

A study To Assess the Evidence-based practice on knowledge, attitudes and practices among staff nurses at selected Hospitals in Lucknow

Prof.Dr.Indra Venkatakrishnan PhD Supervisor, Era University, Lucknow

Mr.SHAMIL.C.B, Research Scholar ,Era University, Lucknow

Introduction

Evidence-based practise is distinct from scientific research and quality improvement processes. Patients and their families' values and preferences are incorporated into a bespoke treatment plan that is then implemented. When evidence is scarce or unavailable, scientific research generates new knowledge, and quality processes include improvements to and monitoring of care that is already evidence-based. For their patients and their healthcare facilities, EBP allows doctors and nurses to customise existing evidence based practise.

Recent developments in healthcare research have a significant impact on evidence-based practise (EBP). EBP models are now available to help nurses navigate the process, to begin with. The use of evidence in practise is encouraged by some models, while teamwork is emphasised in the implementation of institutional changes. A pre-existing model is used by some institutions, while a custom model is developed by others. EBP has benefited from an increase in systematic reviews and well-established evidence-based clinical guidelines or protocols that can be used across settings. There are a number of examples of clinical practise guidelines from professional organisations; practise bundles; systematic literature reviews; meta-analysis or meta-syntheses; and so on.

Despite the availability of these tools, nurses frequently encounter personal and organisational obstacles when attempting to implement EBP. In a recent integrative review of nine English-language publications, Camargo and colleagues identified EBP barriers like "workplace overload," a lack of desire to change practise, and a limited ability to understand research and statistical analysis. It was found that nurses valued evidence-based practise (EBP), but they relied more on their own experience and local protocols than research.

Such EBP stumbling blocks aren't new. Research from 391 Australian nurses found that the most common EBP barriers were lack of time to read, a lack of implementation time, a lack of authority to make changes and difficulty reading statistical results, as well as scattered literature and lack of cooperation from physicians. According to Pravikoff, Tanner, and Pierce, who studied 760 US nurses across the country, collegial advice was more frequently used than literature in their sample, despite the well-known time constraint on nurses.

Individual EBP barriers (e.g., misunderstood value of research or inability to access and interpret it) and institutional barriers (e.g., lack of resources) were identified by Pravikoff and colleagues (such as organisational priorities, inadequate staff retention and recruitment, limited budget, lack of awareness of nurse interest, and lack of ability to incorporate evidence into practice).

The researchers also found that 2,789 nurse leaders from the United States, Europe, and Australia faced similar challenges with time, organisational climate, study accessibility and readability, and a preference for making decisions based on their own experience and the advice of their peers, as opposed to scientific literature.

It was decided to begin with a survey of nurse EBP abilities because of the importance of nurse EBP, the consistent nurse reports of barriers, a preference for clinical experience over research, and a desire to improve EBP in hospitals. In this study, the following questions were answered:

Nurses were asked to rate their own familiarity with EBP and their willingness to put it into action in a survey. To what extent are those levels impacted by EBP barriers?

Methodology

The research team surveyed an inclusive, convenient sample of all regularly employed nurses in selected Lucknow hospitals in order to facilitate customised planning for staff. Contracted/temporary nursing staff and those unable to access electronic survey for any reason, like extended leave, were excluded from the sample.

The nonprofit health system includes all of the hospitals. There is no formal nursing EBP model in use at Hospital A, a 600-bed community-based cardiac referral centre. Nurses at the 500-bed community-based teaching facility Hospital B have adopted the Iowa model.

Select research-based practises, such as Institute for Healthcare Improvement bundles and organisational clinical practise guidelines, had already been implemented in both hospitals. It is highly unlikely that the widespread use of these EBPs reflects the attitudes, abilities, and knowledge of nurses toward evidence-based practise (ERP).

Tools used were knowledge questionnaire ,attitude scale and observational check list . Over the course of 45 days, data was gathered at both hospitals.

Results

Both hospitals received a total of 400 surveys back, with an estimated response rate of 33%. Hospital A returned the SURVEY TOOLS (n = 200) more frequently than Hospital B returned them (n =200). The average age of the combined samples was 38, and the average number of years of practise was 16. 82 percent of respondents were female, 77 percent worked full time, and 20 percent had a BSN; the rest had a GNM.

The research team used descriptive analysis of responses to each SURVEY TOOLS question on its 5-point, anchored, Likert scale to determine nurses' self-reported EBP knowledge, attitudes, and practises. Each participant was given a score from 1 to 5, with 1 representing their overall satisfaction and 5 representing their extreme satisfaction. Survey tools didn't have a total or subscale score because looking at the individual items provided more skill-specific details than total scale and subscale scores could have had. Survey tools and the Attitude subscale results can be found here.)

The research team used item data from the SURVEY TOOLS knowledge subscale to determine respondents' EBP knowledge. Survey participants were tested on their knowledge of 15 items, with "Poor" (1) and "Best" (1) as anchored points on a numbered scale (7). In the SURVEY TOOLS, "Sharing of ideas and information with colleagues" and "Ability to review one's own practise" were the two highest self-reported scores on the knowledge subscale. More than half of the participants rated their knowledge of "Converting information needs into a question" as "poor," and this was the second-worst item score. Of the 16 knowledge items, 41% rated themselves from 1 to 4 on "research skills," and 22% rated themselves from 1 to 5 on 12 of them.

The research team used the SURVEY TOOLS practise subscale item data to analyse practises. How often did nurses perform these six activities "in connection with an individual patient's care" over the past year? Responses were logged on a five-point anchored scale ranging from "Never" to "Frequent." From an average of 4.44 to a median of 5.56 on the practise subscale, participants performed well. On this subscale, nurses reported their lowest SURVEY TOOLS score. It's unclear how you "Critically evaluate, against set criteria, any literature you have discovered." Many (22.30 percent) of the nurses surveyed scored themselves between 1 and 5 on the remaining five practise items, but less than half (42 percent) of them scored themselves between 1 and 4.

Finally, the research team examined attitude subscale items in order to discover people's views on EBP. A 7-point unnumbered scale with full sentences was used to gauge the responses of nurses to four questions. Since only 65 nurses took part in the study by completing an attitude scale, the researchers had to use a yes-or-no scale to categorise the data. EBP sentiments were nearly unanimously positive (88 percent to 98 percent).

Second, the researchers used descriptive and ANOVA testing to investigate how EBP barriers affect nurse EBP engagement. SURVEY TOOLS were adapted to ask nurses to check off any barriers that arose. The reasons for not conducting research include (but aren't limited to) lack of time and resources, lack of interest from the nursing leadership, lack of knowledge/experience in the field, lack of nurses with research knowledge in my practise setting, and other reasons (s). Additional information was provided to those who were unfamiliar with the term "Other".

One barrier was identified by 35% of the nurses, while two or more barriers were identified by 42% of the nurses (28 percent,) Findings from ANOVA testing showed that one or more barriers were statistically linked to a lower score on all items under EBP knowledge and one practise item.

Conclusion

The results of a survey have a number of implications for nursing leaders. EBPQ or a similar tool can provide leaders with site-specific information useful for gap analysis or help those on the Magnet journey, as shown in this study. To the growing body of literature on nurse EBP knowledge, practise, and attitudes, site-specific findings from the research team add value.

Findings also demonstrate the importance of a wide range of resources that can support nurse EBP strengths and improve weaknesses. An EBP toolkit reflecting the specific knowledge, practise, and attitude content of the was developed by the authors for this project. This study's findings and toolkit will be delivered to nursing supervisors in tandem with those reports. EBP efforts can then be prioritised and barriers removed, for example by setting aside a specific amount of time each week for EBP work on organisational priorities. Using questionnaire for follow-up evaluation is a good idea at the right time of the year. For the final time, the attitude subscale weakness suggests the need for comparing it to other measures of staff attitudes.

As nurse leaders, they are uniquely positioned to promote evidence-based care, remove EBP barriers, and assist nurses in changing their practise interventions to reflect the most recent scientific information. Combining current research with data specific to a given location is an effective way to improve outcomes for patients as well as for organisations.

Reference

1. Pittman J, Cohee A, Storey S, et al. A multisite health system survey to assess organizational context to support evidence-based practice. *Worldviews Evid Based Nurs*. 2019;16(4):271–280.
2. Quinn B, Baker DL, Cohen S, Stewart JL, Lima CL, Parise C. Basic nursing care to prevent nonventilator hospital-acquired pneumonia. *J Nurs Scholarsh*. 2014;46(1):11–19.

3. Storey S, Wagnes L, LaMothe J, Pittman J, Cohee A, Newhouse R. Building evidence-based nursing practice capacity in a large statewide health system: a multimodal approach. *J Nurs Adm.* 2019;49(4):208–214.
4. Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press; 2001.
5. Schenk E. The Providence clinical scholarship framework. Presented at: Providence St. Joseph Health Region Evidence Based Practice & Nursing Research Day; September 13, 2016.; Mission Hills, CA.
6. Stevens KR. The impact of evidence-based practice in nursing and the next big ideas. *Online J Issues Nurs.* 2013;18(2):4.
7. Melnyk BM, Fineout-Overholt E. *Evidence-Based Practice in Nursing & Healthcare: A Guide to Best Practice.* 3rd ed. Philadelphia, PA: Wolters Kluwer; 2015.
8. Stetler CB. Updating the Stetler Model of research utilization to facilitate evidence-based practice. *Nurs Outlook.* 2001;49(6):272–279.
9. Buckwalter KC, Cullen L, Hanrahan K, et al. Iowa Model of Evidence-Based Practice: revisions and validation. *Worldviews Evid Based Nurs.* 2017;14(3):175–182.
10. Highfield MEF, Collier A, Collins M, Crowley M. Partnering to promote evidence-based practice in a community hospital: implications for nursing professional development specialists. *J Nurses Prof Dev.* 2016;32(3):130–136.
11. Dang D, Dearholt SL. *Johns Hopkins Nursing Evidence-Based Practice: Model and Guidelines.* 3rd ed. Indianapolis, IN: Sigma Theta Tau International; 2017.
12. Stevens KR. *ACE Star Model of EBP: Knowledge Transformation.* Academic Center for Evidence-based Practice. San Antonio, TX: The University of Texas Health Science Center at San Antonio; 2004.