Quality and evidence in nursing

Consider the following scenario: one of your family members is in hospital and you become aware that the nursing care they are receiving is 10 years out of date. In fact there is robust evidence to show that what is happening to them may make their condition worse! How would you feel about this? Well, while you may be angry, do not be surprised. What I have described is commonplace, and not unique to nursing. One general practitioner asserted that “clinical research is considered by many doctors as erudite and not an activity likely to involve them directly... most practitioners are so distanced from clinical research”.

People in need of care deserve a service that has been proved through research to be the best that can be given. However, it is a truism that several of the nursing interventions carried out on patients are based on little more than ritual and routine. This is easily explained: while we have come a long way since the gin paid “Sairey Gamps” of the last century, nursing is still a young discipline compared with others. Given this, it is hardly surprising that a research culture has yet to permeate many practice settings and interventions.

In their paper in this issue, Thomas et al. searched the scientific literature to uncover those studies that had evaluated the impact of clinical guidelines on evidence-based practices and outcomes. One definition of evidence-based practice is “a shift in the culture of healthcare provision away from basing decisions on opinion, past practice, and precedent toward making more use of research and evidence to guide clinical decision making”. As with most healthcare professions, nursing is slowly making this shift.

Some authorities suggest that currently about 10% of care is based on sound evidence. They also suggest that 50% of practice based on research is the best that can be achieved. We think that it is wrong to argue (as some nurses do) that all interventions should be evidence-based. The idea that each element of care can be dictated by research evidence is unrealistic and indeed undesired. The role of research is to produce information about practice, not dictate it, and there will always be practitioners who ignore best evidence because of preference or condition of the patient, cost, or because of professional judgement. Furthermore, many important, yet invisible aspects of care—such as interpersonal communications—do not lend themselves easily to empirical study.

In most professions the ability to undertake research is restricted to a few people, with most choosing to remain the informed and critical consumers of research. Therefore, the capacity to appreciate the importance of research findings and the need to use them and inform others must be a high priority for every professional worthy of the name. This role is as important as that of a researcher and should not be relegated to secondary status. However, to exploit this role to the full, practitioners need access to valid, up to date, evidence presented in a user friendly format.

CLINICAL GUIDELINES

When a nurse is aware of evidence comes across a clinical problem that requires solving, firstly she should identify questions about the problem—for example, why does this happen? What can I do to help?). Secondly, she should locate the research evidence needed to answer the questions, and thirdly she should judge the benefits and costs of adopting the research evidence. Considering that there are over 400 different nursing journals, with each one having the potential to contribute to best practice, it is impractical to repeat these steps for every clinical issue we come across. Indeed if we did we would be guilty of providing poor quality care because instead of being with the patient we would be in the library trying to find relevant research. Thankfully, there exists a worldwide network of skilled people who sift and appraise the literature, extracting the best evidence on particular topics for inclusion in clinical guidelines. Thomas et al. showed that processes and outcomes of care are improved through the use of such guidelines. However, the methodological flaws they identified shake our faith in guideline directed practice.

IMPLEMENTATION AND CHANGE

Almost 18 years ago, five reasons were put forward to explain why practising nurses do not use research evidence. They do not know how to apply it. They do not believe it. They do not understand it. They do not know about it. They do not know how to make it happen. These “high hurdles” still exist today and even if they are overcome, practitioners must realise that the use of evidence-based practice without evaluating its effectiveness is an empty gesture. Nurses must monitor continually the effects such changes have on patient outcomes. In their paper, Thomas et al. have explored the effect of guidelines on patient outcomes with equivocal results. This is worrying as the thoughtless use of weak, non-replicated research guidelines may do a great deal of harm and may become
just as much a ritual as the habitual acceptance of existing nursing practices.

We have already alluded that much of nursing practice has evolved over the years through personal experience, expert views, and trial and error. Although colleagues in medicine have a longer research tradition, they too have problems in applying best evidence. The advancement in healthcare technologies and changes in the processes of care have led to greater role specialisation across the disciplines. It is possible that such professional expansion will provide a watershed for many more practitioners to accept the centrality of research. All health professionals have a duty to understand each other’s research fields and work together to take the right actions leading to the best outcomes for patients. Soon there will be no reasons left not to do so—there will only be excuses.

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