly argue that any deviation from standards compromises safety; therefore, any temptation to accept deviations must be resisted in the interest of patient safety, and ultimately EBP. CNMs resisted deviations from best practice standards; however nurses vehemently defended their deviations by justifying their actions. CNMs persevered with maintaining best practice standards; nevertheless they admitted that monitoring and supporting best practice was challenging for them.

Changing habits or introducing new ways of working is never easy; however, CNMs may need to explore other ways of maintaining best practice standards. For example, the CNM, who described her endeavours to keep the medication press locked, admitted that 'locking' generated problems for nurses regarding access to medication, and perhaps the focus needed to address 'access to medication' in addition to ensuring 'safe storage of medication'. Likewise, the CNM who repeatedly reinforced the 'wearing of goggles' might need to explore nurses' rationale for 'not wearing goggles' in order to gain further insight into nurses' behaviours that compromised EBP.

7.4.2 The current clinical environment

Nurse managers in Ireland must foster an environment that positively values a questioning approach to practice, which demonstrates a positive and proactive approach to research and evidence-based practice (Timmins, McCabe and McSherry

2012). Nurse managers who participated in my study were both positive and proactive in their endeavours to achieve evidence-based practice; however, the current environment of staff shortages impacted on nurse managers' capacity to maintain standards of patient care. Mid-level nurse managers acknowledged that introducing change in the current environment was met with increased resistance from both frontline nurse managers and nurses. Participants acknowledged that CNMs and nurses were busy, with one participant describing the environment as 'staff flying all day, every day'. CNM2s described how they juggled priorities on a daily basis depending on the number of staff available. One participant described how she once had five nurses on duty, but now had four, sometimes three; therefore, she completed daily nursing tasks including the administration of medication. Jasper (2012) agrees that a major challenge for nurse managers in the current cost-containing environment is juggling priorities whereby fundamental patient care takes precedence over strategic issues including leadership and management.

CNMs described how they supported staff by working alongside them to deliver patient care; yet there was evidence that task allocation existed as CNMs referred to student nurses 'blending into the task culture'. In fact one CNM described how 'everyone piles into the ward in the morning' and another CNM referred to 'washing the patients and then doing the obs'. According to Abdelhadi & Drach-Zahavy (2012), the ward environment impacts on nurse-patient relationships, affecting nurses' engagement with patients. An environment, which clarifies expectations, provides support in patient safety standards, and addresses obstacles in the environment, compensates for inhibiting factors such as workload (Abdelhadi & Drach-Zahavy 2012). However, many of the CNM2s in this study were so subsumed in delivering patient care that they struggled to fulfil their managerial

responsibilities, with one CNM describing her guilt when she went to the office to read emails.

CNMs displayed a sense of powerlessness as they worked with their teams, conforming to the dominant values of task allocation and subscribing to the ethos of getting the job done. Likewise, Milton-Wildey & O'Brien (2010) in their Australian study contend that a constant atmosphere of cost cutting and staff shortages causes nurses to feel neglected and disregarded by senior hospital management. Of real concern in my study was nurse managers' inability to resist cost cutting measures, as they described their lack of influence over staffing levels. The current environment impacted on nurse manager's abilities to support teaching and learning.

7.4.3 Support for teaching and learning

Bourgeois, Drayton and Brown (2011) acknowledge the many challenges associated with clinical practicum teaching and learning, including competing demands on clinical nurses. Evaluating a 'cluster model' for supporting student nurses during their clinical placements in Australia, Bourgeois, Drayton and Brown (2011) contend that student nurses repeatedly acknowledge their need for 'belongingness', whereby they feel supported by the team (pg. 116). Participants' responses in my study illustrated that student nurses 'belonged' to the team, as everyone worked together to get the job done. There was an expectation that students and newly qualified graduates would utilise their knowledge and beliefs to challenge and contest nursing practices; however, from participants' reports students and new graduates did not challenge practices or routines. Although student nurses were supernumerary, participants described how students worked alongside qualified staff, blending into the culture and routines of the unit. Nurse managers acknowledged that students and

graduates had the capacity to enhance patient care by questioning practices and standards; however, consideration was not given to the supports required to enable such shared learning. In addition, participants anticipated that students and newly qualified nurses would deliver care based on their beliefs, values and knowledge, without recognition of the need for newly qualified nurses to be assisted with the transition from learner to practitioner. Dyess & Parker (2012) emphasise the key role of nurse managers in supporting senior students and newly qualified nurses with the transition to practising in the reality of the acute healthcare environment. Senior students and newly qualified nurses could contribute to evidence-based practice with appropriate supervision and support; however, mentoring and clinical supervision must be facilitated. Nurse managers need support and guidance to enable newly qualified nurses to contribute to evidence-based practice.

7.5 Study Limitations

The qualitative descriptive methodology mitigates against drawing of any firm conclusions or inferences. However, the methodology does provide useful insights, which could inform policy development regarding service-user involvement at both strategic and clinical level, and the use of national and local policies and guidelines to guide nursing practice to enhance EBP.

I acknowledge that the small sample size, limits generalisability of the findings, yet both mid-level and frontline nurse managers accounts provide new levels of understanding into evidence-based practice in the current environment. The study was conducted in three acute hospitals, in one HSE region.

Selection of participants was based on the unique contribution of each nurse manager, providing valuable descriptions and insights into evidence-based practice at front-line and mid-level nurse manager level. Participants' descriptions of evidence-based practice may have been influenced by other variables such as portraying the department/unit as adhering to recommended best practice, although I consider that participants were candidly open during the discussions. I acknowledge that some participants may have focused on facilitators to evidence-based practice where as others were eager to share their challenges and frustrations with the current environment. There is no doubt that the environment impacted on the findings of this study; however the reality of clinical practice informs evidence-based practice.

I acknowledge my own role as a nurse educator and the impact this may have on participants' responses. Participants may have construed the interview as an assessment of their knowledge of evidence-based practice; however, I reiterated at the outset of each interview the need to explore his/her understanding of the concept. On reflection, I think participants were honest and willing to share their experiences.

I omitted Clinical Nurse Managers 1 (CNM1) from the study. CNM1s are frontline nurse managers who contribute to daily decision-making and support the CNM2.

It is beyond the scope of this study to make inferences regarding the role of Clinical Nurse Specialists, patient education and shared decision-making; yet, participants' accounts provided useful insights into shared decision making between informed patients and healthcare professionals.

It is beyond the scope of this discussion to revise the roles and responsibilities of front-line nurse managers; however, it is imperative that immediate measures be taken to enable CNM2s to regain control of patient care standards in their respective wards/units.

7.6 Recommendations

Initiatives such as 'Transforming Care at the Bedside' and 'Return to Care' facilitate staff to make changes to care delivery systems which enable person-centred care (IOM 2011, p.416). The Productive Ward: *Releasing Time to Care* programme from the National Health Service Institute for Innovation and Improvement (NHSI) aims to empower healthcare teams to improve the way they work by providing staff with the knowledge, skills and time to identify and change systems, processes and other aspects of the environment (NHSI 2011). During the past year, the 'Productive Ward' has been introduced in hospitals throughout Ireland. Although such initiatives were not identified or discussed as part of this study, nurse managers descriptions indicated that they needed assistance to change from the current task allocation approach to patient care, and the 'Productive Ward' may provide them with the tools to enable nurses to spend more time on direct patient. Research conducted by the NHSI in the UK found that nurses spent on average only 40% of their time on direct patient care (Davis & Adams 2012). However, since the launch of the 'Productive Ward' preliminary research findings indicate that increasing the time to care for patients delivers increased patient and staff satisfaction, and improved patient outcomes (NHSI 2011, Davis & Adams 2012). Other initiatives in the UK such as 'Intentional Rounding' (King's College London 2012) endeavour to change the way nurses deliver patient care. 'Intentional Rounding' or 'Hourly Rounding' is defined as a member of the healthcare team spending time with the patient, completing a

series of care assessments, which includes evaluating the patient's pain, position, personal needs and personal elimination (Rondinelli, Ecker and Crawford 2012). Introduced in the United States over ten years ago, research indicates that hourly monitoring of patients' needs reduces patient falls, decreases the risk of pressure ulcer development, whilst increasing patient satisfaction (Struder Group 2007).

7.6.1 Recommendations for management

- Re-instate the role of the ward sister/charge nurse as the gatekeeper of quality safe patient care. S/he should be supernumerary, enabling him/her to lead, manage, supervise, and role model best practice. S/he will maintain best practice by observing, monitoring, auditing and appraising best practice care standards. The ward sister/charge nurse will be the visible leader who will support nurses to deliver person-centred safe care to patients at the bedside.
- Review and revise the scope of mid-level nurse managers such that these professionals have clear roles and responsibilities in relation to evidence based practice. Although the number of CNM3s (n=3) is limited in this study, there is evidence that CNM3s balance their clinical and leadership responsibilities, maintaining time to fulfil responsibilities such as audit and policy development and this must be promoted and maintained.
- Revise the process of developing, disseminating and implementing policies and guidelines such that the process is streamlined, roles and responsibilities are clarified, ensuring staff have easy access to relevant information to inform their clinical practice.

- Provide guidance regarding shared decision-making to all practitioners as some professionals may consider that they know best for the patient.
- The National Clinical Effectiveness Committee could be the national foundation for best practice quality care if:
    a. Analysis of best practice standards, which currently exist in Irish hospitals are collated;
    b. Priority is given to patient safety issues such as medication management, and interdisciplinary collaboration & communication;
    c. National and international recommendations are incorporated into NCEA guidelines, thus limiting the need for clinicians to seek additional information from other authorities
    d. Hubs or other accessible information technology systems streamline clinician searches such that practitioners have rapid access to best evidence.

7.6.2 Recommendations for clinical practice

- Nurses at all levels must value the contribution of knowing the patient to evidence-based decision-making.
- Nurses at all levels must prefect their communication and assessment skills to enable them to truly know the patient.
- Acknowledge and address lack of communication between members of the multidisciplinary team, which compromises patient safety.
- Create an environment whereby all members of the team are confident to speak up and express concern when patient safety is potentially compromised.

- Revise care delivery systems by increasing the amount of time that nurses spend on direct patient care by supporting initiatives such the 'Productive Ward' and 'Releasing Time to Care'.
- Create an environment whereby all members accept deviations from best practice standards cannot be tolerated.

7.6.3 Recommendations for education

- Development of an education programme on Evidence Based Practice, which incorporates 'knowing the patient'.
- At local level, implementation of key recommendations from national and local policies and guidelines should be supported with short summaries, coloured diagrams or algorithms to highlight key messages, providing aid memoirs for practitioners.
- Interdisciplinary education programmes and modules should be developed focusing on patient safety, which addresses interdisciplinary communication and collaboration, 'service-user involvement' and respect for each other's roles.
- Interdisciplinary education is required to enable shared decision-making, to include the patient.

7.6.4 Recommendations for further research

- Further research is required to explore the normalisation of deviance from best practice standards.

- Further research is required to establish that 'knowing the patient' is the critical first step to achieving evidence-based practice.
- Further research is required to explore service user involvement at clinical and strategic levels.
- Further research is required to explore the clinical learning environment for nursing students, focusing on nurse managers understandings that nursing students and graduate nurses contribute to evidence-based practice.
- Further research is required to explore care delivery systems in the current environment.

7.7 Conclusion

There is increased impetus in the Irish Health Service towards efficient, effective and positive outcomes for patients whereby care is safe, easily accessible and timely across the continuum of care (HSE 2012). This study focuses on front-line and mid-level nurse mangers and their perceptions of their roles in achieving evidence-based practice in the current environment. The qualitative descriptive approach provides further understandings and insights into the realities of participants' daily practices. Having conducted in-depth interviews with frontline and mid-level nurse managers (n=23), I analysed the data using conventional content analysis to present categories under three main themes, '*Nurse Managers Perceptions of Evidence-Based Practice (EBP)', 'Nurse Managers Views on Enablers and Barriers to EBP',* and '*Nurse Managers Opinions on making EBP a Reality'.*

Having considered the finding in the context of contemporary literature, the discussion focuses on enabling nurses to truly know their patients. Truly knowing the patient necessitated nurses to know and understand the patients' psychological,

emotional and physical state. This level of knowledge about the patient facilitated evidence-based decision-making. Achieving positive outcomes through effective clinical governance necessitates service user involvement and shared decision-making. From participants' perspectives, service user involvement at strategic level was more of an aspiration than a reality. Shared decision-making at clinical level was complex, requiring patients who were informed about their care needs. Participants perceived that patients who attended Clinical Nurse Specialist were well informed and engaged in shared decision-making.

Likewise, participants perceived physicians more likely to collaborate with Clinical Nurse Specialist than staff nurses regarding clinical decision-making; although, overall participants felt nurses were more likely to speak up on behalf of patients, with medical colleagues more likely to listen in recent times. In relation to capacity to fulfil their roles and responsibilities, mid-level nurse managers articulated frustration and disillusionment with their lack of influence over current circumstances such as staff shortages. Similarly, frontline nurse managers had limited time /capacity to engage in policy development as fundamental patient care was a priority.

Participants unanimously agreed that policies procedures and guidelines were linked to EBP, however anomalies emerged regarding the development, dissemination and use of PPPG's to direct and guide practice. Furthermore, the availability of PPPG's did not ensure adherence to these evidence based standards as nurses deviated from standards despite consistent monitoring by CNMs.

The current environment necessitated the CNMs to juggle priorities on a daily basis, with fundamental patient care taking precedence over strategic issues including leadership and management. This constant atmosphere of staff shortages and cost cutting impacted on the CNM's own motivation to achieve EBP. Furthermore, there was little time for CNMs to engage students and newly qualified graduates in evidence based decision-making as task allocation dominated, preventing questioning of routine practice. Nursing students and graduates blended into the culture and routines of the unit, choosing to socialise rather than question the application of their knowledge to practice.

The small sample size of this study's limits generalisability of the findings. Clear recommendations for management, clinical practice and education are formulated to enhance implementation of Evidence-Based Practice based on mid-level and frontline nurse managers' understandings of EBP in this study. Further research and investigation is warranted to enable nurse managers achieve EBP in the context of this study's findings.

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Appendix A

Letter seeking access from the Directors of Nursing

Return Address,

Date

Director of Nursing,

Dear,

My name is Mary Doolan and I work as a nurse tutor in the Regional Centre of Nursing and Midwifery Education, HSE, Dublin-Mid Leinster.

I write seeking your co-operation with a research study I am undertaking. I attach an information leaflet that outlines the background and aim of the study, which I am doing as part of the Professional Doctoral Programme in Education, at the School of Education, Dublin City University.

My interest in Evidence Based Practice stems from the educational programme which I co-ordinate in the Centre of Nursing and Midwifery Education. This has been a steep learning curve both for the participants and for myself, however having recently evaluated the programme it is evident that much learning has taken place. Yet there is no doubt that nurses need support to enable them to adopt the EBP approach to clinical decision-making. Therefore I have decided to elicit the views of nurse managers and seek their interpretations and understandings of EBP.

With your permission, I plan sending a 'Letter of Invitation' to all nurse managers working in the hospital, outlining the details of the study. I will ask those who are interested in participating in an informal interview to return an 'Expression of Interest form'. I will then contact ten volunteers in your hospital and I hope to commence interviews in July/August.

Please do not hesitate to contact me if you have any queries regarding the study.

Yours sincerely,

_____

Mary Doolan

Appendix B

Letter of Invitation

Address

April 2011- January 2012

Mid-level/Front-line Nurse Manager

Dear,

I work as a nurse tutor in the Regional Centre of Nursing and Midwifery Education, HSE, Dublin-Mid Leinster.

I invite you to participate in a research study that I am undertaking. I attach an information leaflet that outlines the background and aim of the study, which I am doing as part of the Professional Doctoral Programme in Education, at the School of Education, Dublin City University.

My interest in Evidence Based Practice stems from the educational programme which I co-ordinate in the Centre of Nursing and Midwifery Education. This has been a steep learning curve both for the participants and for me; however having recently evaluated the programme it is evident that much learning has taken place. Yet there is no doubt that nurses need support to enable them to adopt the EBP approach to clinical decision-making. Therefore I have decided to elicit your views on EBP. It is anticipated that the findings of this study will inform future education programmes on EBP focusing on the particular needs of clinical nurse managers.

Having read the attached information leaflet, and if you wish to take part in this interview, please complete the enclosed 'Expression of Interest Form' and return to me via the internal post or you can let me know by e-mail.

I will then contact you over the next few weeks to discuss the study further and arrange the informal interview with you.

Please do not hesitate to contact me if you have any queries regarding the study.

Yours sincerely,

_____

Mary Doolan

Appendix C

Information Leaflet

TITLE OF THE STUDY
An exploration of clinical nurse managers' understandings and use of Evidence Based Practice (EBP) in Acute Hospital Services

INTRODUCTION
My name is Mary Doolan and I work as a nurse tutor in the Regional Centre of Nursing and Midwifery Education. I facilitate the three and a half day programme of education on EBP. Some of you may have attended this course over the past two years. I am conducting this research as part fulfilment of the Taught Professional Doctoral Programme (Education) at DCU.

BACKGROUND
EBP is a concept, which is quoted in most of our strategies and policy documents. The recent publication of the Report of the Commission on Patient Safety (DoH&C 2008) identify evidence based practice as a critical element of the health system and make strategic recommendations to support the use of evidence in clinical practice. However, having recently evaluated our EBP programme I find that nurses are willing to contribute to the development of EBP by defining it in real terms, but they need leadership and support. Clinical nurse managers are in the ideal position to advance and support EBP in the clinical setting. Therefore the aim of this study is to explore clinical nurse managers' (CNMs) constructions and use of EBP. The objectives of the study are:
To explore mid-level and front-line nurse managers' interpretations, conceptions, and understandings of EBP;
To establish the extent to which nurse managers use EBP to inform their decision making;
To determine the mechanisms that nurse managers employ to enable them to use an EBP approach;
To explore factors that influence nurse managers' use of EBP;
To determine what supports are needed to enhance nurse managers' use of EBP working in the region,
To make recommendations for action to develop nurse managers' decision-making using an EBP approach.

PROCEDURES
Being part of this study means that you are willing to share your views and opinions of EBP and what EBP means to you as a practicing clinical nurse manager. This will involve agreeing to engage in an informal interview with me. I aim to interview thirty CNMs in total. If more than thirty participants volunteer for interview I will randomly select from the returns, but I will personally contact all participants who return the 'Expression of Interest form' to let you know the outcome. If your name does not emerge during random selection, I will seek your permission to retain your details in case someone drops out.

The interview will last approximately one hour and will be audiotaped. You do not need to have completed the educational programme to participate in the study. There is no right or wrong way to describe EBP; therefore this is not an evaluation of your

knowledge. I am interested in what EBP means to you when you are making clinical decisions on a daily basis. This is an opportunity for you to share what you consider are the supports needed to enable you to make evidence based decisions. In addition, as a leader you may wish to consider the actions needed to enable you to support staff nurses and other staff members to make evidence based practice a reality in the clinical settings.

RISKS

There is no foreseeable risk to you being involved in this study. Should you decline to answer any questions, your decision will be respected. You will not be asked for an explanation for your decision.

CONFIDENTIALITY

At all times your identity will be protected. I will not be informing anyone that you participated in the study. Information that might identify you will not be used in any presentation or publication resulting from the study. If you wish to talk to people about the study, you are free to do so.

VOLUNTARY PARTICIPATION

There is no obligation on you to participate in this study. If you choose to participate you are free to withdraw your consent at any time without obligation to anyone. This means that you can opt out before, during or after the interview, refuse to answer any question, turn the tape off, or request to stop the interview at any time. If you decide not to participate, or if you withdraw, you will not be penalised in any way.

PERMISSION

This research has been granted ethical approval from the Regional Ethics Committee.

Appendix D

Expression of Interest Form

Please complete this form and return it in the envelope provided if you are interested in taking part in the interview.

Name:_____

Telephone: _____

Email:
_____

I will contact you to discuss the research in further detail and to answer any questions that you may have. If you are still happy to take part in the interview, a time, date and location will be organised.

Thank you for taking the time to read this information

Appendix E
Extracts from diary

Jottings of contextual factors noted in the research setting

ADON

Office some distance away from wards, in another building- Spacious- has desk and two chairs
Has access to computer in office- computer is on
Shelving with lever arch files which are clearly labelled- organised
Reference books, which were referred
No interruptions at all - proceeded as planned, no delays
Tone was business like but became more relaxed. Confident
Initial impressions- Competent to search for sources, formulates PPGs;
Does not feel personally confident regarding clinical practices in all the units as 'not my area of expertise'
Delighted to vent and discuss EBP, commented that the interview was beneficial as insights happened which were not intended….. its only when you start talking about it

ADON

Office is right in the centre of the hospital- accessible to all staff
Has access to computer in office- computer is on
Small office- small desk, which contained the computer, two chairs
Member of medical team in the office when I arrived
Three knocks to the door during the chat (which we ignored)
Did answer the telephone on one occasion
Chat proceeded more or less as planned, but this DNM was under pressure to stay focused for the duration of the interview.. Jovial
Initial impressions- direct link to clinical setting/in the thick of it all

CNM2

Office was situated in the ward

My second attempt to interview this person as last time, the ward was just too busy. Busy again today and when I arrived, CNM is at the board with a group of doctors, going through their patients. There was a queue including family members waiting to meet with this CNM. A lot of student nurses noticed on the ward.

Has computer in office, computer is switched off.
Spacious office- Desk, and three chairs- A lot of paper work spread on desk
Lots of folders but many are not labelled, loose pages falling from folders
Participant was called to the ward during the chat, delay of about 10 minutes.
No phone calls
Initial impressions- juggler, fits me in with difficulty, struggle to keep going, EBP is way down the pecking order yet very patient focused. Pressure, pressure

CNM2

Office was situated in the ward
Tiny office with no computer- Bench going length ways with space for three chairs
No personal computer- uses the ward computer situated at front desk (also used by staff to access blood results) There is a phone but it didn't ring..

Shelving has lever arch folders, which are used to store time sheets and policies. CNM notes these folders need to be sorted as many of the policies are out of date
No interruptions during the chat. I waited for 20 minutes while CNM finished ward round.
This CNM has no personal computer, takes work home; has active caseload but has no time to manage.
Calm amidst the storm; not rushing even though I sense the ward calls.
Confident
Initial impressions- Is keeping it all going; sense of frustration regarding the off-duty, which this CNM has no control over…

CNM3

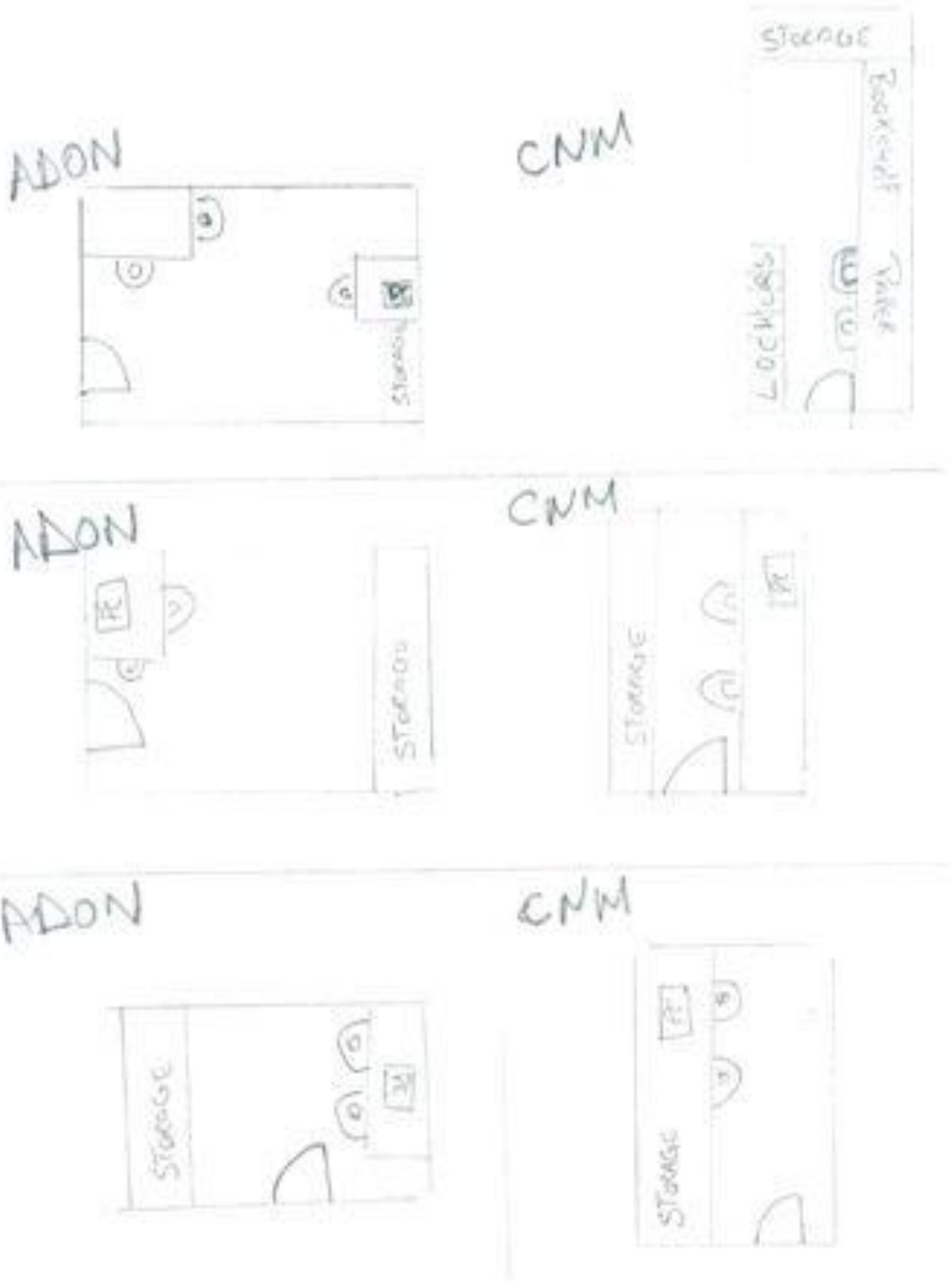
Office right in the centre of the unit - Small office with desk and three chairs.
Lever arch files are clearly labelled
Computer is on the desk and it is switched on
Reference made to folders on the computer and the multidisciplinary work which is ongoing related to development of policies
CNM3 left the office once during the chat to speak to a staff nurse (less than 5mins)
Confident
Is in control
Clinical and managerial responsibilities – there's a balance here… is in the thick of it all and knows exactly what is going on outside

ADON

Office is away from main hospital building
Not overly big but functional
Long bench with computer one end and workspace along the bench
Paperwork scattered all over the place
ADON is busy and office is busy
Phone rings three times, answered but deferred as' with someone'
Yes confident
Hasn't time really but is obliging me
Proactive re- service user involvement and good examples but still hesitant – not ready for this
I regret the interview was rushed I felt because I didn't want to delay her as she is busy. Pity this ADON doesn't take time to reflect on all the good changes and evidence based practice examples which are given ..doesn't have time

Appendix F

Sample sketches of nurse managers' offices



Appendix G Sample coding and category formation using spider diagram

Formation of Codes, Categories and Themes

Policies, Procedures, Protocols and Guidelines

Now to me if you want to implement a PPG the HSE now have a new template as you know yourself and they are telling you before you develop a PPG you have to actually look at why you want to develop this PPG, the scope of it and how is it going to be implemented and what are going to be the costings and things like this, we have never done that before, we have just written the PPGs and we went out and we handed it out to them and we tried to implement it, the HSE now are saying that before we even do that that we should look at costings. At the moment within the HSE if you want to introduce anything it has to be costed and that is where we are falling down in PPGs at the moment. Basic PPG, basic nursing PPGs there are about 600 of them out them, they are more clinical guidelines and more procedures and things like that but every time we write one we just hand it out but we never do information sessions about it (DNM)

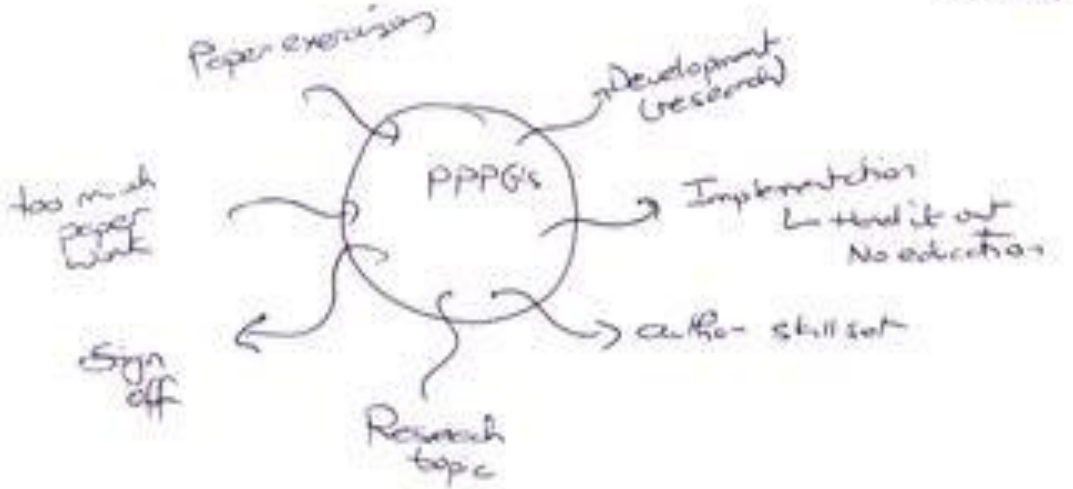
When you try to develop a PPG it has huge work load with the nurses on the ground, the development of a PPG, it might take a while to get agreement on the content of it but sometimes to get that implemented is going to be very difficult, the majority of them are a paper exercise and they are not implemented (DNM)

Even though we have had the celtic tiger, it is a top down approach and we are still doing it. The people on the ground cant write the PPGs because they don't have time (DNM)

I would feel in my role as Divisional Nurse Manger to be accountable to make sure PPGs are done and also to be responsible on another level. What I am trying to do, it is both our responsibilities but on a different level. It is more for the CNMII as she is working in the department. Now I do think that it is advisable to update them as the staff would be using them. That is what I think but I mean some staff, not all staff have to take responsibility to do them and some do have to be asked more than once to do them. I do think it's the responsibility of the CNMII to make sure that they are updated. Most things are to be honest are the responsibility of the CNMII which involves a responsibility to ensure they are done and my responsibility to double check it. Maybe on a different level but I mean you still have to make sure that they are done, I think the staff that are using the policies predominately should be updating them and its the CNM2s responsibility to ensure they are done and working okay. Once they have come back with it updated, what I would do is I would read over it. Now to be honest they would be more accurate than me on the clinical side of things but I would check it. Then I would send it to the Director of Nursing to approve it (DNM)

Say for instance at the moment I am working on pre op assessment so for me evidence based is going on line and picking out what other places are doing that are similar in size to ourselves or also going to the bigger hospitals or those kind of places and getting information from places that already have it up and running and that it is working successfully, that sort of thing, and then of course going to I suppose the legislation or, documents official documents that would back up the practice. So it is basically researching whatever the PPG is about (DNM).

For the most part I do because it is so busy on the wards at the moment that I am so short staffed, not short staffed but skills are not as good as I suppose as some of the previous nurses so it is very difficult for CNM staff to get to grips with doing any of this sort of stuff. Now I am very lucky that I have the CNMs there and we work together but a lot of it would fall on me to actually do. When they have all read it basically it is up to themselves to be accountable for their practice and what they are doing or whatever and what their practice is and what we have to do then is review it on a two yearly basis but if we need to do it before that say if something happens we would take time to renew it early or subtract or take from it at least we can do that (DNM).



Appendix H

Informed Consent Form

WORKING TITLE OF THE RESEARCH STUDY:
An exploration of Nurse Managers' understandings and use of Evidence Based Practice (EBP) in Acute Hospital Services.

RESEARCHERS CONTACT DETAILS:
Mary Doolan; Telephone: …… Email: mary.doolan@hse.ie

BACKGROUND AND PROCEDURES

EBP is a concept, which is quoted in most of our strategies and policy documents. However, nurses need leadership and support to deliver care which is evidence based. Nurse managers are in the ideal position to advance and support EBP in the clinical setting. Therefore the aim of this study is to explore nurse managers' constructions of EBP. Being part of this study means that you are willing to share your views and opinions of EBP and what EBP means to you as a practicing clinical nurse manager. This will involve agreeing to engage in an informal interview with me. The interview will last approximately one hour and will be audiotaped.

DECLARATION

I have read the information leaflet and this consent form: Yes No

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction: Yes No

I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential: Yes No

I understand that the interview will be audio taped: Yes No

I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights: Yes No

I have received a copy of this agreement and I understand that the results of this research may be published: Yes No

I understand that my participation is voluntary and that I may withdraw from the study at any time: Yes No

PARTICIPANT'S NAME (Block Capitals):_____

CONTACT TELEPHONE NUMBER:_____

PARTICIPANT'S SIGNATURE:_____

DATE:_____

Appendix I
Statement of Investigator's Responsibility

STATEMENT OF INVESTIGATORS RESPONSIBILITY

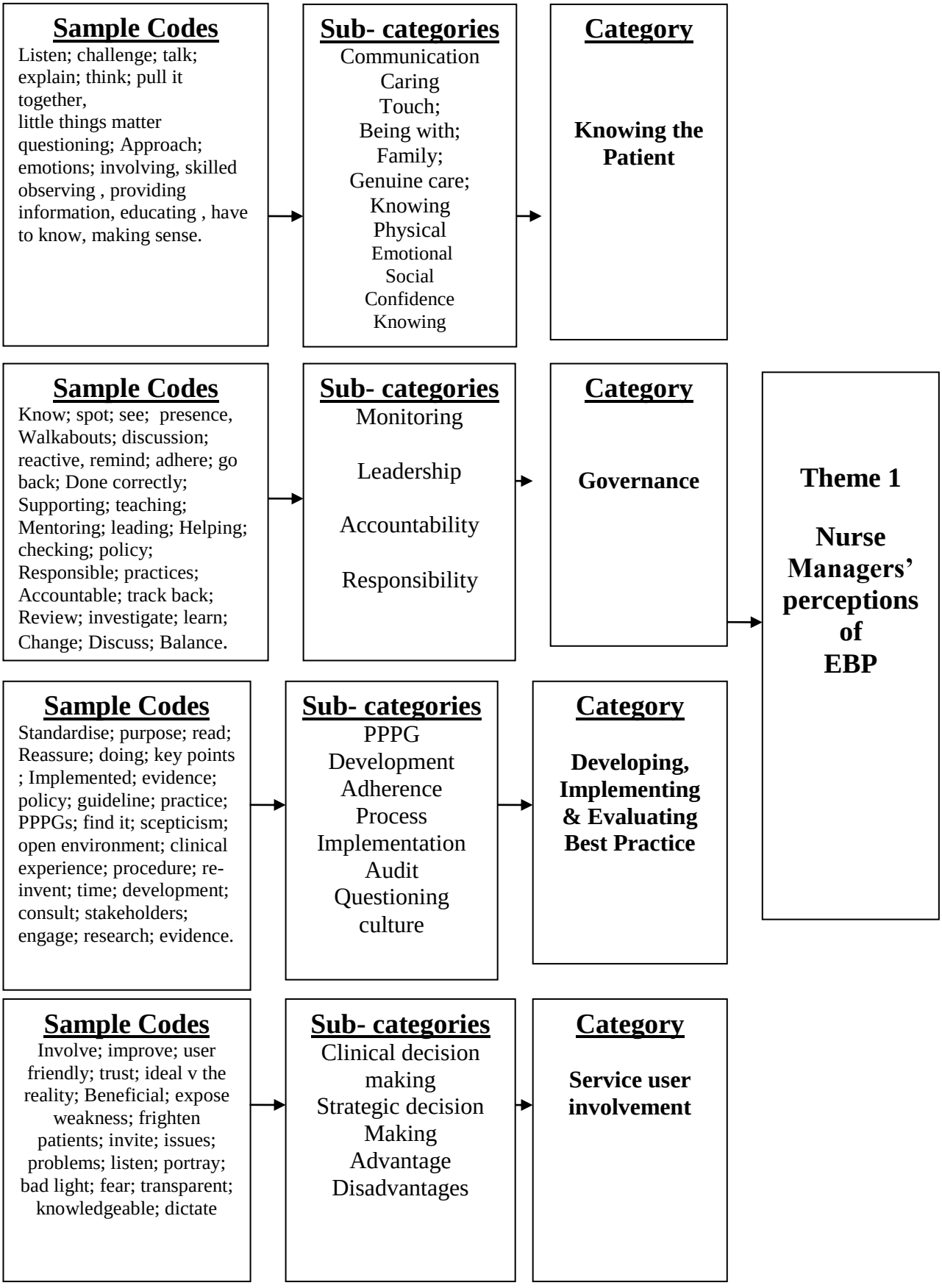
I have explained the nature and purpose of this study to the persons named above, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and have fully answered such questions. I believe that the person named above understood my explanation and have freely given informed consent.

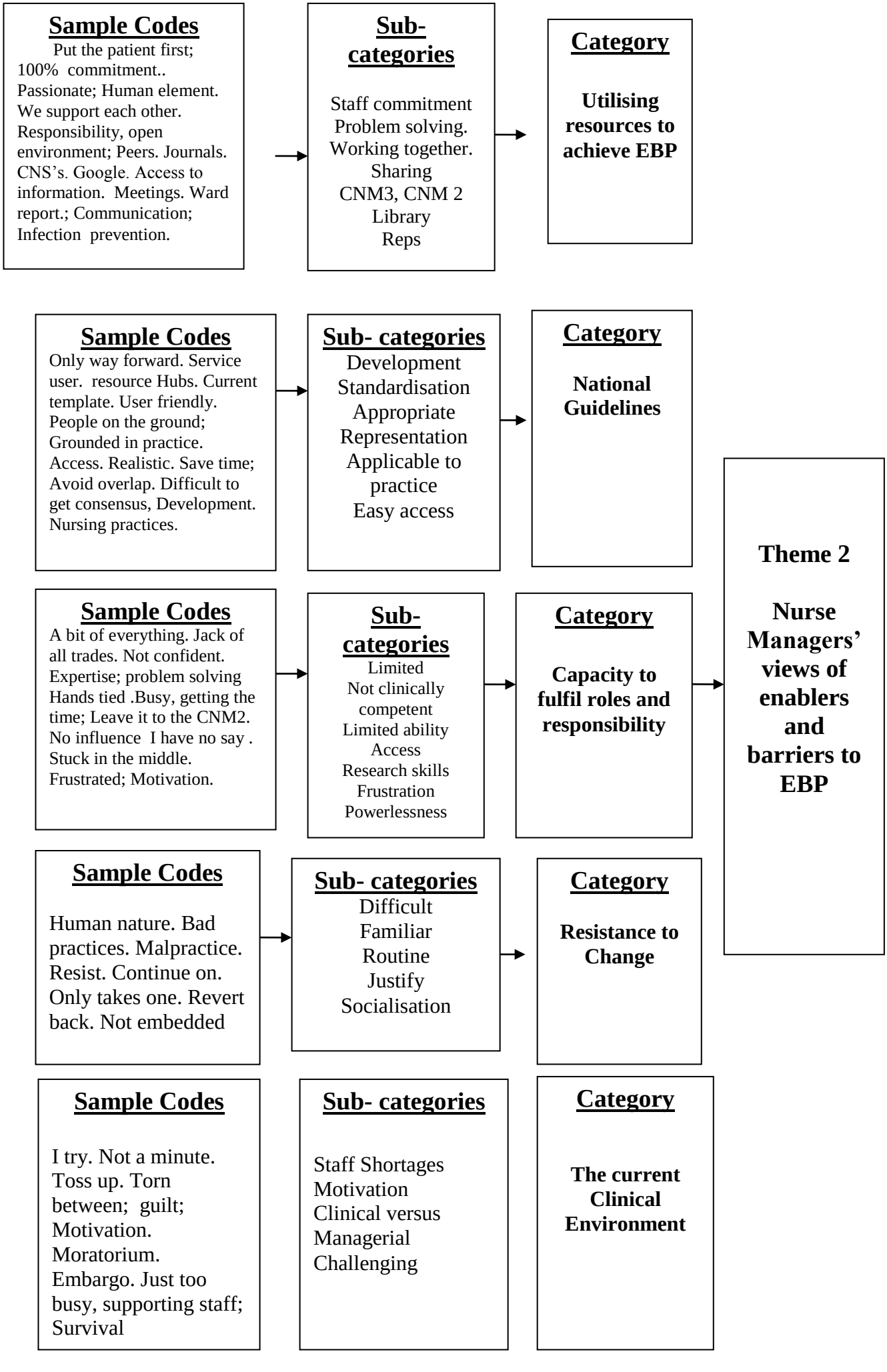
INVESIGATORS SIGNATURE:_____

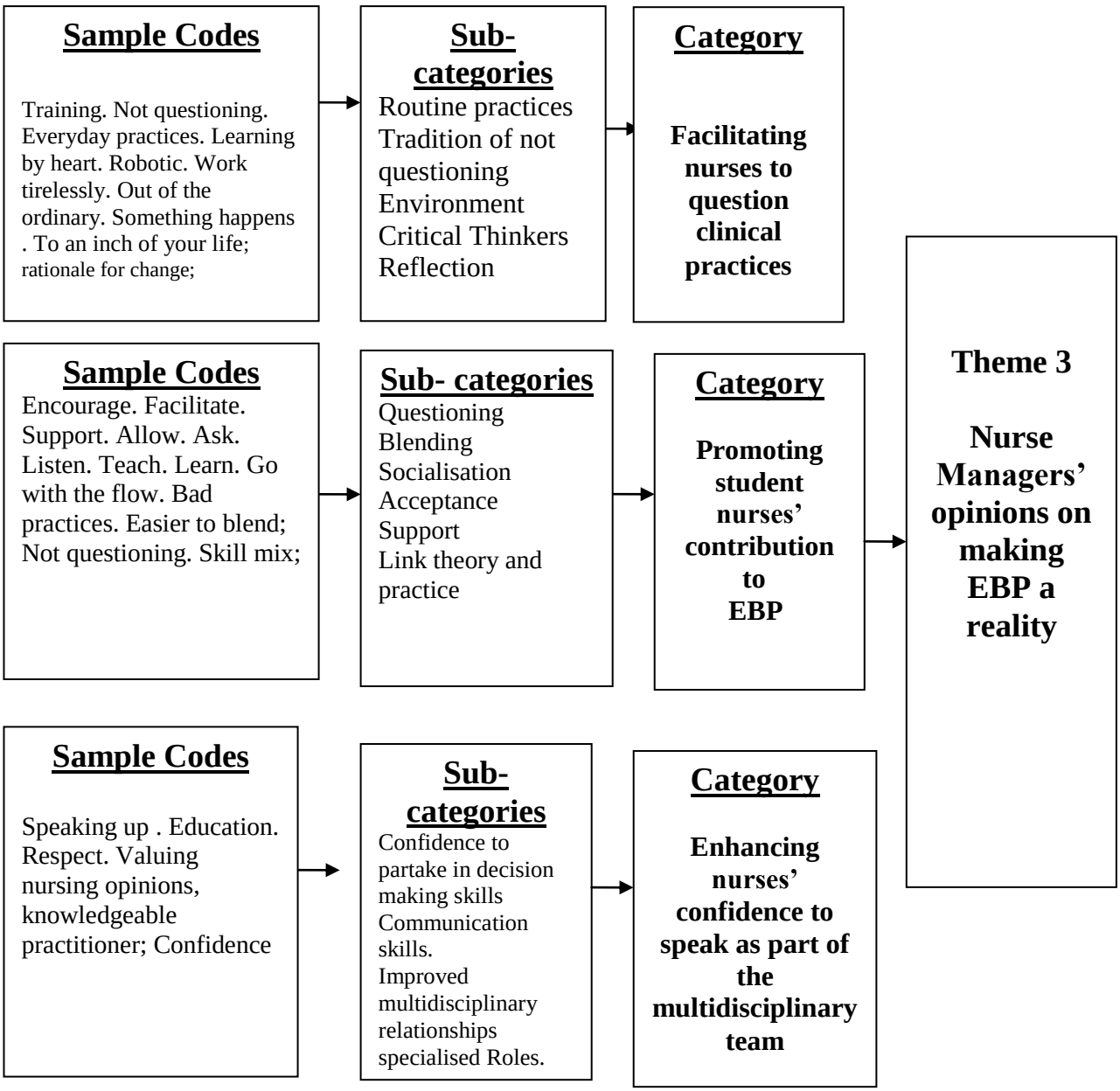
DATE:_____

Appendix J

Overview of coding, category and theme formation




Sample Codes
Put the patient first; 100% commitment.. Passionate; Human element. We support each other. Responsibility, open environment; Peers. Journals. CNS's. Google. Access to information. Meetings. Ward report.; Communication; Infection prevention.
Sub-categories
Staff commitment
Problem solving.
Working together.
Sharing
CNM3, CNM 2
Library
Reps
Category
Utilising resources to achieve EBP
Sample Codes
Only way forward. Service user. resource Hubs. Current template. User friendly. People on the ground; Grounded in practice. Access. Realistic. Save time; Avoid overlap. Difficult to get consensus, Development. Nursing practices.
Sub- categories
Development
Standardisation
Appropriate
Representation
Applicable to practice
Easy access
Category
National Guidelines
Sample Codes
A bit of everything. Jack of all trades. Not confident. Expertise; problem solving Hands tied .Busy, getting the time; Leave it to the CNM2. No influence I have no say . Stuck in the middle. Frustrated; Motivation.
Sub-categories
Limited
Not clinically competent
Limited ability
Access
Research skills
Frustration
Powerlessness
Category
Capacity to fulfil roles and responsibility
Theme 2
Nurse Managers' views of enablers and barriers to EBP
Sample Codes
Human nature. Bad practices. Malpractice. Resist. Continue on. Only takes one. Revert back. Not embedded
Sub- categories
Difficult
Familiar
Routine
Justify
Socialisation
Category
Resistance to Change
Sample Codes
I try. Not a minute. Toss up. Torn between; guilt; Motivation. Moratorium. Embargo. Just too busy, supporting staff; Survival
Sub- categories
Staff Shortages
Motivation
Clinical versus Managerial
Challenging
Category
The current Clinical Environment


Sample Codes
Training. Not questioning. Everyday practices. Learning by heart. Robotic. Work tirelessly. Out of the ordinary. Something happens . To an inch of your life; rationale for change;
Sub-categories
Routine practices
Tradition of not questioning
Environment
Critical Thinkers
Reflection
Category
Facilitating nurses to question clinical practices
Sample Codes
Encourage. Facilitate. Support. Allow. Ask. Listen. Teach. Learn. Go with the flow. Bad practices. Easier to blend; Not questioning. Skill mix;
Sub- categories
Questioning
Blending
Socialisation
Acceptance
Support
Link theory and practice
Category
Promoting student nurses' contribution to EBP
Sample Codes
Speaking up . Education. Respect. Valuing nursing opinions, knowledgeable practitioner; Confidence
Sub-categories
Confidence to partake in decision making skills
Communication skills.
Improved multidisciplinary relationships
specialised Roles.
Category
Enhancing nurses' confidence to speak as part of the multidisciplinary team
Theme 3
Nurse Managers' opinions on making EBP a reality

Appendix K

Extracts from my diary illustrating category formation

Evidence Based Practice involves 'Knowing the Patient Story'
2011
One participant describes her anguish regarding professionals being sharp with patients. Nurses may not think. They just proceed and do. But nurses have to stop and think of the patient as a person who needs their attention. It may be brief but it means a lot to the patient.
I didn't anticipate this element of EBP. I'm unsure where it fits.. Is this something which participants would like to mention as it illustrates the caring philosophy of nursing or is there more to this … should it be discussed again, I will probe in relation to 'Give me examples of this'. I need to find out if participants mean holistic care in the sense that they don't just look at physical symptoms..

2011
DNM today refers to caring for the person as if the patient is my brother, mother or sister… there's a family connection… my own family is different though.. are nurse managers expecting themselves and their nurses to consider every patient as their brother or mother… I'm still unsure… Ask again, if it is possible to care for the patient at a level because there is a difference.. I personally do care more for my family than I do for patients; I have to because otherwise I couldn't do it
I'm not sure about this, wait and see will this come up again

2011
'I was thought this when I did my own training'. Care for every patient as your mother, father, brother or sister and you wont go too far wrong… there is a difference of course but its about 'being sensitive'… The difference between being aloof, distant and being sensitive.. Patients are not family but while I'm caring, I must be tuned in… I must be consciously aware… There is a skill in this…. The nurse cant afford to be insensitive or she will miss out on the patients vulnerabilities.. and patients are vulnerable, so there is a relationship between being sensitive and addressing patients vulnerabilities… but its not automatic… it has to be taught or thought of at least..

2011
This is different to service user involvement… it is about the philosophy of nursing… I read Geraldine McCarthy's article today on the personhood of nursing. I considered the model in terms of what I was hearing and seeing in the data. The model considers the nurse as the anam cara, the soul friend of the patient. I read this article before and purposely decided to dismiss it. I considered it too much.. Nurses would think Ive definitely lost it if I asked them to consider the patient as a soul friend when I teach care planning. Too much and not practical.
But now, reading it again, I see the patient and the nurse as unique persons with spiritual, biological, emotional and sociological dimensions… Caring, love, hope and spirit come together to form personhood.. From an Irish perspective caring is maternalistic and holistic (pg.345). Caring is an integral component of nursing and this is what the participants are saying to me.. The caring presence of the nurse is defined in the model as Anam Cara.. reference to being sensitive and understanding.. the exact words of some of my participants … links directly to the spider diagram in my diary …. Being sincere and open … McCarthy refer to Gra, love which is unselfish care.. providing care without seeking personal gain.. altruism.. Nursing is a sensing process with emphasis on seeing, hearing, touching and presencing (the model of personhood) and I can see and hear these concepts in the data.
There is evidence of empathy, respect, active listening, understanding, touch … the patient who acknowledge the benefit of holding her hand .. this caring humanist element.. I need to probe for

more examples and what is the nurse managers role.. there is a lot of reference to what the nurse should do.. is there a sense that the nurse manager wants a more therapeutic nurse-patient relationship and there would be a better outcome for everyone.

2012

An awakening for me today when I read an article called 'Humanbecoming: not just a theory- It is a way of being… I'm reading and crying at the same time because it is so sad..Yet as the tears roll down my face, I'm trying to make sense of where this all fits with me and my research. Am I sad because it's a sad story, or am I relating it to my own life experiences. Am I influencing the data and the findings because of my own experiences of caring for my ill mother and her subsequent death or are there other angles to this… Findings don't emerge from the data, I know that and yes I probably am influenced by my own experiences but the data do speak for themselves here (Not what Sally Thorne & Margarite Sandelowski would say but I disagree with them on this one). Participants say that being sensitive to the needs of the person is a fundamental part of evidence-based practice.. its not automatic… one must be consciously alert or aware and it takes time…

Smith's article advances my thinking and analysis further.. Ive been looking for examples from participants but sometimes its difficult for them to describe… Smith describes exactly what I am looking for but its so simple and straightforward that participants may not value this enough to share it…. And I'm to blame too… I need to go back to the raw data and re examine for words which I might have overlooked as not important… for example I remember one CNM describing how little time there is now to listen and hear..to be present yet that s what Smith is saying ..'my primary task as being attentively present to the persons and families assigned to my care; how meaningful it was to be fully present; she warmed to my presence; attentively present, I evidenced interest; attentively listen; the richness of true presence'.

It so simple and this is the wrong word because its not simple, it's 'presence'.. what is presence.. being there and being sensitive… and is this what participants are saying when they refer to patients as family… Are some people better at this than others, is it empathy or more than empathy… whatever it is, its real and its fundamental to evidence-based practice..

2012

Data collection is finished and I've written a draft. My supervisor thinks its somewhat repetitive and disjointed without good supporting evidence from quotes. I haven't done it justice.. Why … Did I overlook the simple .. did I not ask enough questions or did I make all of this up? No. I didn't make it up because the data came first… its there.. Have I mis-represented the participants' views… possibly.. but I've already gone back to the data on this when I was looking for evidence of 'presence'.. Re-reading the theme here again, I haven't represented participants views as I've kept the content all too broad… the data is emotional but I don't reflect this emotion because maybe I'm only recognising this now…So back to the raw data I go again.. this time I need to go deeper .. Up to now, I've stayed superficial because maybe I still don't see the worth…

2012

Ive gone back to the raw data, different sections of analysed data and I'm still not sure. Ive arranged to meet a participant. Ive sent her the analysis and she's read it. She doesn't recognise herself in the analysis at all. But yes, she agrees that nurses must know the patient. 'It's all a bit too touchy feely for me though' she said. There is a professional boundary. As a nurse you can't afford to get too attached to patients as you must be the advocate and you must be professional. <u>But you do get the best out of it when you know the patient and you know the family.</u> When you know the patient and the family, things run smoothly. But stay objective. You have to maintain some distance in order to stay objective and be professional. It's getting the balance and if you get too close to the patient or the family, then you can't be objective.

Being honest, my heart sank as I chatted this out with the CNM. She is not sure and I wanted her to be sure. Yes you have to know the patient and the family but don't get to close and keep a professional distance. Overall she doesn't disagree with 'knowing the patient', it's the touchy feely bit that she has problems with. And that's ok, because in the context of the data, its not about being touchy feely. Its about being appropriate and its about things running smoothly. And it is about knowing the patient and the family. But again, I cant be certain. Ive sent the revised analysis to another CNM and Im going to meet her.

2012
Another perspective when I meet this CNM. She thinks this is all very encouraging. As nurses we fundamentally want to get it right and we really are trying but its not easy. Its hard to describe.. so its not just me. This is hard going, but its real and its work. She proceed to explain a call from a patient and she had to rationalise (not justify) a doctors behaviour but she was skilled to do this and whilst she equates this to being kind and sensitive, I think she was very skilled with her communication. Its nice to be nice but this is more than being nice.

2012
The two ADONs who read this category agree that knowing the patient is important. There's no excuse why nurses don't know the patients and their famililies.. As regards staffing levels and agency nurses, the ADON doesn't accept that agency nurses don't know the patients. The same nurses tend to return to the same ward so they should know the patient.
But I still think this is about abilities and skill. Nurses must be willingness and competent to know the whole story. There is also self-awareness and recognises how capable or good am I at this .. nurses need to ask themselves if they are answering the questions. CNMs know they will be asked so they know because it's like a poor reflection on them if they don't know. Do the ADONs know the patients… no they don't. They might know some patients names and as they say if there is an issue or problem, they go and meet the patient and the family but they don't know the whole story. And that the crux of it all. ADONs and some nurses know at a superficial level or a practical level to greet and fulfil their own duties but they don't know the patient as a person … There are levels of knowing and CNMs are right… they themselves and the nurses must know all the story at all levels including what might be masked… And this is a learned skill.. CNMs have learned through the years to know the story because they had to. It's a reflection of their abilities and competence.. and that consultant assessed competence by asking the patient after he asked the CNM. And I can remember similar situations. I knew when the full story would be requested depending on the consultant or the night super who would do her rounds and ask me, or the clinical tutor who would likewise do rounds … so we learned to perfect skills in 'knowing' and remembering the patient's story. And this is part of EBP because knowing the patients story means answering questions, bringing vital pieces of information together including blood tests or scan results and combining this with the fact that this 75 year old man doesn't like living in a nursing home and doesn't want to go back there .. its not easy, its difficult, but knowing the story makes the difference…

2012
More insight from Agnes, go back to the definition of evidence based practice and what it says about patients perspectives.. how does this fit with knowing the patient..
Having reviewed a recent definition of EBP, I get it … knowing informs us of the patients values and preferences so knowing is central to achieving EBP…

I removed the word story as I feared it may underestimate the significance and skill required to accomplish 'knowing at the evidence-based practice level. There is skill required to truly know. The focus must remain on knowing and it is knowing the patient at different levels that I would like to investigate further. There is the meet and greet level and then there is the practical level.. I have to give you a drug, therefore I must know you. But it is interesting what Dougherty's study

found.. I know you so I don't adhere to policy of checking name, date of birth, allergy status because I know you… but is this knowing .. I don't think so. Knowing at the evidence based practice level requires skills to truly know the health, personal and social needs of the patient.

Appendix L

Sample of Audit Trail, which identifies use of codes to form categories and themes

Extracts from transcripts that contribute to 'Knowing the Patient'.

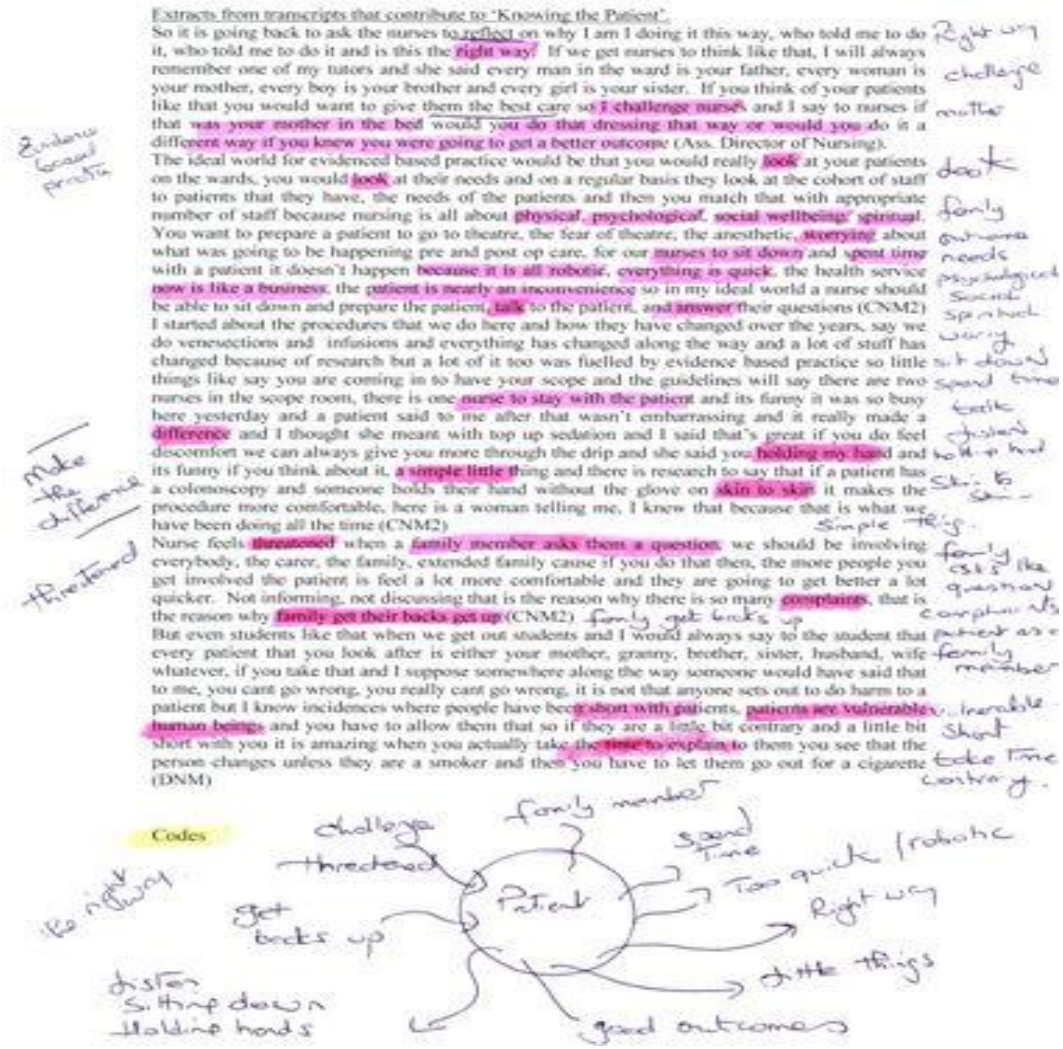
So it is going back to ask the nurses to reflect on why I am I doing it this way, who told me to do it, who told me to do it and is this the right way. If we get nurses to think like that, I will always remember one of my tutors and she said every man in the ward is your father, every woman is your mother, every boy is your brother and every girl is your sister. (Ass. Director of Nursing).

The ideal world for evidenced based practice would be that you would really look at your patients on the wards, you would look at their needs and on a regular basis they look at the cohort of staff to patients that they have, the needs of the patients and then you match that with appropriate number of staff because nursing is all about physical, psychological, social wellbeing, spiritual. You want to prepare a patient to go to theatre, the fear of theatre, the anesthetic, worrying about what was going to be happening pre and post op care, for our nurses to sit down and spend time with a patient it doesn't happen because it is all robotic, everything is quick, the health service now is like a business, the patient is nearly an inconvenience so in my ideal world a nurse should be able to sit down and prepare the patient, talk to the patient, and answer their questions (CNM2)

I started about the procedures that we do here and how they have changed over the years, say we do venesections and infusions and everything has changed along the way and a lot of stuff has changed because of research but a lot of it too was fuelled by evidence based practice so little things like say you are coming in to have your scope and the guidelines will say there are two nurses in the scope room, there is one nurse to stay with the patient and its funny it was so busy here yesterday and a patient said to me after that wasn't embarrassing and it really made a difference and I thought she meant with top up sedation and I said that's great if you do feel discomfort we can always give you more through the drip and she said you holding my hand and its funny if you think about it, a simple little thing and there is research to say that if a patient has a colonoscopy and someone holds their hand without the glove on skin to skin it makes the procedure more comfortable, here is a woman telling me, I knew that because that is what we have been doing all the time (CNM2)

Nurse feels threatened when a family member asks them a question, we should be involving everybody, the carer, the family, extended family cause if you do that then, the more people you get involved the patient is feel a lot more comfortable and they are going to get better a lot quicker. Not informing, not discussing that is the reason why there is so many complaints, that is the reason why family get their backs get up (CNM2)

But even students like that when we get out students and I would always say to the student that every patient that you look after is either your mother, granny, brother, sister, husband, wife whatever, if you take that and I suppose somewhere along the way someone would have said that to me, you cant go wrong, you really cant go wrong, it is not that anyone sets out to do harm to a patient but I know incidences where people have been short with patients, patients are vulnerable human beings and you have to allow them that so if they are a little bit contrary and a little bit short with you it is amazing when you actually take the time to explain to them you see that the person changes unless they are a smoker and then you have to let them go out for a cigarette (DNM)



Grouping of codes into sub categories

The following **codes:**

Look; holding hand; sitting down; environment; rationalise not justify; challenge; spending time; talk; answer questions; short with patients; time to explain; make it my business; I know from patients reactions; listen to their worries don't get backs up; made a difference; as a family member; stay with the patient; I have to explain; contribute to the **subcategory** 'Communication'.

The following codes:

The right way, the best care, family, mother, brother sister, challenge yourself, listen, look, simple things; he became emotional and he couldn't stop crying; he was distraught and he just cried and cried; psychological social physical, holding my hand, skin to skin, advocate; touchy feely; too close; stay objective; keep distance; patients are vulnerable contribute to the **subcategory** ' Meaningful relationships'

The following codes:

Family, challenge, feel threatened, family member asks a question, being short, time to explain, vulnerable, 'social and psychological' 'get their backs up' complaints contribute to the **subcategory** 'Family involvement'.

The following codes:
Challenge, feel threatened, robotic, complaints, listen, talk to, stay with the patient, human beings, 'too touchy feely', 'too close' 'staying objective' 'getting the balance' 'time to explain' 'its not easy'; 'we are trying'; 'its hard going'; contribute to the **subcategory** 'Abilities, effort and willingness'

Subcategories are merged and discussed using the **category '***Knowing the Patient'.* I had initially labelled this category the 'humanity of caring' but on further reflection and discussions with the participants, we decided that 'Knowing the patient' captures the 'presence', 'time', 'pace' 'meaningfulness', 'interventions which include communication with patients and families. 'Knowing the patient' necessitates communication, a therapeutic relationship, humanity which informs holistic nursing care I acknowledge that these codes could be grouped to form a different category such as 'Person-centred care'; but, we wanted to emphasise participants' views on nurses spending time getting to know the patient. Memos in my diary track my evolving thoughts with reference to participants' comments and the literature. Every patient is a unique person with physical, psychological, social, emotional, worries, vulnerabilities, feelings and needs. The story is included because it refers to the life story, which can impact on the patient's healthcare. Story makes it personal and it also implies that nurses have to actively listen. The nurse intervenes by getting to know the person, including his or her social and emotional state. The nurse knows the person by sitting down, looking, spending time, being aware, and being attentive. Pace is important because knowing takes time and nurses use astute nursing skills to get to know the patient. Knowing is at a superficial level without the meaningful relationship which informs the story.

Categories are grouped to form themes. Knowing the patient was grouped under **Theme one: *Nurse Managers' perceptions of Evidence Based Practice*.** I had no idea at the outset of this study that 'Knowing the patient' would emerge as part of the findings. I judged that this subcategory was important to participants and it formed part of their understanding of evidence-based practice. Participants perceive that if nurses care affectionately for patients, using their astute assessment skills, they will know the patient, and this is evidence-based practice. But its not easy, it is challenging and it's about getting the balance between being too close and too distant.