

# Evidenced-based practice for renal nurses

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## Abstract

Although the concept of ensuring high quality care has been discussed for decades, it has more recently been coined evidenced-based practice (EBP). In quantifying EBP clients, clinicians and academics bring together a variety of opinions, skills and views, however defining “best practice” is extremely personalized and contextualized. This paper will discuss some of the arguments regarding benefits and obstacles, and the ambiguity related to the implementation and standardization of EBP. This commentary endeavours to provide some insight into current views and how best to support renal nurses in keeping up to date with clinical practice.

## Evidence Based Practice (EBP)

EBP in essence is the delivery of high quality care based on the current available evidence, encompassing client wishes and utilizing clinical judgment, to achieve best possible outcomes (Zietz & McCutcheon, 2003). In order to effectively implement EBP a clinical issue needs to be identified and reviewed, valid research should be conducted, the results analysed and then applied to patient care situations (Hewitt-Taylor, 2002). The challenge for nurses is how to develop and implement well-focused evidence-based nursing to improve quality and efficiency, whilst providing the best possible standards. Health care providers still do not base client care on evidence despite the desire to receive the best care themselves and research has not always been incorporated into practice. The information may be poorly organized, inaccessible, of inferior quality, be conflicting or non-existent (Courtney

et al, 2004). Staff may not be skilled in searching and appraising the literature and there may be a lack of individual and organizational support to implementing findings and change practices (McInnes et al, 2001). Therefore it is understandable that nurses may perceive the obstacles to outweigh the benefits. However, as professionals and patient advocates all nurses need to understand the ‘how and why’ of maintaining the best possible standards through EBP.

Rather than relying on tradition or ‘unproven’ habit EBP is the process whereby the systematic evaluation of the evidence and interventions, is applied at an individual level. Historically, alternatives to EBP have been colleagues opinions, policies, textbooks, journals, conferences or educational forums (Pape, 2003). EBP is ‘caring’ that is grounded in investigation, intuition and reaction, which has been enthusiastically adopted by nurses (Simpson, 2004, Ferguson &

## Key Words

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Day, 2005). However, debate continues regarding what is considered the most appropriate ‘gold-standard’ nursing evidence that is to be combined with clinical expertise, which takes client preferences into consideration (McInnes et al, 2001; Hewitt-Taylor, 2002). Staff in opposition to EBP view it as a rigid and prescriptive practice that neglects individualised care, diminishes professional autonomy, and poorly acknowledges the complexity of nursing itself (McInnes et al, 2002).

EBP not only focuses on research to improve decision making, but also identifies knowledge gaps, systematically appraises and condenses evidence to assist implementation into clinical expertise (Courtney et al, 2004). The practice of effective nursing can only be achieved by using several sources of evidence, namely research, clinical experience, client experience and local information that has been tested and found credible (Rycroft-Malone et al, 2004). Therefore, the clients, their families and the multi-disciplinary health care team need to discuss all aspects of evidence when making clinical decisions (Hewitt-Taylor, 2002). Clients may be uncomfortable with the concept of their involvement in decision-making and may be reluctant to take this

## Author

Angela Henson RN, Grad. Cert. (Health Management), Grad. Dip. Nephrology, Grad. Dip. Women’s Health, M. Nursing is the Clinical Nurse Consultant/Renal Educator in the Department of Nephrology, Princess Alexandra Hospital, Brisbane, Australia

## Correspondence to:

Angela Henson Department of Nephrology, ARTS Building, 1st Floor Princess Alexandra Hospital Ipswich Road, Woolloongabba 4102, Brisbane, Australia [Angela\\_Henson@health.qld.gov.au](mailto:Angela_Henson@health.qld.gov.au)

responsibility. If clients are expecting the health care professionals to make decisions for them then significant time needs to be invested in ensuring that the individuals concerns and beliefs are identified, and their degree of involvement determined (Di Censo et al, 2005). Research evidence alone is never sufficient to make a clinical decision as there must always be a balance between benefits, risks and inconvenience, costs and client wishes, and therefore this influences our decisions. Despite there being a great emphasis on research forming a basis for EBP, this is not without biases itself as there are a variety of different bodies of evidence influencing each clinical topic which are competing and open to different interpretations (Rycroft-Malone et al, 2004; Melnyk & Fineout-Overholt, 2005).

Research needs to be meaningful and directly transferable into the clinical setting as practice guidelines have little impact if they are not relevant or if there is no compulsion to adhere to them (Craig & Smyth, 2002; Rycroft-Malone et al, 2004). Guidelines are based on available research and when not evident, on expert opinion and consensus.

Current clinical guidelines may not be explicit enough or sufficient to provide comprehensive information, whereby EBP endeavours to link such guidelines with clinical experience. It is guided by clinicians and integrates clinical experience through objective data with practice-based processes and methods.

Evidence cannot be used in the absence of clinical judgment or without supporting client preferences therefore an individual's uniqueness may mean it is difficult to apply scientific evidence to practice, and hence why EBP may not be considered realistically viable in nursing. There are many variations evident in disease states, and in individuals' beliefs and influencing factors, therefore evidence provides a guide whereby comprehensive information can be given

to individuals, to enable them to make a well thought out decision that best meets their needs.

### **Obstacles for Staff**

The obtaining of comprehensive evidence is highly resource dependent and reviewing is a skill in which staff require training. Healthcare literature is diverse, is in increasing abundance, may be filled with bias, poorly undertaken or have questionable validity or replicability. The delay between the publishing of evidence and its utilization in practice is a concern for healthcare organizations, professionals and the community alike. The amount of literature is growing at a rate of 4% annually and to ensure high standards are met, this needs to be reviewed for quality and completeness (Craig & Smyth, 2002). Therefore, due to the fast pace of technology and the pressure from workloads and consumers, not every nurse can be expected to keep up-to-date with all the changes, and "no single" expert or group of nurses can successfully maintain the sustainability of EBP initiatives. (Sanares & Heliker, 2006; Roberts, 1998).

Without increasing the speed at which information is available then it is likely that new information will be superseded by the time it is accepted as clinical practice. Internet resources provided by evidence based panels are one way the nursing and renal communities are trying to address these needs. Guidelines such as Joanna Briggs Institute, Cochrane Renal Group and Caring for Australians with Renal Impairment (CARI) publish a range of issues, discuss the available evidence and provide recommendations to guide clinical practice. As a profession and health service we need to make attempts to keep abreast of changes as consumers are becoming more educated and expectations of care are increasing (Simpson, 2004).

EBP may be perceived as being focused on randomized controlled trials and empirical knowledge, methods which don't accept other suitable domains of 'knowing' such as ethical, personal and aesthetic knowledge (Di Censo et al, 2005). Health care systems are often based on traditions, and new knowledge may be challenged or unwelcome and professional conflict may result due to historical focus on medical criteria (Osborne & Gardner, 2004; Dale, 2005). EBP can also be viewed as obstructive to nursing process, client care and professional accountability. It may restrain nurses from defining values that guide nursing process, reduce the focus on client centered care, and may be inconsistent with the values of consumers (Di Censo et al, 2005).

Although most nurses have a positive attitude about EBP and its impact on client care, they lack the skills in evaluating the quality of research, lack the confidence to implement change and lack the resources to develop, initiate and implement innovation (Van Buskirk, 2005). Nurses use reflection and intuition as traditional research methods, but EBP focuses on science and associated methodologies which are problematic for nurses to accept. Rejection of evidence by nurses because it is not considered useful is legitimate, provided the decision to do so is made in an informed, skilled and justified manner (Dale, 2005).

### **Benefits of EBP**

EBP provides a framework for health care professionals to assess efficiency and effectiveness and its impact on client outcomes. Nursing practice needs to be constructed around evidence to ensure nurses are accountable, to gain and maintain credibility amongst health professionals and consumers, and to build a knowledge base that can influence policy and government (Di Censo et al, 2005). It provides a more structured and streamlined way of keeping

abreast of relevant new developments without becoming overloaded and it enables nurses to give rationales, have increased confidence and be more legally accountable (Courtney et al. 2004). Direct links have been established between research and outcomes, with evidence based nursing practice focusing on behaviour, knowledge, physiology, and psychosocial aspects, having significant benefits in improving patient outcomes by 28% (Melnik & Fineout-Overholt, 2005).

### EBP at a Practical Level

Nurses may not feel free to change practice without organizational or multi-disciplinary involvement therefore if EBP is to be successful then we must understand organizational influences and develop a supportive infrastructure (Sanares & Heliker, 2006). Nurses need to be empowered at a ward level to feel that they are able to instigate and make changes with adequate support. To overcome barriers there must be “champions” and support mechanisms, misconceptions need to be corrected and skills enhanced (Melnik & Fineout-Overholt, 2005). Senior nurses are pivotal in conveying information about current evidence and resources, as they are the most accessible nursing staff on the ward, with mentorship being a key factor in implementing EBP. Organisational capacity for change, an “open-minded” infrastructure, a “shared vision”, credible guidelines, allocated time and accessibility to information are all vital factors in ensuring implementation is possible (Melnik & Fineout-Overholt, 2005). Managers who are interested, motivated leaders, that are visionary and support potential changes are essential, as implementing findings cannot be reliant on simply disseminating findings. There needs to be pivotal people such as managers, educators and clinical nurses, to explain the relevance and rationales

in changes to practice. There needs to be consistent acknowledgement and support from managers regarding the contribution of nurses, and support them to have time and resources to undertake research and data collection. Training needs to be undertaken in how to commence and maintain momentum, and develop skills in obtaining and critiquing studies. Nurses also need to develop and promote nursing networks, foster ideas and replicate studies to increase validity and prove conclusions.

Australia, Canada and the United Kingdom have been leaders at the forefront of widespread implementation of EBP. In Australia it is recognized as an essential ingredient of continuous quality improvement by accreditation agencies, is a requirement for graduate educational curriculum and a designated priority by the National Health and Medical Research Council (Melnik & Fineout-Overholt, 2005). Attempts are being made to support staff to undertake research to validate nursing practice however limitations exist, namely time, motivation and confidence. In the field of nephrology we are guided a national consortium of renal consultants, senior nurses and allied health professionals which set out guidelines for “Caring for Australians with Renal Impairment”. At a unit level key senior nurses should be responsible for creating policies and procedures based on current available evidence, and educate staff in how to incorporate this into daily clinical practice, whilst adapting these to meet the specifics of the client. This however is time consuming due to the need to update them regularly as new information becomes available.

### Conclusion

Utilising and implementing EBP is evident within the care of people with kidney disease and while it is being

adapted to meet the needs of the clients, and acknowledge clinical experiences it will continue to be promoted and utilized. As it becomes part of our daily practice it will become more readily accepted across the nursing community. EBP is not specifically a research or academic exercise; it provides a valid foundation for clinical activities and contributes to positive health outcomes. It defines organizations as quality focused which legally provides clinicians with valid practices which ensures effectiveness and increases confidence. The implementation of EBP is vital to provide high quality care, consumer and practitioner satisfaction and possible cost savings in the current environment of increased workloads and healthcare accountability.

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## Errata

The chief editor and publisher would like to draw the attention to the following errors in the Renal Society of Australasia Journal Volume 3 Issue 2 Supplement 1. The corrected abstracts are:

*Ren Soc Aust J* 3:2 S1. Page S14 Abstract 227

### **The Chronic Kidney Disease Clinic - A New Model of Care and a New Role for Nurses**

Veronica M Oliver, Princess Alexandra Hospital, Australia  
Bettina Douglas, Princess Alexandra Hospital, Australia

Princess Alexandra Hospital is the Queensland pilot site for a multidisciplinary Chronic Kidney Disease (CKD) clinic. This clinic opened in April 2006 and has created a new model of patient care, and also a new role for nurses. The model of care is a multidisciplinary team (MDT) approach involving Medical and Nursing staff, Dietician, Diabetes Educator, Pharmacist and Social Worker. The MDT works collaboratively to achieve evidence based treatment targets and manage risk factors for progression of CKD. The goals of care are to delay the need for dialysis and/or transplantation, to prevent and treat the complications of kidney disease, and to prepare the patient for kidney replacement therapy, if required. The nursing role involves providing support and education to develop each patient's self management skills so they can take a central role in treatment decisions, and participate in the creation of an individual health care plan. The nurse then co-ordinates the MDT to achieve individual patient treatment targets according to priority. This new role will be illustrated by outlining case studies of two patients who attend the clinic, following their progress from the initial CKD Clinic assessment to the present time. Evaluation and monitoring of clinical outcomes will indicate if we are able to demonstrate improvements in the health and welfare of patients with CKD. This is an important aspect of the clinic and will influence future decision making for Queensland Health.

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### **Advanced Care Planning for Dialysis Patients - A Rural Dialysis Unit Experience**

Christine T Shannon, Singleton Dialysis Unit, Australia

Advanced Care Planning (ACP) is a process that aims to achieve the choices of an individual. The focus for ACP is not merely death and the right to refuse treatment, but rather about living well, addressing the ethical and psychosocial well being of patients. The opportunity to further augment the palliative process and extend care beyond the technical and medical aspects of renal nursing was recognised in our dialysis unit. A journey through the care of two patients with end stage renal failure will demonstrate the pitfalls, lessons learned and successes of ACP. This patient-centred process involves teamwork (consultation and collaboration), integrity in the practice you deliver (honesty, ethics, respect, excellence, caring and courage), commitment and communication. Through this shared decision making process the patient is empowered, having the confidence to make choices and their pride highlights the effectiveness of ACP.

The chief editor and publisher regrets and apologises for the above errors.