Chapter 1
Introduction

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Evidence-informed practice has, in the western world, been the driver for many changes in nursing education, policy, and research. As Ciliska (2006) indicated it is now accepted as the norm “Every nurse should have at least an understanding of the purpose and process of evidence-based practice, be able to ask relevant clinical questions, and know who in their environment can assist them in answering questions.” (p. 38). Concerns over adverse events, quality of care, and the quest for clinical effectiveness have led to guides, books, and decision-aids being developed to assist nurses, and other health professionals, with the utilization of evidence in their practice.

Implementation of evidence is a science in its own right, and is associated with specific challenges. One of these relates to the detailed knowledge and skills that health professionals have been encouraged to learn and adopt. The plethora of published works (research and textbooks) is testament to the attention that evidence-informed healthcare has attracted over recent years. This series adds further to the toolkit of resources available for use by health professionals.

So, there is no shortage of resources but what is lacking is a sound understanding of the issues that positively or negatively influence the uptake of evidence into practice. Increasingly, the importance of “context” as a key influence on the translation and use of evidence in practice is recognized. However, context is not a simple concept; the multifaceted nature of the factors related to context raises a variety of challenges to the systematic implementation of evidence into practice. This complexity has resulted in context being referred to by many knowledge translation researchers as “the black-box of practice”
Despite many years of research into evidence-based practice, knowledge utilization, and knowledge translation, we continue to know very little about what makes a context receptive to evidence, what contextual factors have the most impact on clinical effectiveness and clinical decision making, what interventions work best to change practice context, and possibly the most challenging of all—how best to evaluate changes in practice context. Thus there is a clear need for ongoing research in this field to clarify the concept and to develop methods for assessing and appraising the potential impact of individual contextual factors on evidence implementation and the resulting impact of context on implementation interventions.

McCormack et al. (2002) highlighted the variability of contexts in which healthcare takes place and the breadth of factors that subsequently influence practice settings. The context of healthcare can be seen, on one level, as infinite as it takes place in a variety of settings, communities, and cultures that are all influenced by a variety of factors, for example, sociocultural, political, economic, and historical factors. However, in their concept analysis of context, McCormack et al. (2002) used the term to refer to the environment or setting in which people receive healthcare services, or in the context of getting research evidence into practice, “the environment or setting in which the proposed change is to be implemented” (Kitson et al., 1998). They suggested that, in its most simple form, context refers to the physical environment in which practice takes place. Whilst this may seem like an oversimplistic idea, having some boundaried understanding of context is important. In particular, international evidence suggests that nurses have a strong allegiance with the setting in which they work (e.g., a ward, department, clinic, community) (Aiken et al., 2001) and less so with an organization at large and thus the systems, structures, processes, and patterns in an organization are experienced differently in particular practice settings. The boundary of the practice setting shapes how a clinician experiences the organization and, ultimately, how such things as evidence are translated into practice. With this notion of a boundaried practice environment in mind, McCormack et al. (2002) identified three characteristics of context—culture, leadership, and evaluation.

The literature on culture in health and social care is complex, broad, and diverse. Manley (2004) has argued that some of the problems associated with understanding culture arise from a lack of distinction in the literature (and among decision makers) between “organizational culture” and “workplace culture.” Davies et al. (2000) argue
that whilst there are many conceptions of culture, broadly speaking perspectives are divided between those that view culture as something an organization “is” and those that view it as something that an organization “has.” The former being characteristics that are “fixed,” immutable, and serve as descriptors of an organization. When an organization is considered to “have” culture then these are “aspects or variables of the organisation that can be isolated, described and manipulated” (p. 112). Davies et al. (2000) also purport that it is only through the view that organizations “have culture” that it is possible to consider ways in which culture can be changed. Manley (2004), however, argues that organizations are cultures, incorporating such things as language, myths, rules, and stories. However, Manley suggests that this (organizational culture) is not the culture that patients and staff experience everyday, instead, what they do experience is the culture of different settings (contexts) or workplaces. Wilson et al., (2005), Coeling and Simms (1993), and Adams and Bond (1997) have all argued that there is a need to understand the culture of the individual workplace prior to implementing innovations or developments, as culture has been found to vary between units within the same organization. An effective workplace culture is one in which there is (Manley, 2004, p. 2):

- a person-centered approach with patients, users, and staff;
- daily decision making that is transparent and evidence-based, where evidence is the blending of different sources of knowledge (patient preferences, empirical research, critical reflection of experience and professional expertise, and local knowledge [e.g., audit findings]);
- a learning culture in which through formal critique there is a focus on individual, team, and service effectiveness;
- development of leadership potential to achieve a culture of empowerment, continuing modernization and innovation.

The impact of leaders, and leadership roles and styles in particular, has been shown to be a significant factor in shaping culture and the context of practice. There is a large and diverse literature espousing the virtues and otherwise of particular leadership roles and styles. In modern healthcare, much emphasis is placed on “transformational leadership.” Transformational leaders create a culture that recognizes everybody as a leader of something. They inspire staff toward a shared vision of some future state, as well as a number of other processes such as challenging and stimulating, enabling,
developing trust, and communicating. Transformational leaders require emotional intelligence, rationality, motivational skills, empathy, and inspirational qualities and the intellectual qualities of strategic sensing, analytical skills, and self-confidence in public presentation (Kouzes & Posner, 1993). Schein (1985) suggests that transformational leaders can transpose their individual beliefs and values into collective beliefs and values and that these eventually become assumptions because they are seen to work reliably and then are taken for granted. Thus, it is implied that the transformational leader can alter the dominant practice culture and create a context that is more conducive to the integration of evidence and practice. Transformational leaders can facilitate the integration of the “science” component of healthcare practice (the application of science and technology) and the “art” component (the translation of different forms of practice knowledge) to enable the development of expertise in practice and a shared understanding of knowledge for practice. However, whilst such integration enables greater effectiveness in practice, it raises challenges in terms of evaluating practice effectiveness, the effectiveness of interventions, and patient outcomes.

Evaluating outcomes from practice is essential to healthcare effectiveness and in everyday practice is manifested through medical audit, clinical audit, standard setting, quality improvement programmes, care pathway monitoring, and accreditation. However it is widely recognized that measuring effectiveness is complex and the answering of one effectiveness question raises many others and, indeed, most effectiveness evaluation can only ever “partially answer” questions. Whilst the “hard” data of cost-effectiveness and resource management provide a particular perspective on the effectiveness of practice, if we believe that an effective workplace culture is multifaceted and multilayered, as described earlier, then the evaluation of these perspectives and layers is also important. Thus, the “hard” outcome data that can inform the effectiveness of particular interventions and the “soft” data of user experiences, staff feedback, peer review, and reflections on practice are equally valid.

A good example of the influence of contextual factors on evidence uptake is found when the practice of preoperative fasting is explored. Despite high quality evidence-based guidelines, such as those issued by the UK’s Royal College of Nursing (2005), many patients continue to suffer unduly from dehydration, delayed healing, and other complications. Lorch (2007) explored the implementation of these
guidelines in the orthopedic setting and identified barriers to their uptake, which included:

- resistance from theater staff and a few consultant surgeons
- difficulty educating night staff
- rapid turnover of domestic staff
- fear from junior doctors and nursing staff of upsetting the surgeons’ routines
- lack of awareness by nursing staff of free space on morning elective lists.

Here we have evidence of attitudinal, environmental, economic, and communication factors that combine in various ways resulting in poor application of evidence within clinical practice settings and the adverse effects experienced by patients.

So what can be done?

Education or the presence of clinical guidelines, as a sole activity, is insufficient to change health professionals’ behavior (Grimshaw et al., 2004). A greater understanding is needed, supplemented by practice examples, and that is what we hope to achieve with this book. Experts in evidence-based practice and knowledge translation have summarized the key contextual factors that impact positively and negatively on practice change in their various healthcare settings. There will be some overlap but we make no apologies for this. It is useful to understand that there are some common contextual influences, while others tend to be setting or field specific.

There are some guides to assist evidence implementation or knowledge translation, the latter of which is the term currently favored by many implementation scientists and is widely used as a key word in articles published in many leading journals (Kent et al., 2009). Understanding how knowledge is translated into practice is important; it focuses on methods or processes that can be used to increase clinicians’ practice-related knowledge and how they can use that knowledge to improve patient outcomes or health services to close or lessen the evidence-practice gap (Westbrook & Gagnon, 2009).

This brief overview of context and the way it is understood in the context of this book highlights the need for different perspectives of practice context to be brought together into one volume and to analyze how these perspectives help shape our thinking. It is for this reason that we have asked different experts in the field of
Clinical context for evidence-based nursing practice

evidence-based practice to comment on and discuss the contextual factors that commonly affect the uptake or utilization of evidence by practitioners. Implementation scientists have to consider differences in settings, organizational factors, the variability in cultures that exist within practice settings and all the other external and internal influences such as micro-, meso- and macroeconomics, environment, history, and politics. Add to these individual psychosocial factors such as attitudes, beliefs, and knowledge and the complexity of context as a mediating factor for successful evidence implementation becomes acutely apparent.

In Chapter 2, context is explored further by drawing on relevant models and theories that will help to develop an overview of the work that has been taking place in terms of conceptualizing contextual factors that affect evidence-based practice. By no means is this overview comprehensive and all-encompassing; that was not the aim of this chapter. What it does is highlight the common contextual factors that have been identified over the past decade or so and provide possible tools for use when considering implementing evidence into practice.

In Chapter 3, the contextual factors associated with primary care settings are explored, using examples of studies conducted within this setting. Debbie Kralik and John Rosenberg have many years of primary care experience between them, and they have worked in a variety of settings including district nursing and community palliative care.

Chapter 4 moves the exploration to the other extreme of care provision; the acute care sector. Alison Hutchinson and Tracey Bucknall draw on implementation projects that they and others have conducted to capture the key contextual factors that commonly impact on knowledge translation in the acute care setting. Alison and Tracey both hold joint clinical and academic appointments and actively engage in the promotion and uptake of evidence-based practice on a daily basis.

Pediatrics forms the focus of Chapter 5. Val Wilson, an experienced pediatric registered nurse, also draws on research conducted by herself and others to provide examples of how contextual factors can positively and negatively influence knowledge translation and practice change. She uses work conducted in the special care nursery environment to illustrate key factors related to embedding evidence into practice, and also reveals how problems arising in practice
can be addressed by research and practice change to reflect new evidence.

Chapter 6 takes the reader to the specialised perioperative setting. Victoria Steelman has extensive expertise infusing evidence-based practice into healthcare settings and has a particular interest in studying safety and quality. She has made significant contributions to perioperative nursing, in the USA and further afield, and once again, she draws on her research to provide an overview of the factors that should be considered when undertaking knowledge translation activities in the perioperative setting.

We move to another specialist field of healthcare, Midwifery, in Chapter 7. Marlene Sinclair, who is Ireland’s first Professor of Midwifery Research, draws on her research experiences, particularly in birth technology, that span both qualitative and quantitative methods. She captures the contextual factors that are associated with Midwifery practice and includes examples that will not only enhance our understanding of issues in this area of practice but also our knowledge and understanding of technology in the birthing process and birth outcomes.

Mental health is the focus of Chapter 8. Dawn Freshwater and Jane Cahill explore the context of evidence as developed and applied in mental healthcare settings. In particular, they draw on two examples of how evidence can be used to both define and influence practice environments and subsequently impact on care; the process of benchmarking and the practice of reviewing research and research evidence.

In Chapter 9 the focus shifts to the care of older persons. In a world where people are generally living longer and healthier lives, it is important to explore how to provide the best in healthcare for older persons. Nadine Janes has a wealth of experience to draw on; she has worked as an unregulated care provider, a registered nurse, and as an advanced practice nurse in both institutional and community settings. Therefore she is extremely well placed to consider the aged care setting, in particular the factors that affect knowledge translation in long-term care facilities.

We move from the specific to the wider world in Chapter 10. Gill Harvey explores issues relating to the wider policy context of implementation, looking in particular at the relationships between policy and practice in relation to delivering evidence-based healthcare.
She discusses the factors that influence decision making at a policy level and draws on specific examples to illustrate how the policy process can mediate the translation of evidence into practice, pushing some issues higher up the agenda and others lower down.

We know that we have not included all settings or fields of practice; that would be virtually impossible in a book of this size. We also recognize that many of the examples are from the western world and few from the rapidly developing eastern societies. By exploring context in various clinical settings, we hope that the factors will be seen in such a way that they can be transferred to other settings that we have not covered and similarly be considered when undertaking knowledge translation in any part of the world. In the final chapter we will synthesise the key issues emerging from previous chapters and propose some options for moving forward with advancing our knowledge of context and identifying future research priorities in this field.

We will begin however with the next chapter, which provides an overview of context, and draws on frameworks or models that can be used by health professionals to identify and assess the impact that each has on achieving successful practice change.

References


