

Nursing and Midwifery Practice Development Unit

Best Practice Statements
Summary Report
of the Impact Evaluation Study

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Foreword

Demonstrating the impact and added value of what we do is important to all of us who work in healthcare, but poses a particular challenge to those of us who have no direct responsibility for patient care; any 'success' we may have in improving the delivery of safe and effective care is largely dependent on the skills and dedication of clinical practitioners and others who work with patients and the public on a day-to-day basis.

For that reason, the decision to attempt to define 'best practice' and to develop consensus-based guidance for staff on important clinical topics was only taken after widespread consultation with staff. Similarly, we have been dependent on our clinical colleagues for their leadership of, input to, and promotion of, our best practice statements. From designing a method for developing the statements, through choosing the topics, to reaching agreement on content, our clinical colleagues have participated and supported fully and we are indebted to them. We were also delighted at the levels of support and participation that we encountered from multidisciplinary colleagues; at times medical and allied health professional staff were amongst our most enthusiastic and vocal supporters. We want to continue to build on these high levels of collaboration in future work.

We had hoped that the results of this study might demonstrate that we had made a good start with our Best Practice Statements and we believe the results suggest exactly that. We would have expected that awareness and use of the statements would vary between sites as their success is dependent on local promotion. We would have expected that awareness and use of the statements would vary between the clinical areas depending on the applicability of individual topics; we would not, for example, expect anything like the number of practitioners to have heard of or used the statement on the use of oxygen with children in the community as should have heard of and/or used the statement on pressure ulcer

prevention. Any future evaluation will therefore concentrate on examining use and awareness in the setting where that would most logically be expected.

Of equal importance to us was that the study provide recommendations to help us improve the whole process for developing, disseminating, implementing and evaluating the Best Practice Statements and we have indeed been given some very valuable pointers for improvement. We are also learning lessons from our ongoing project with Glasgow Caledonian University to develop, disseminate and implement Best Practice Statements in the care of older people. In this project a much more structured and intensive process has been piloted and is beginning to reap rewards, particularly in terms of practitioner-ownership of the work and in local innovation in implementation (<http://www.geronurse.com>).

We have developed, and included here, with the study results from the research team at the University of Stirling, an action plan describing our response to the recommendations. We remain committed to developing evidence-based guidance with nurses and midwives, for nurses and midwives, that is relevant to them, used by them and which crucially, brings about improvements in patient care. As noted above, none of this can be done in isolation, least of all from the practitioners whose willingness and ability to change their practice we are so dependent upon, or from patients and the public who are the ultimate arbiters of good practice. Our action plan then is concerned with developing further work in collaboration with these groups.

We would like to express our gratitude to the research team at the University of Stirling for the way in which they dealt and communicated with us throughout this project and also to our colleagues in the Service, particularly the Directors of Nursing and their staff at the participating study sites. We have been privileged to have had the support and involvement of some very able and committed colleagues from clinical

practice in selecting, and leading the development and implementation of our Best Practice Statements and we are very grateful to them.

Copies of the full report document are available on response from the Practice Development Unit, NHS Quality Improvement Scotland (NHS QIS).

A handwritten signature in black ink, appearing to read 'Rhona Hotchkiss', with a wavy, decorative flourish at the end.

Rhona Hotchkiss,

**Interim Director of Practice Development and Clinical
Effectiveness Support**

NHS Quality Improvement Scotland.

March 2004

1 Background

The Nursing and Midwifery Practice Development Unit (NMPDU) was set up in January 2000 to support the identification, dissemination and implementation of best practice across Scotland. In January 2003, the NMPDU became part of NHS Quality Improvement Scotland (NHS QIS). One of the initial aims of the NMPDU was to 'identify areas of nursing and midwifery practice amenable to the development of Best Practice Statements (BPSs)'. BPSs describe best and achievable practice in a specific area of care and their purpose is to reduce variations in practice and improve the quality of patient care. The first five BPSs were launched in June 2002. In March 2003, NHS QIS issued a call for bids to conduct an impact evaluation study that would inform future work on BPSs. A research team from Stirling University was awarded the tender.

This evaluation focused on the first five BPSs:

- continence in adults with urinary dysfunction
- home oxygen therapy for children being cared for in the community
- nutrition for physically frail older people
- nutrition assessment and referral in the care of adults in hospital
- pressure ulcer prevention.

2 Aim and objectives of the evaluation

Aim

The main aim of this evaluation was to determine the dissemination, support and impact of the first five BPSs amongst a sample of nurses and midwives working within Scotland.

Objectives

- to determine awareness of the first five BPSs amongst a representative sample of nurses and midwives working in clinical practice, practice development and management across Scotland
- to determine within this sample the extent to which the BPSs are currently being implemented, including identification of benefits of the BPSs on practice
- to explore the benefits of the BPSs on practice from the perspective of a sample of nurses and midwives from the five BPS development groups
- to identify and review systems for BPS dissemination and support
- to identify local examples of good practice which have maximised use of the BPSs
- to make recommendations for maximising the impact of the BPSs on future nursing and midwifery practice.

3 Methods

The study used two main methods of data collection: a postal survey and telephone interviews.

3.1 Postal survey

- This consisted of a questionnaire and an additional proforma that encouraged feedback about local initiatives promoting BPSs.
- The survey sample consisted of 1,278 nurses and midwives selected from clinical practice (n=1,166), the NMPDU Network (n=82) and Directors of Nursing (n=30). Participants recruited from clinical practice were qualified nurses and midwives (grades C to I) working in seven NHS Trusts/Island NHS Board areas with a small group from the independent sector. NHS clinical participants were identified using stratified random sampling. Directors of Nursing, NMPDU Network members and nurses working in the independent sector were purposively selected.
- Questionnaires and proforma were administered by post. The overall response rate for the questionnaires was 42% (n=539). Response was greatest among Directors of Nursing (73%) and Network members (81%). Among clinical respondents, the total response rate was 39% (n=451) but this varied between sites (range 25-51%).
- A total of 353 (28%) proforma were returned. While 59 respondents reported details of local initiatives to promote BPS use, only 30 recommended any of these initiatives as effective in promoting local BPS use.
- Questionnaire data were analysed using a statistical software programme (SPSS). Qualitative data were content analysed, manually and electronically, using NVivo software, to identify emergent themes and trends.

3.2 Telephone interviews

- These were conducted to gather more detailed, qualitative information about use of the BPSs.
- Fifteen nurses were selected for the telephone interviews, including five BPS project leaders and two members randomly selected from each development group.

4 Results

Key findings from the postal survey and telephone interviews are presented in relation to the areas of dissemination, support and impact as identified in the aim of the study.

4.1 Dissemination

- Less than half (45%) of all clinical respondents were aware of the BPSs prior to receiving the postal questionnaire.
- Of those clinical respondents who were aware of the BPSs prior to receiving the questionnaire, three-quarters (77%) of them had been aware of the BPSs for less than a year, only hearing about them after they had been launched. By comparison, three-quarters of Directors of Nursing and Network respondents (79%) had been aware of the BPSs for over a year, usually knowing about the statements before they were launched.

Using the statements

Lack of awareness of the BPSs was cited as one of the commonest barriers to their use.

'...only barrier is a lack of knowledge of the statements by some practitioners'.

Suggestions for encouraging future use of BPSs highlighted the importance of sharing experiences.

'[Give] examples of other areas where [BPS] implementation has been successful (plus problems encountered)'.

- There was a statistically significant association between BPS awareness and clinical grade, the higher the grade, the greater the likelihood of the respondent being aware of the BPSs.
- The most popular routes for first learning about the BPSs were from employers (36%), receiving a personal copy (36%) and reading about them in a journal (31%).
- Only a small number of respondents heard about the BPSs at a national (12%) or local launch (7%) or directly from the NMPDU (5%).
- The majority of Directors of Nursing and Network respondents had personal copies of the BPSs but less than a third of clinical respondents did. Highest clinical ownership of any BPS was for continence.
- Only a small minority of respondents, less than 6%, reported that it was difficult accessing copies of the BPSs, although it was highlighted that:

IT access for all isn't possible'.

Further comments by respondents recognised the value of a structured approach to dissemination and implementation.

4.2 Support

- From the 59 returned proforma detailing local initiatives to support BPS use, 30 respondents recommended initiatives considered effective in encouraging local use of the BPSs.
- Dissemination, practice development, training, the use of local groups, incorporating the BPSs into clinical guidelines, measuring practice against the BPSs, and having local leads identified, were all recommended in proforma responses as effective in encouraging BPS use.
- Such initiatives were reported as working best as part of an integrated approach, which embedded the BPSs into the NHS Trust/Board culture and enabled practice against the statements to be measured:

'To distribute and leave to chance is not successful – requires structured and resourced approach to implementation and this must compete with numerous other developmental needs'.

'Require good strategic leadership to take a co-ordinated approach [to implementation]'.

'To put a raft of standards out to staff causes difficulties and is not encouraging. By incorporating [BPSs] into local guidelines which contain audit and monitoring mechanisms, it's hoped [this] will support the implementation into practice of the evidence contained within the statement' (Director of Nursing).

At the same time it was recognised that BPSs were not always regarded as a priority:

'The documents that I have read are clear and sound (evidence-based) but are not deemed as an urgent organisational need - perhaps [there is a need to] shift the emphasis to one of clinical governance and risk management.'

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- All groups of questionnaire respondents reported the existence of key drivers encouraging change and promoting local BPS use.
 - The BPS for continence and pressure ulcer prevention had the most drivers encouraging use, reported by a third of respondents.
 - From the questionnaires, the most commonly cited drivers promoting change were specialist nurses (n=56) and local leaders (n=42).
 - From the interviewees, the most commonly cited suggestions for encouraging future BPS use were awareness raising and more resources, including training and specialist nurses.

Responses relating to the impact of the BPSs on patient care indicated possible benefits to patient care through standardising care:

'There is a set standard for guidance for staff. Patients also know standards to expect'.

In some cases, respondents felt that BPSs consolidated existing good practice rather than changing practice:

'.... a large chunk of what was presented as best practice was already going on here'

4.3 Impact

- Significant or key parts of the BPSs were more likely to be used than the full document.
- For all BPSs, except pressure ulcer prevention, more respondents reported planning to use the statements than were currently using them.
- The BPS reported as being used the most, with all or some relevant patients, was pressure ulcer prevention, although usage was only reported by half of all respondents.
- Among clinical respondents, the BPSs for pressure ulcer prevention, continence, and nutrition (frail elderly) were currently being used the most with all relevant patients. However, such usage was only reported by about a quarter of respondents.
- From questionnaire data, when the BPSs were being used, they were integrated into local clinical guidelines or standards, used in the development of care plans and used for audit and teaching purposes.
- Only a small minority of respondents reported the BPSs had no benefits for patients.
- Approximately 40% of respondents considered the BPSs for pressure ulcer prevention, and continence to have major benefits to patients, the highest response for such benefits.

'nurses who didn't quite have an understanding of the incontinent patients, it would lead them in the right direction, like a care pathway'.

-
- Almost a quarter of questionnaire respondents reported the BPSs benefited patient care through facilitating evidence-based practice, benchmarking and raising awareness of the topic among nurses and midwives.
 - The majority of questionnaire respondents reported the BPSs had benefited nurses and midwives. The BPS for pressure ulcer prevention was most commonly cited as producing major benefits for nurses and midwives. Comments relating to the pressure ulcer BPS indicated general and specific benefits:

'pressure ulcers in Scotland have never been taken so seriously and treated so professionally'.

'[the] incidence of pressure sores [has been] reduced'.

- The most frequently reported benefits of the BPSs to nurses and midwives were the availability of good evidence on which to guide practice, raised awareness of the topic, positive reinforcement of existing good practice and local discussion and agreement of good practice.
- From the accounts of interviewees, the BPSs benefited nurses and midwives by facilitating care management and delivery, increasing knowledge and raising awareness, driving local change, and increasing accountability.

'the initial [development] process made a lot of people really have to go public with what they're doing it's made people question their practice'.

'[the BPS has] helped raise the profile of nutrition, it's become much more of a clinical priority'.

'nursing staff, once they are aware they can use the statement to put pressure [on others] to say ... we need better disabled toilets, we need better signage, we need more toilet facilities around out-patient departments'.

- Interviewees reported patients benefited generally from the BPSs through raised awareness of particular topics and increased emphasis on fundamental aspects of care. This resulted in previously overlooked topics, such as continence, being seen as clinical priorities.
- Specific patient benefits from the BPSs reported by interviewees were new documentation, improved care and discharge planning, policy changes, and increased monitoring of patients. The potential of BPSs to strengthen team working was also mentioned:

'[the BPS] has been very good for partnerships [it] has made a big difference in team working and ... certainly gave much more of a team ownership of nutrition ... that has come about as a direct result of the BPS'.

5 Recommendations based on study responses

In summary:

- Development of the BPSs should continue, but existing NHS QIS processes for BPS development and support should be systematically reviewed and action taken where appropriate.
- Topics for new BPSs should be relevant to nurses and midwives, address national priorities, and link to specialist groups and networks that can support local implementation.
- To increase the priority for BPS implementation, statements should be explicitly linked to other national quality initiatives, especially NHS QIS standards, Regulation of Care Commission standards, and SIGN guidelines.
- Prioritisation of the BPSs needs to be considered from the perspective of implementation; in particular, whether key parts of each BPS should be identified as priorities for implementation.
- BPS project leaders should be expected to continue as national clinical leaders once their statement has been developed.
- Clinical leaders for each BPS are also required at a local level.
- Awareness of the BPS (both concept and content) needs to be raised among clinical nurses and midwives, especially those in lower clinical grades and those working in the independent sector.
- Access to the BPSs by clinical nurses and midwives must be improved, especially for those working in the independent sector.
- BPS dissemination needs to include academic institutions and non-healthcare organisations such as local authorities. Quick reference guides should be developed for the BPSs.

- When these five BPSs are being reviewed, audit and/or benchmarking tools should be developed to enable consistent measurement of performance.
- Reporting mechanisms need to be put in place nationally to encourage local compliance with the BPSs.
- Systems should be put in place across Scotland to actively share local resources developed to support BPS implementation, including training packs, assessment and audit tools.
- An evaluation focusing specifically on the clinical outcome of these five BPSs needs to be undertaken at a later date.
- Future evaluation must also address the impact of the BPSs from the perspective of the patient. Disseminating the BPSs should be part of a strategy developed by the relevant bodies working with NHS QIS, and which includes opportunities for training and education.

6 Conclusion

This evaluation was initiated less than a year after the first five BPSs were launched. Nonetheless, there is early evidence from a range of sources that the BPSs have benefited patients, nurses and midwives through increasing the consistent use of evidence-based clinical practice. Although it was too early for this evaluation to capture clinical outcome data, it seems that the BPSs do have the potential to considerably benefit patients and professionals in the future. To some degree, their eventual effect will depend upon the extent to which they are considered a priority for implementation and, by implication, implemented.

The full potential for the BPSs to benefit patient care in Scotland has yet to be realised, and the exact nature of such benefits needs to be the subject of a future patient-focused evaluation.

7 Action Plan

As indicated in the foreword, the above recommendations indicate that action is required by NHS QIS, between NHS QIS and the Service and by the Service, supported by NHS QIS. The following summarisation and grouping of action, planned in response to the recommendations, reflects this:

Action for NHS Quality Improvement Scotland

Recommendation	Action
Continue development of BPSs; review existing development processes and support	Commitment to BPSs to be reflected in future work programme; staffing and support requirements of Practice Development Unit to be reviewed
Link statements to other NHS QIS products and to those of other organisations	NHS QIS work programme and products to be complementary and cross-referenced; other organisations to be consulted and involved in planning and development processes
Academic institutions and other agencies to be included in dissemination process	Dissemination process to be reviewed and modified
Quick reference guides to be developed	Possibility of process for, and likely use of 'quick guides' to be explored
Systems to be put in place around 'active' sharing of resources linked to BPS use	Practitioners to be engaged in defining most effective way of sharing good practice
Future evaluations to include patient perspective and to further examine use of the initial five BPSs	Longer term BPS evaluation plan to be developed

Action for NHS Quality Improvement Scotland in conjunction with the Service

Recommendation	Action
BPS topics to be relevant to practitioners and linked to existing specialists and networks	Process for selecting topics to be reviewed and refined in light of competing drivers for development
Project leaders to continue as 'national clinical leaders' after BPS has been developed	Possibility and specifics of ongoing involvement of project leaders to be explored
Awareness of BPSs to be raised among clinical staff	Dissemination/implementation strategies to be reviewed and the need for more targeted dissemination to be considered; possibility of linked education initiatives to be explored with, eg NHS Education
Audit/benchmarking tools to be developed to assist review of BPSs	Development and use of audit tools for baseline and review measurements to be considered
Reporting mechanisms to be put in place nationally for BPSs	Acceptability and 'do-ability' of reporting on BPS use to be explored and opportunities to link to existing reporting frameworks to be considered

Action for the Service supported by NHS Quality Improvement Scotland

Recommendation	Action
Prioritisation of BPSs/component parts to be considered Local clinical leaders for the BPSs to be identified Access to be improved for clinical staff	Consideration to be given as to how to achieve this locally, with appropriate support from NHS QIS

Practice Development Unit
NHS Quality Improvement Scotland
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