# The Essentials of NURSING AND HEALTHCARE RESEARCH

*Edited by*

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# 2

# EVIDENCE-BASED PRACTICE AND RESEARCH

NEIL JOHNSON

## Chapter learning outcomes

On completion of Chapter 2, you will be able to:

1 Appreciate the historical development of research in the nursing profession.
2 Outline key influences in the evolution of evidence-based practice in healthcare.
3 Discuss the ways in which research informs evidence-based practice.
4 Consider contemporary drivers in research and evidence-based practice.
5 Reflect upon the impact of research and evidence-based practice on personal and professional development.

## Key concepts

Research in nursing, evidence-based practice, development of research and evidence-based practice in nursing, professional development, research impact.

## INTRODUCTION

Research is for researchers, nursing is for nurses. From my experience as a lecturer in nursing, this is a relatively common perspective taken by students as they begin to learn about research and evidence-based practice. Indeed this viewpoint is borne out by literature exploring student nurses' attitudes and perceptions toward research (Ax and Kincaid, 2001; Johnson et al., 2010). Apprehension about research as a subject has been reported amongst nurses, both qualified practitioners and new students of nurse education. You may yourself be concerned about such aspects as understanding research methodology, and engaging in nursing practices in placements where the translation of research to practice can be evidenced. What this book aims to do is assist you in the process of reducing your apprehension by providing the tools to understand and appreciate research and evidence for practice.

Common questions that are asked of lecturers who teach research, and that you may also have about research for nursing and healthcare practice, may include *why* the topic is included in nursing curricula. My reflections have led me to firmly believe that I cannot expect learners to understand a topic (and its relevance to nursing) if I cannot articulate its importance to practice. I think back to the numerous research studies that I have read, that had a personal and professional impact in terms of my practice, my self-awareness, personal beliefs and attitudes, the ability to see things from the perspective of others (e.g. patients/families/carers), and in some instances humbled me by my lack of insight into how individuals cope and deal with crisis events in their lives. Without a knowledge of research in healthcare and the ability to be research 'literate' (i.e. to be able to read and understand original research studies as published in professional journals), I would still hold those initial expectations and images that I had accumulated as I embarked on a career in nursing.

The quote 'Research is to see what everybody has seen and to think what nobody has thought' (Szent-Gyorgy, 1957, cited by Field and Morse, 1995: 1) conveys to me the answer to the questions posed by my students. The ability either to undertake or to read and appraise research evidence opens up a whole new world for us as healthcare providers. It has the ability to provide new perspectives, to help us make sense of our experiences in practice, to advance our knowledge and understanding, to make us more effective practitioners/teachers, to influence our careers/roles, and to shape and change our beliefs and attitudes about the world in which we work and live. Crucially, it enables the delivery of safe, effective, and person-centred care. We have a duty to provide the best care possible for our patients and clients, using the best available evidence. This ability either to engage in real-world research or to become research literate provides us with the key skills that will underpin how we develop as individual professionals, enhance the care that we provide to patients, solve problems, make decisions, and build knowledge and understanding.

This initial introduction has served to acknowledge some of the concerns that you may have regarding your learning. The rest of the chapter seeks to provide you

with an understanding of the development of research in nursing, the evolution of evidence-based practice in healthcare, the ways in which research informs evidence-based practice and the contemporary drivers that shape the ways in which research and evidence are applied in healthcare provision today. In doing so, the aim is to facilitate your understanding of the need for research and evidence-based practice in healthcare to inform your personal and professional development.

## PERSONAL IMAGES OF NURSING AND THE ROLE OF THE PROFESSIONAL NURSE

Thinking back to the statement made earlier in this chapter regarding personal expectations and images of nursing roles, and to assist you in clarifying and reflecting upon your own personal images of the role of the nurse, as well as the notion of research in nursing, take some time to consider Activity 2.1:

ACTIVITY 2.1

Take some time to consider your current attitudes, beliefs and images of nursing.

1 What has shaped and formed these?
2 What types of knowledge underpin what nurses do in caring for their patients – where does this knowledge originate?
3 What are your current attitudes and beliefs toward research as a subject in nurse education?

The purpose of having this activity at the start of this chapter is three-fold. Firstly, it will facilitate your own personal understanding of the role of the professional nurse. Secondly, it challenges you to consider what types of knowledge underpin the practices of the professional nurse – this should generate a broad spectrum of responses. Finally, the activity challenges you to think about why research is included in nursing and healthcare education and when considering this question to ask yourself this: how is the knowledge underpinning what nurses do in practice created? You may find, following discussions with your peers and/or tutors, that learners hold a variety of attitudes, beliefs, and images of nursing: some may suggest that a key role of the nurse is to be a kind and caring professional with good communication skills; others may see the nurse as a professional who needs to have an excellent knowledge base in relation to human anatomy and physiology, or a professional who requires technical mastery in procedures such as wound care, injections, or taking a patient's vital signs. It is also important to identify both the positive and less well-informed responses to these questions in order to identify where further learning, self-awareness and reflection are required. This is crucial in your developmental journey, recognising the impact of where your learning about research and evidence-based

practice will take you, both in terms of practice and your ongoing continuous personal and professional development.

Other discussion points from this activity may include asking such questions as where do our attitudes, beliefs and images of professional roles come from, what influences these, and what types of knowledge do nurses draw upon in caring for patients and clients? The responses to the second question in this activity may take a little more time to clarify as the issue of knowledge in nursing is a complex and well-debated one. Later chapters in this book will help you understand this concept in terms of how differing approaches to research can help expand certain types of nursing knowledge, and how specific questions that we have about our practice can be answered with the most appropriate types of evidence. However, a useful starting-point here is the seminal paper by Barbara Carper (1978) 'Fundamental patterns of knowing in nursing'. It would be helpful in respect of the notion of identifying differing types of knowledge utilised in nursing to read Carper's paper. This should be accessible either via your library or online search databases.

## RESEARCH AND EVIDENCE-BASED PRACTICE: AN EXPLANATION OF TERMS

Although the terms 'research' and 'evidence-based practice' have been introduced to you in Chapter 1, it is worthwhile spending a little more time exploring their definitions. These terms are frequently used interchangeably and it can be easy to become confused! Thus, before exploring the development of research and evidence-based practice in nursing, it is vital to define these two terms and highlight how they *differ*.

### What do we mean by 'research' in nursing and healthcare?

Within Chapter 1 of this book, research is defined as, 'A systematic approach to gathering information for the purposes of answering questions and solving problems in the pursuit of creating new knowledge about nursing practice, education and policy' (Hek and Moule, 2006: 10). Parahoo (1997: 7) defines nursing research as 'the systematic review and collection of data on the organization, delivery, uses and outcomes of nursing care for the purpose of enhancing a client's healthcare. It is not only about what nurses do but also about clients' behavior, knowledge, beliefs, attitudes, perceptions and other factors influencing how they make use of, and experience, care and treatment'. Parahoo's definition is significant here as it emphasises and recognises that the knowledge required for professional practice is not solely based on one domain of knowledge, but that instead – as nurses – we must integrate knowledge from the health and social sciences, knowledge of patient experiences,

circumstances and perspectives, knowledge from the arts and humanities, as well as knowledge of the attitudes and experiences of healthcare providers, in order to provide holistic care for our patients and clients.

One key theme can be identified across definitions – the fact that research is a *systematic* and *planned* process which seeks to investigate given issues or questions in order to enhance our knowledge and understanding. At this juncture, it is worth pausing and thinking about how the outcomes of research impact upon us professionally. Nutley et al. (2007) usefully considered this question in presenting a continuum of research impact. Research does not always translate into practice directly (e.g. by altering the way we *do* things for our patients or undertake particular procedures), but it can alter the way we think about things, change our attitudes, influence our values, and enhance our self-awareness. The utilisation of research outputs can be considered, according to Nutley et al. (2007), on an instrumental and conceptual impact continuum (see Figure 2.1).


**Figure 2.1** Research impact continuum

Source: Nutley, Sandra (2007) *Using evidence: How research can inform the public services*. ©Republished with kind permission of The Policy Press.

*Instrumental* impact relates to the ways in which research outputs directly lead to demonstrable changes in practice – for example, the practice of intramuscular injection technique is well documented. Publications by Workman in the late 1990s highlighted the practice of the Z tracking technique when administering medication via intramuscular injection in order to provide enhanced patient outcomes, in terms of patients receiving the full therapeutic dose of the medication as well as the prevention of tissue or skin damage during the procedure: a demonstrable outcome which one could witness nurses applying when performing an intramuscular injection (Workman, 1999). Further instrumental impacts can be seen by the way in which research translates into local policies and procedures – for example, local hospitals providing clinical procedure guidelines for practices such as indwelling urinary catheterisation by basing these on the best available research.

*Conceptual* impact relates to the ways in which the outcomes from research shape our attitudes, help us understand the experiences of others, and develop

insight into the lived experiences of healthcare providers and users. For example, Dunniece and Slevin (2000) published research which explored the lived experiences of nurses being present when a patient was given the diagnosis of cancer. This work presented a number of useful findings and made one think about how one would feel, act and react while being present with a patient when they were receiving such a diagnosis: this should encourage us to reflect upon our interpersonal skills as well as to seek out further knowledge and understandings about conceptual impact.

## What do we mean by 'evidence-based practice' in nursing and healthcare?

All of us use 'evidence' in the regular decisions we must make throughout life (e.g. when deciding upon where to rent or buy a property we would review the evidence in relation to location, services and amenities, transport or costs). As a learner you will constantly be faced with decisions and challenges which you will need to resolve by using an evidence-based approach.

As with the definitions provided for the term 'research', a number of researchers in this field have provided their position on what is implied by the term 'evidence-based practice'. Sackett et al. (1996: 71) define this as the 'conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients'. In Chapter 1, evidence-based practice was defined as 'The process of integrating evidence into healthcare delivery' (Titler, 2011: 291), while Moule and Goodman (2009) refer to this as the process of making choices about what are the most appropriate/effective approaches to care for individual patients. Considering all these definitions, evidence-based practice is a *process* of making decisions about the care of patients and clients based on not only the best available valid research but also a consideration of:

- Professional expertise.
- The needs, abilities, preferences, circumstances, attitudes and beliefs of the individual patient or client.

Evidence-based practice is therefore a *process* about making the right decisions for individuals and does not imply the translation of research outcomes and recommendations in a prescriptive manner. Even when the best available current evidence is translated into a practice guideline or standard, consideration must be given toward patient preferences, circumstances and beliefs.

The main *differences* between the aims and purpose of research and evidence-based practice are helpfully outlined by Carnwell (2000), and these can be reviewed in Table 2.1 below.

**Table 2.1** The three essential differences between research and evidence-based practice (adapted from Carnwell, 2000)

| | Research | Evidence-based practice |
|---|---|---|
| 1 | The research process is applied to investigations or enquiry with the primary aim of providing new knowledge/insights. | Evidence-based practice is the process by which all the relevant evidence available (of which original research forms part) is appraised and reviewed, thereby generating recommendations about the best approaches to practice/care. |
| 2 | The outcomes of research relate to the initial aims of the study which may provide findings relating to the effectiveness of particular interventions or improved insights into specific phenomena. | The outcomes of evidence-based practice are decisions about the best course for clinical actions which may lead to changes in approaches to practice. |
| 3 | The research process uses existing evidence to justify new study/ enquiry/investigations. | Evidence-based practice draws on existing research and evidence (including patient needs and preferences) on which decisions about approaches to care are based. |

## How does research inform evidence-based practice?

In applying an evidence-based approach to care, one has to consider what counts as evidence. Research evidence in the form of original, credible research studies is generally considered to be more reliable than sources of evidence that are not derived from original research studies (e.g. non-research based literature, evidence from the opinions of clinicians). The general consensus around the ranking of sources of evidence in terms of value/strength is outlined in Figure 2.2. (Don't worry if some of these terms are alien to you at present as they will be explained in more depth in later chapters of this text.) Although this hierarchy exists, outlining the relationship between research and evidence, differing sources of research evidence will be reviewed for differing types of questions that we may have about our practice. Qualitative research – an approach which seeks to understand human experiences – would be reviewed if our questions about practice were related to understanding the experience of nurses or service users as regards specific phenomena. So whilst not acknowledged as being the strongest type of research evidence, the point that is made here is that in answering questions about practice we must source the most appropriate types of evidence. In doing so, we will need to utilise the best research evidence currently available to us with our expertise and experience as healthcare providers, whilst also considering the preferences and circumstances of the individual

*Research-Based Evidence*

- *Systematic reviews and meta-analysis*
- *Randomised controlled trials*
- *Non experimental studies, surveys*
- *Qualitative research studies*
- *Published, evidence-based practice guidelines*

*Non-Research-Based Evidence*

- *Opinions and the consensus of experts*
- *Case studies*
- *Evaluations and audits of practice*

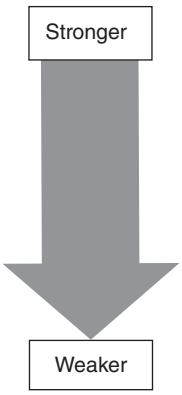


**Figure 2.2** Hierarchy of sources of evidence

patient, to provide evidence-based practice. Note however that there may be instances in practice where no research evidence is available and therefore the consensus opinion of experts or data from local evaluations of care may influence our decisions.

## Research and evidence-based practice in nursing: A historical perspective

Contemporary healthcare provision has an established approach to care that is firmly based upon the best evidence available (for which research makes a significant contribution). For many years, however, healthcare was delivered in what could be described as a ritualistic manner, one that was based upon the ways things were done rather than considering what was best for the patient. In reviewing nursing practice based upon rituals, Walsh and Ford (1989) discovered that much of what nurses did for their patients was based upon exactly that – ritual with no evidence to justify the practices. Some examples here include the use of unorthodox methods for moving and handling patients which had the potential for harm just because it was the done thing in a ward, insisting that pre-operative patients fasted for a length of time that was more excessive than required, recommending bed rest for patients with back pain when it had been shown to make that pain worse, and using the application of egg white in the management of wounds without any credible evidence that it was effective. As Muir Gray (2001) states, healthcare has shifted away from practices that were based solely on personal opinion and preferences as to how patients were treated and cared for, towards an era where decisions are firmly underpinned by justification and rationale via the use of evidence.

ACTIVITY 2.2

Megan is a second year student studying to become an adult nurse. She is on placement in a busy minor surgery unit. She has studied pain and the management of pain in a university module prior to this placement and is aware of the differing analgesic groups of medicines (medicines prescribed to manage patient pain) and she also understands the different ways in which a patient's pain can be assessed. She has observed that all patients are prescribed the same analgesic medication post-operatively even though different patients have had differing procedures, and as her tutor at university emphasised, pain is a subjective phenomenon and therefore the management of pain must be based on individualised assessments. She asks her mentor why all patients are prescribed the same analgesic medication following surgery. Her mentor replies 'because that is the preferred medication within the ward that we have been prescribing for years ... it seems to work'.

In this scenario what are the risks of basing care on ritual and routines to the:

- Nurse?
- Patient?

Your responses to this activity may vary depending upon your level of experience, however it is important to consider the consequences of such approaches both from the perspective of the consequences for patients (e.g. the prevention of harm and promotion of safety) and the implications that ritualistic approaches could have in terms of a nurse's ability to account for, and justify, all that he or she does for the patient. What would you do if faced with Megan's experience in practice placement?

By basing our practice on evidence of interventions that have a proven value, we aim to eliminate ritualistic care and provide positive patient outcomes. Even with good intentions at heart, compassionate but ill-informed care can be dangerous if based on interventions that could potentially harm patients.

The historical development of research in nursing has had an interesting journey and it is worth taking some time to examine the pathways to research and evidence-based practice in contemporary healthcare which in many ways also reflect the development of nursing as a profession.

**Pre-1970s:** Much of the activities of early nursing pioneers were aimed toward enhancing the recognition of nursing as a profession, enhancing the educational preparation of nurses, and raising the standards of care for the sick. The work of Florence Nightingale during the Crimean War, in which she recognised the need to review the way in which sick and injured soldiers were cared for, can be seen as the first evidence of research in nursing. Nightingale, and her empirical observations and collections of data, gave rise to changes in practice for the sick and wounded as regards nutrition, cleanliness, and water, as well as the importance of considering the environment in which care was provided. Other notable pioneers in nursing research in this pre-1970s period included:

- Jeanne Quint Benoliel: a researcher devoted to the study of death and dying who worked with the sociologists Strauss and Glaser examining communication between healthcare providers and dying patients (Quint, 1967).

- Lisbeth Hockey: an internationally renowned researcher in the field of community nursing research who was responsible for the initiation of the Queen's Nursing Institute in Scotland, she recognised and emphasised the need for continuous quality improvement in care and the importance of nurses questioning and challenging ritualistic approaches to care.
- Marjorie Simpson: acknowledged as being instrumental in the development of nursing research in the UK in the 1950s, as Smith (1992: 893) states: she was 'totally dedicated to fostering "research mindedness" among nurses, midwives and health visitors worldwide'.

Although nursing academics had begun to write theories and models of nursing, notably in the USA, within this pre-1970s period, and in spite of the aforementioned devoted pioneers, the ethos of altruism, vocation and service before professional development in nursing was not truly challenged until the late 1960s (Bradshaw, 2010).

**1970s:** In reviewing as its remit the professional role of the nurse, educational preparation of nurses and the use of nursing as a resource in healthcare, the Briggs Report (Department of Health and Social Security, 1972) encouraged the nursing profession to become more mindful of the need for a nursing research base in practice, and to develop its own professional knowledge base grounded in empirical research – much of the knowledge utilised by nurses up until this point had been derived from other disciplines such as medicine, psychology, and sociology. Partly as a result of the report's recommendations, over the following decade nursing research output increased, and in the 1970s itself prominent nurse researchers (including some of the pioneers of the pre-1970s period) started to publish more seminal work which provided nursing with research on which to guide and base practice: for example, Stockwell's (1972) *The unpopular patient*, Franklin's (1974) *Patient anxiety on admission to hospital*, Hawthorn's (1974) *Nurse – I want my mummy!*, and Hayward's (1975) *Information – A prescription against pain*, are all good examples of studies administered by the Royal College of Nursing (RCN) and sponsored by the then Department of Health and Social Security in the UK government. Around the same time a British epidemiologist, Archie Cochrane, questioned the effectiveness of healthcare interventions and emphasised that they needed to have evidence that they promoted desirable patient outcomes. Cochrane's work would eventually lead to the establishment of the Cochrane Collaboration in 1993, a non-profit making organisation that publishes systematic reviews of studies of clinical effectiveness, providing practitioners with evidence of which clinical interventions promoted positive patient outcomes.

ACTIVITY 2.3

It would be useful to look at Hayward's 1975 study and read the introduction to this paper (pp. 8–9). This provides an interesting insight into the context of research in nursing in the 1970s and the underpinning social and historical factors influencing it. It also provides insights into the developing rationale for nurses to move away from ritualistic practice and towards an approach to care that could be challenged with the use of research evidence. This can be accessed by typing the search term, the title of the study *Information – A prescription against pain*, into your internet browser.

The Briggs Report also made recommendations for changes in nurse education and training, as well as recommending the establishment of a new statutory body for nursing (which eventually led to the creation of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting in 1983, later to be renamed the Nursing and Midwifery Council (NMC) in 2002). These recommendations would ultimately impact upon the nature and use of research in nurse education and practice in that these bodies provided and, in the case of the NMC, continue to provide, guidance for registered nurses on the standards of conduct, performance and ethics for nurses and midwives (NMC, 2008), as well as guidance as to the standards for pre-registration nurse education (NMC, 2010). In both practice and educational preparation, the NMC continues to emphasise the ethos of basing care on best evidence and nurses developing research literacy skills as core values.

**1980s:** Throughout the 1980s, nursing research activity continued to grow steadily and the notion of individualised care was becoming more apparent in the field of health and social care, coupled with the need to recognise the rights of individuals and patients that was embedded in government reports around this time. This being the case, some commentators implied that nursing had not realised the recommendations made by Briggs (i.e. that nurses did not understand research, were unable to apply research findings to their practice, or did not accept the need to utilise research in that practice). The Report of the Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting (Department of Health, 1993) sought to address some of these perceived deficiencies and acknowledged that not all nurses would be expected to be researchers. However, there was a need for nurses to be research literate.

In 1983, a new UK statutory body for nursing, midwifery and health visiting (the UKCC) informed a radical reform of nurse education in the UK, with a new philosophy for the education and preparation of student nurses with an emphasis upon learning in the classroom. National Boards for each of the four countries within the UK were also set up with a brief to monitor the quality and standards of nursing programmes. Concurrent with this was an increase in research capacity within educational institutions delivering nurse education. The introduction of the Research Assessment Exercise (RAE) (now known as the Research Excellence Framework (REF)) by the then Conservative government in 1986 resulted in educational institutions devising strategies to increase the level and quality of nursing research. The REF is undertaken approximately every five years and academic departments of nursing strive to improve their rating (in terms of the quality of research output) to obtain funding from one of the four funding councils in the UK. Indeed the need for research and scholarly output has now become imperative within academic department strategies, thus enhancing not only the level and quality of research produced but also the numbers of nurses undertaking Master's and Doctoral level study. This latter trend is also reflective of the modernisation of nursing careers and the new roles that nurses have developed and undertaken in healthcare provision, resulting in nursing career frameworks which expect individuals to undertake these higher degrees.

At the end of the 1980s, government policy shifted toward the notion of assuring quality and standards of care, rather than what had been a focus upon finance and ensuring budgets were achieved. Concurrent with this policy shift, toward the

later part of this decade, work undertaken by researchers at McMaster University in Ontario, Canada, would become pivotal in the creation of the evidence-based practice movement in healthcare. The work of the researchers was focused upon decision making and problem solving in medicine and involved students as well as professionals searching and reviewing evidence for specific medical practice interventions/treatments. The positive results generated by this project in terms of evidence of clinical and cost effectiveness gave rise to other healthcare professional disciplines drawing from this work and developing the process of evidence-based practice.

**1990s:** Since the beginning of the 1990s there has been a global drive toward basing practice on the best evidence available. Initially this notion was known as evidence-based medicine. The work of the researchers at McMaster University sought to change the culture of decisions made by medical professionals from one based upon individual opinion and preferences to one based upon evidence of effectiveness and improved patient outcomes. There were also a number of key drivers during the 1990s which served to enhance the notion of healthcare systems being based on an awareness and use of research and evidence of what works in terms of improving the quality of care provided to patients. Initially centring on ensuring the best value for money within the health service, the term 'quality' toward the end of this decade became synonymous with the delivery of care of a consistently high standard with minimisation in variations in the way in which care was provided (i.e. a patient with a similar condition or healthcare need could expect to receive the same care and treatment irrespective of where the care was provided in a geographical sense). Around this time national review bodies were implemented within the UK (e.g. the National Institute for Health and Clinical Excellence (NICE) in England and Wales and the Scottish Intercollegiate Guidelines Network (SIGN) in Scotland). Such bodies continue to develop evidence-based clinical practice guidelines which are published following a rigorous and methodological appraisal of the research evidence (mainly from randomised controlled trials and experimental studies) involving specialists from all the healthcare professions as well as service users. Governmental drivers were therefore centred on addressing the perceived fall in standards of care.

By 1997 pre-registration nurse education provision had moved from what were termed Colleges of Nursing and Midwifery to Higher Education Institutions (HEIs). Additionally commissioned reports such as the Peach Report in 1999 (UKCC, 1999), in reviewing nursing and midwifery education, placed an emphasis upon the future direction of healthcare provision and the roles that these professional groups would play in a changing healthcare system which, according to Peach, would impact upon nursing and midwifery by placing 'greater demands upon nurses and midwives for technical competence and scientific rationality' (UKCC, 1999: 3).

**2000–present:** As we entered the twenty-first century the focus of governmental policy was clearly centred on the notion of clinical effectiveness and enhancing the quality of care for patients and clients. This has continued to the present day with publications such as the *Healthcare quality strategy* (Scottish Government, 2010) focusing upon safe, effective, person-centred care. Coupled with this is a range of other factors which have shaped and altered the ways in which care is provided, the places where care is provided, the roles of healthcare professionals,

and the nature of the needs of the public. There is now a multitude of standards, guidelines, and research-based studies published annually. Electronic databases and methods of communication have improved to enable ease of access to such resources.

## IMPLICATIONS FOR HEALTHCARE PROVIDERS

All professional groups that provide health and social care must articulate and develop their practice by utilising best available evidence. There is a wide range of

**Table 2.2** Contemporary drivers influencing the provision of health and social care

| **Patient/service user expectations** | **Demographics** |
|---|---|
| • Access to services.<br>• Consultation in the planning, evaluation and reviewing of healthcare provision.<br>• Increased access to health related information resulting in users having higher levels of understanding regarding their illness, disease or health.<br>• Quality of care.<br>• Safety and risk of harm. | • Populations are living longer.<br>• Increase in complexity of care needs.<br>• Increase in populations living longer with a long-term condition.<br>• Increased dependency upon health services. |
| **Advances in knowledge** | **Changes in the provision of services** |
| • Epidemiology.<br>• Advances in health science knowledge.<br>• Advances in Arts and Humanities knowledge.<br>• Advances in technology.<br>• Advances in medicines.<br>• Increase in research outputs.<br>• Improvements in the management of healthcare. | • Shift in location of care delivery e.g. care in the community.<br>• Changes in duration of care delivery.<br>• Changes in the roles of professionals in the delivery of healthcare.<br>• Shifts in emphasis toward focus of care delivery e.g. public health and promotion of health in populations.<br>• Telemedicine. |
| **Professional expectations of practice** | **Media and societal influences** |
| • Expectations of professional regulatory bodies e.g. standards and professional codes.<br>• Expectations around service provision.<br>• Personal professional accountability.<br>• Changes in the educational preparation of student nurses in the UK. | • Increased scrutiny of health services.<br>• Increase in issues of public confidence.<br>• Increased threat of litigation. |

drivers underpinning the continued advancement of evidence-based practice in all areas of healthcare provision (see Table 2.2). As you will see, the impact of these drivers is huge in relation to the direction and delivery of nursing and healthcare provision.

In responding to changes in healthcare provision with changing priorities and environments, the NMC *Standards for pre-registration nurse education* (NMC, 2010) aim to prepare nurses of the future with the knowledge, skills and behaviours that will meet future challenge, thereby enabling nurses to base decisions upon best available evidence. The learning that you are undertaking in research and evidence-based practice will also impact upon your future career pathways – roles such as clinical nurse researcher and advanced and specialist practitioner, as well as leadership and management roles, education roles, and practice development. The fundamental skills of research literacy and the ability to understand and engage in the process of evidence-based practice are a core requisite for the advancement of knowledge beyond pre-registration education (e.g. Master's and Doctoral research degrees). As regards public expectations, the NMC has stated that there are a number of values that mean the public or service users can have confidence in these nurses of the future. Of particular relevance to the context of this text is the public's confidence in nurses being able to:

> Act to safeguard the public, and be responsible and accountable for safe, person-centred, evidence-based nursing practice. (NMC, 2010: 5)

You will already be familiar with the NMC's competencies and, as you will be aware, there are *generic* competencies (i.e. competencies that must be achieved irrespective of your chosen field of practice) and competencies that are *specific* to each field of nursing, organised into four domains. These are:

- Professional values.
- Communication and interpersonal skills.
- Nursing practice and decision making.
- Leadership, management and team working.

Table 2.3 offers some examples of where there is a reference to evidence-based competencies – emphasising the need for all student nurses to engage in evidence-based learning and practice.

Irrespective of your chosen field of practice, it is clear that research and evidence-based practice are fundamental areas of learning that will equip you with the knowledge and skills to ensure that the care you provide for your patients and clients is of a high standard, as well as contributing to your own personal professional development and the multifaceted array of career pathways open to nurses following registration. Activity 2.4 aims to bring together your learning from this chapter and help prepare you better as you go on to subsequent chapters.

**Table 2.3** Examples of competencies for evidence-based practice for entry onto the register

- **All nurses** must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person-centred, evidence-based nursing that respects and maintains dignity and human rights.
- **All practice** should be informed by the best evidence and comply with local and national guidelines. Decision making must be shared with service users, carers and families and informed by critical analysis of a full range of possible interventions, including the use of up-to-date technology.
- **All nurses** must use up-to-date knowledge and evidence to assess, plan, deliver and evaluate care, communicate findings, influence change, and promote health and best practice. They must make person-centred, evidence-based judgments and decisions, in partnership with others involved in the care process, to ensure high quality care. They must be able to recognise when the complexity of clinical decisions requires specialist knowledge and expertise, and consult or refer accordingly.
- **All nurses** must appreciate the value of evidence in practice, be able to understand and appraise research, apply relevant theory and research findings to their work, and identify areas for further investigation.
- **Adult nurses** must recognise and respond to the changing needs of adults, families and carers during terminal illness. They must be aware of how treatment goals and service users' choices may change at different stages of a progressive illness, loss and bereavement.
- **Mental health nurses** must be able to apply their knowledge and skills in a range of evidence-based individual and group psychological and psychosocial interventions, to carry out systematic needs assessments, develop case formulations and negotiate goals.
- **Mental health nurses** must be able to apply their knowledge and skills in a range of evidence-based psychological and psychosocial individual and group interventions to develop and implement care plans and evaluate outcomes, in partnership with service users and others.
- **Mental health nurses** must work positively and proactively with people who are at risk of suicide or self-harm, and use evidence-based models of suicide prevention, intervention and harm reduction to minimise risk.
- **Learning disabilities nurses** must use data and research findings on the health of people with learning disabilities to help improve people's experiences and care outcomes, and the shape of future services.
- **Children's nurses** must use recognised, evidence-based, child-centred frameworks to assess, plan, implement, evaluate and record care, and to underpin clinical judgments and decision making. Care planning and delivery must be informed by a knowledge of pharmacology, anatomy and physiology, pathology, psychology and sociology, from infancy to young adulthood.

ACTIVITY 2.4

What strategies, goals and actions could you adopt during your practice placement experiences which would enhance your knowledge and awareness of evidence-based practice in action?

## SUMMARY

The key points for your learning in this chapter include:

- Understanding that research and the process of evidence-based decision making are core fundamental attributes of the registered nurse.
- Recognising that healthcare provision is changing: there a number of factors presenting new challenges to nursing and healthcare in terms of the roles that must be undertaken as regards the changing healthcare needs, priorities and developments that exist in health-care. Even for nurses who do not pursue a career in research, research literacy skills are crucial in engaging with evidence-based decision making.
- Recognising also that career pathways in nursing are changing: information and research literacy skills are core requisites for Master's and Doctoral-level degrees.

## FURTHER READING

International Council of Nurses (2012) *Closing the gap: From evidence to action*. Geneva: International Council of Nurses.
http://nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/Improving-Your-Practice/Research-Toolkit/ICN-Evidence-Based-Practice-Resource/Closing-the-Gap-from-Evidence-to-Action.pdf
From a global perspective this 2009 publication by the International Council of Nurses is helpful in clarifying further the notion of evidence in practice, where evidence comes from, how evidence can change practice, and how the outcomes of evidence-based practice can be evaluated.

National Institute for Health and Clinical Excellence: www.nice.org.uk/
The National Institute for Health and Clinical Excellence provides clinical guidelines for healthcare professionals, guiding best practice that is based upon an appraisal of the evidence currently available.

Rycroft-Malone, J., Seers, K., Titchen, A. et al. (2004) What counts as evidence in evidence based practice, *Journal of Advanced Nursing*, 47 (1): 81–90.
This paper by Rycroft-Malone et al. provides some interesting discussion around what is seen as 'evidence' in relation to evidence-based practice. It also covers the debate around the notion of four differing types of evidence: research, clinical experience, patient experience and local context, and how these are melded together to inform decisions about patient care.

Veermah, V. (2004) Utilization of research findings by graduate nurses and midwives, *Journal of Advanced Nursing,* 47 (2): 183–191.

This work by Veermah presents an original research study which evaluated the impact of research education on the attitudes toward, and utilisation of, research by nurses and midwives. It is especially interesting as there may be some similarities between the study's findings and your own personal current perspectives upon research as a topic.

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