What are the challenges for community nurses in implementing evidence-based wound care practice? (part 2)

KEY WORDS
- Barriers
- Community nursing
- Evidence-based practice
- Wound care

Part 1 of this article identified that community nurses caring for patients with wounds experienced challenges in the implementation of evidence-based practice (EBP) and the use of evidence-based clinical decision-making tools. An initial questionnaire was designed to collect demographic and professional information about the participants and to gain background information, assist with the formation of qualitative questioning, and identify participants to take part in semi-structured interviews. Results suggested that 85% of respondents were confident or very confident in recognising the symptoms of wound infection, yet only 70% of the 17 always used the wound infection pathway, and 12% never used it. In order to investigate the reasons why the evidence-based pathway was not being fully implemented, using purposive sampling, six individual interviews were conducted. The results from these interviews are presented in here.

LORRAINE GROTHIER
Head of Clinical Services
Urgo Medical

This article is based on the author's MSc in Healthcare Practice submitted to the University of Essex. The author was a consultant nurse tissue viability at the time of this study.

The aim of the study was to identify if community nurses caring for patients with wounds experience challenges in the implementation of evidence-based practice (EBP) and the use of evidence-based clinical decision-making tools. Using a mixed-methods approach, a quantitative questionnaire provided background information, assist with formation of qualitative questioning and identify participants to take part in semi-structured interviews. Twenty (74.07%) were returned, the results of which showed that 85% of respondents were confident or very confident in recognising the symptoms of wound infection, yet only 70% of the 17 always used the wound infection pathway, and 12% never used it.

In order to investigate the reasons why the evidence-based pathway was not being fully implemented, using purposive sampling six individual interviews were conducted with community nursing team staff. The questions asked are shown in *Box 1*.

RESULTS

Transcripts were read and re-read and key words and phrases coded. Six key themes were identified from the data analysis including the characteristics of:

- The individual
- The organisation
- The research
- Communication
- Education
- External factors.

THE INDIVIDUAL

When making clinical decisions, community nurses may rely on a multitude of factors such as available evidence, knowledge, experience and peer support. Participants demonstrated a genuine commitment to wanting to provide a high standard of care and the importance of 'not doing any harm' while acknowledging that at times they made clinical decisions based on experience, intuition and ritualistic practice. When asked if they made clinical decisions considering the available evidence one stated:

> *"...I don't think I would always, but I think you would sort of have an idea in your head about perhaps trying something different and you'd*

Box 1. Interview questions

1. Can you tell me about yourself with regards to your nursing career?
2. Can you tell me about your educational background including within nursing?
3. Can you describe to me what you understand about the term 'evidence based practice'?
4. With regards to wound management can you describe any challenges you face when implementing evidence based practice?
5. When diagnosing or treating patients with a possible wound infection can you tell me what tools and information you use/access to help inform your clinical decision making either internal or external to the organisation?
6. Can you describe any challenges with the information or tools available?
7. Is there any other information, tools or type of education you feel would be beneficial to help with making appropriate clinical decisions for patients with wounds?
8. Is there anything else you would like to add to the information you have given me?

try something for a couple of weeks and then if it didn't work you'd know. As long as it wasn't doing the patient any harm you'd know after a couple of weeks whether the wound was progressing or not..."

Attitude to planning and delivery of care appeared to vary depending on the individual's interest in the particular field of wound care. A clinician who expressed a keen interest in wound management explained the term EBP as:

"You've gotta have the evidence to back up what you are doing basically you know I often say to patients, gone are the days when the doctor says you need to go and do this and we say, ok how many times a day would you like that"

Regarding professional obligations (Nursing and Midwifery Council, 2015), one participant stated:

"It's about best practice really; I think it is up to the individual to make sure their knowledge is up to date".

THE ORGANISATION

Participants expressed frustration of knowing that evidence-based clinical guidelines exist but cannot be implemented due to lack of resources. They felt overwhelmed by the workload, and lacked motivation and time to be holistic in their practice:

"I think at the moment the district nursing service is on its knees; it's absolutely struggling, wherever you go the morale is so low, it worries me, and I think when you are demotivated your work often becomes sloppy..."

When asked if nurses used the tools and information, one experienced nurse stated:

"Probably not to be honest and it's probably down to time, yeah it is, well I suppose you know if we did it in our own time would we do it? Probably not, you know once we go home we like to relax and probably wouldn't get the books out"

THE RESEARCH

Participants admitted that they didn't access information to support their practice on a regular basis and generally looked up policies guidelines and appropriate research on a 'need-to-know' basis. However, a senior nurse with a higher grade and level of qualification explained that there was more emphasis on the individual having a professional responsibility to access research in relation to clinical competence. Surprisingly, none discussed specifically that they found research difficult to understand or interpret. Discussion evolved with one participant as to what would influence the implementation of an evidence-based clinical pathway:

"I suppose it's just believing the evidence and, erm, perhaps nurses aren't open to new ideas and sometimes old ideas sit in people's heads and they are not willing to try new things."

Many of the participants discussed using the local wound infection pathway booklet on a regular basis.

COMMUNICATION

Time spent with colleagues appeared to be of significant value and an opportunity for debriefing, sharing of knowledge and seeking advice. It was particularly noticeable that the informal support network was a fundamental factor including the local link practitioner for wound care, who was well respected by the team and nurses appeared to value this role as an essential resource:

"I often ask the link nurse what she thinks: I'd take a photograph of the wound and show colleagues."

Communicating with colleagues and seeking reassurance was particularly important for the more junior staff as poor communication led to reduced confidence in decision making:

"Sometimes you go in and think I don't know if it's X Y or Z, so then I think for me, especially being fairly new, I think experience is a great help in nursing. I'd always ask the team just to say, oh by the way I've done this but I don't know if that should have been done, I'm just trying to cover all angles really."

EDUCATION

Education was valued by the participants and most of them discussed completion of clinical modules and study days, although it was not established if training was self-selected or mandatory in relation to specific and responsibilities. However, ritualistic and unreflective practice was evident:

"A lot of nurses just like certain dressings, so they'll put on certain dressings; you'll go in and it won't necessarily be what was on before so that can obviously impact on the patient".

"I hear mixed things from different nurses, so sometimes I'll try to follow the pathway and then somebody will say that doesn't work so they'll put something else on, so they're not necessarily always following it."

Attendance at study days and taught sessions by community nursing staff has proven problematic locally, due to staffing and time issues. One participant who had shadowed specialist wound care nurses explained that the experience had increased her knowledge and clinical confidence.

EXTERNAL FACTORS

External factors were identified as the working environment, patient concordance and the influence of others when planning care, for example, family members and carers. Participants reported that promoting concordance was a priority, but explained it is important to educate patients and their families and include them in the decision-making process, wherever possible:

"Looking at the patient and their understanding of what you are trying to do, so you have to involve the patient and educate them and their families and carers and take into consideration their lifestyle and adapt the care to meet what they would agree to, patients have a right to make an unwise choice."

However, education of patients is not always effective, and despite giving information about the evidence supporting a particular care plan, a patient may choose an alternative treatment plan:

"Patient choice, you know if you're going to use compression therapy and the patient doesn't like it, well you know, we can't obviously because we have to respect the patient's wishes, but we would give them the information and the evidence that it will benefit them in the long run."

The working environment may also be a barrier to implementing EBP and it is often beyond the control of the nurse:

"Sometimes the environment when we are out working in the community can be challenging because we are working in confined areas, and it's not a clinical area and we have to be careful and some people have pets and you know it can cause infection..."

Participants expressed that they would consider the patients' environment, wishes and lifestyle as part of holistic assessment so as to respect their wishes but ensure that care was not harmful. They discussed that, at times, it was not reluctance on their part or a compromise on implementing best practice but a compromise with the patient to maintain quality of life, comfort and dignity.

DISCUSSION

The findings of this study are consistent with previous studies exploring the barriers and challenges for nurses in implementing EBP and sustaining change. The 'BARRIERS' scale (Funk et al, 1991) has been used in multiple studies where time, lack of resource and organisational support have been identified as barriers (Hannes et al, 2007). It is widely recognised that relevant research should be guiding clinical practice to ensure care

"I hear mixed things from different nurses, so sometimes I'll try to follow the pathway and then somebody will say that doesn't work so they'll put something else on, so they're not necessarily always following it."

is delivered in a consistent manner taking into account the best available evidence. However, in this study, as with others, there is poor access and limited uptake of research evidence, with nurses tending to rely on experience, intuition, peer support and ritualistic practice.

The participants in this study were aware of the importance of research-based decision making but interviews revealed there was limited use in practice. Clinical guidelines and care pathways available were often not accessed or observed with the majority of nurses relying on experience and peer support to guide their judgement. This is not unique to the practice area, it is thought that between 30–67% of decisions taken are not in accordance with wound care best practice guidelines (Gillespie et al, 2014). However, it could be suggested that seventeen of the nurses identified in this study had three years or more experience as a qualified nurse and would have been exposed to many situations where they may have used their clinical judgement successfully and would have a tendency to rely on previous experience.

This study population included a nurse with a specialist interest in wound care who had a positive influence on the clinical decision making and confidence of junior colleagues. The importance of such individuals has been highlighted within other studies, recognising that link practitioners are a valuable resource and that nurses with an interest in a speciality can disseminate evidence-based care (Gerrish et al, 2011).

Locally, it is the responsibility of individuals and their line manager that education and professional development should link with the required competencies for that role. This is of particular importance for community nurses where wound management accounts for a significant proportion of their workload (Drew et al, 2007).

Nurses should be able to use their skills and knowledge to engage with other health professionals and patients to ensure that decisions are made in partnership and considering the best available evidence (Department of Health [DH], 2010). Although it is acknowledged that knowledge and practice improve following educational intervention (Dowsett, 2009,) the question still remains as to how evidence-based decision making and practice is sustained. Virani et al (2009) suggest that in addition to educational intervention, a more comprehensive implementation plan may help to improve sustainability.

Specific workflow processes, documentation systems with embedded prompts and reminders, linked to individual clinician's performance may ensure education and knowledge is retained (Virani et al, 2009). Evidence-based practices, supported by a systematic approach that utilises protocols and guidelines assist clinicians with making an informed decision, are more likely to increase clinical confidence and sustain change (Ho and Bogie, 2007).

Political influences, the need to make financial savings, assure quality and be a provider of choice are important factors for health care organisations particularly within a competitive healthcare market (Fitzsimons and Cooper, 2012). Therefore, it could be suggested that organisations should pursue investment in effective systems, processes and accessible education that supports clinicians in the promotion of evidence-based practice (Fitzsimons and Cooper, 2012). Freedom to question and affect change should be encouraged as clinical staff may be best placed to identify challenges but also provide the solutions to overcoming barriers.

Ogiehor-Enoma et al (2010) suggested that in order to create an evidence-based environment, a full review of organisational infrastructure should be undertaken to include financial, intellectual and operational resources available. Virani et al (2009) suggested that organisational commitment to evidence-based practice increases the likelihood of sustainability as they are responsible for appropriate resources being made available and practice being supported through excellent clinical and managerial leadership.

As a result of these findings, the challenges faced by community nurses can be acknowledged and an organisational strategy formulated to address the issues and improve practice. Engaging with clinicians in a collaborative approach to improvement will ensure changes are practical, achievable and promote ownership (Gallagher-Ford, 2014). To reduce resistance to change communication with staff at the earliest opportunity will ensure they feel listened to and take on an active role (Levasseur, 2010). Participants in this study demonstrated their commitment to

caring for the patient but recognised the need for improvement. It could be suggested that by taking part in this evaluation, they have engaged with the beginning of a change process.

LIMITATIONS

It is recognised that the limitations of this study are that the sample was small and only took account of one geographical team of community nurses based within the organisation. The interviewer was known to the participants as a senior nursing colleague, which may have led to non-disclosure of some information. For the purpose of this study, the analysis of the data and coding was undertaken by the author with no input from a second coder, which would have enhanced validity of the coding exercise. A larger scale organisational wide research study would be recommended to determine the generalisability of these findings.

CONCLUSION

It was clear that time poses a major barrier to nurses accessing and implementing EBP. Therefore, it is important that efforts are made to develop strategies that bring evidence into everyday practice and to the bedside of patients. Clinical specialists can facilitate this process through closer engagement and mentoring within clinical teams and sharing expert knowledge and skills.

The themes were reflective of those identified within similar studies examining the barriers to implementation of evidence-based practice. Clinical judgement and decision making by community nurses in wound management is multifactorial. Clinical experience, the influence of others including health professionals, patients, their families and the organisation will all impact on the assessment, treatment and clinical outcomes of patients with wounds. Individuals and organisations have a responsibility to recognise the barriers to evidence-based practice and develop appropriate strategies.

These findings will generate implications for clinical practice and it is hoped it will raise organisational and staff awareness. WUK

REFERENCE LIST

Department of Health (2010) *Equity and Excellence: Liberating the NHS.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf (accessed 9.10.2018

Dowsett C (2009) Use of TIME to improve community nurses wound care knowledge and practice. *Wounds UK* 5 (3) 14–21

Drew P, Posnett J, Rusling L on behalf of The Wound Care Audit Team (2007) The cost of wound care for a local population in England. *Int Wound J* 4 (2) 149–55

Fitzsimons E, Cooper J (2012) Embedding a culture of evidence based practice. *Nurs Manag (Harrow)* 19(7) 14 –9

Funk S G, Champagne M T, Wiese R A, Tornquist E M (1991) BARRIERS: the barriers to research utilization scale. *Appl Nurs Res* 4(1):39–45

Gallagher-Ford Lynn (2014) Implementing and sustaining EBP in real world healthcare settings: transformational evidence-based leadership: redesigning traditional roles to promote and sustain a culture of EBP. *World Views on Evidence-Based Nursing* 11(2) 140–2

Gerrish K, McDonnell A, Nolan M et al (2011) The role of advance practice nurses in knowledge brokering as a means of promoting evidence-based practice among clinical nurses. *J Adv Nurs* 67(9):2004-14

Gillespie B M, Chaboyer W, St John W et al (2014) Health professionals' decision-making in wound management: a grounded theory. *J Adv Nurs* 71(6): 1238–48

Ho CH, Bogie (2007) Integrating wound care research into clinical practice. *Ostomy Wound Manage* 53 (10): 18–25

Levasseur R E (2010) People skills: Ensuring project success – A change management perspective. *Interfaces* 40(2) 159–62

Nursing and Midwifery Council (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives.* Available at: https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf (accessed 16.10.2018)

Ogiehor-Enoma G, Taqueban L, Anosike A (2010) 6 steps for transforming organizational EBP culture. *Nurs Manage* 41(5): 14–7

Virani T, Lemieux-Charles, Davis D A, Berta W (2009) Sustaining change: once evidence-based *Healthc Q* 12 (1): 89–96