Nursing – a research-based profession

by Jennifer M Hunt (FRCN 1982)

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It is now almost 50 years since the title phrase, taken from the Briggs Report (DHSS 1972), became well known. Then, nurse researchers were few and the quantity and scope of research limited.

As a hospital-based nurse researcher from the 1970s to the 1990s, I had become increasingly aware of the mismatch between the focus of much nursing research and what nurses did in practice. I was also acutely aware of how difficult it was to change practice and implement best evidence.

My initial inspiration came from studies in the United States (Ketefian 1975, Horsley et al 1978, Krueger et al 1979, Haller et al 1979). This US work coupled with my own work on the nursing process (Hunt 1978, Hunt and Marks-Maran 1980) provided the impetus for the paper that I had published in 1981 and have chosen to revisit for this article.

Despite the paper not being research-based it was published in the Journal of Advanced Nursing (JAN) and has been regularly cited. The content and propositions included in the paper evolved from presentations I gave on getting research findings into practice and was predominantly based on a lecture delivered in 1980 at the Second International Cancer Nursing Conference.

Subsequent work added to the understanding of barriers to non-acceptance as I became aware of the need to change not just practice but also policy (Hunt 1981, Hunt 1996, Hunt 2001).

Indicators for practice: the use of nursing research findings

Abstract
Until recently, discussion about nursing research centred on the need to get it carried out. Attention is now being focused on how to get nursing research used since so far, such research findings have not, on the whole, been assimilated into practice. Until this occurs, the practice of nursing will not and cannot be research-based in any meaningful way.

It is postulated that nursing research findings provide nurses with indicators for practice. This assumes that such findings are available and that the main barrier to their use is the poor communication of this research (in a form they can understand), to nurse practitioners. However recent research into the use of research findings casts doubt on this assumption and it can be argued that such a view is too simplistic. In this paper therefore, three questions are asked:

1. Are relevant nursing research findings available which provide indicators for practice?
2. What indicators do such findings provide?
3. Are such findings used by nurse practitioners?

Using specific examples from nursing research, ideas and suggestions are put forward which provide a basis for possible answers. Finally, the paper discusses the interdependence of research and practice and the need for them to develop together.

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Introduction and background

For over 50 years I have been involved in nursing research. During that time, I have seen major changes in health and medical care, organisational structures, and the development of nursing research. I have moved from being

learner to doer to supervisor to director and now, commentator and assessor.

I was fortunate to start my career in the early days of nursing research as one of the first group of nurses selected for the Department of Health and Social Security (DHSS). Study of Nursing Care Project, the brainchild of key nursing leaders Marjorie Simpson and Jean McFarlane (Inman 1975). The intense research education I received provided a solid knowledge base to progress with nursing research and later senior posts in management and government.

It is only in retrospect I realise how expert and eminent our lecturers were in their fields and how unusual their commitment to a nursing group was at that time. I was influenced too by the fact I had always been questioning and this project gave the opportunity to do just that, to look for evidence and to use knowledge to improve practice. It is worth remembering though that looking for evidence was more difficult then. There was no internet, electronic databases, digital journals, email or even photocopying. Everything had to be done by hand.

My focus then, as now, was clinical practice and hands-on nursing, always with the aim of improving care and outcomes. Except for my last research post, I was always based in hospitals engaging directly with nurses, other clinicians, and the senior managers. I felt at times that I was not considered a 'proper' researcher because I was not in a university.

At the time, as a hospital-employed researcher, unlike many of my academic peers who were focusing on the characteristics of the profession, my focus was on what nurses did in practice (Hunt 1981). My chosen article, from early in my career, was my first publication in an academic journal, though I had published others in weekly nursing journals. It was based on a lecture given at a Cancer Nursing conference organised by Bob Tiffany, chief nurse at the Royal Marsden Hospital in 1980 where I was director of nursing research.

Bob was passionate about nurses and nursing, committed to quality, to developing and stretching nursing staff and engaging them in research – a true nursing leader. He had asked me to chair the Nursing Practice Committee, usually seen by members as a necessary chore rather than an exciting opportunity. But my interest in nursing research utilisation gave me the idea of developing evidence-based nursing procedures. It was a challenge and by allowing each member to develop a procedure of importance to their practice, we succeeded. The originality lay in each procedure having three sections: the evidence, the nursing problems linked to that evidence and a step-by-step procedure.

The first manual was a huge success on the wards. Numerous journals showed interest, papers were presented, and as a result full time clinical staff were employed to accelerate the work. We increased the number of procedures, published it in book form and it became a runaway best seller (The Royal Marsden 1984). It showed me what could be done and how research and nursing could become synergistic in the right environment.

Influence and impact

The lecture and the subsequent article made two assumptions. First, that relevant nursing research findings are available and second, that they would be used by nurses. This is what drove my original interest in determining if these assumptions were true.

My answer then was a qualified 'yes' followed by 'but'. The reasons I outlined then still hold true today. Namely, in some areas of research, findings provide reliable evidence to inform practice but despite research being available, nurses do not always use it. Also, there are still many practices which have not been studied sufficiently to produce reliable findings. But what are the findings needed to inform practice? My answer was three-fold: what nurses should do, what they shouldn't do, and lastly, are 'should do' findings used by nurses? To understand why findings are not used I identified six reasons for nurses not using relevant findings. These are that nurses:

- Have problems the research does not address.
- Do not know about the research findings.
- Do not understand the findings.
- Do not know how to use the findings.
- Do not believe the findings.
- Are not allowed to use the findings.

Fifteen years later, reflecting on my experience in senior managerial posts and membership of research and other advisory committees, I added another four (Hunt 1996). These are that nurses:

- Lack the necessary skills to identify and evaluate relevant research findings.
- Lack time to undertake this kind of activity.
- Lack access to the right resources.
- Work in a managerial ethos and culture where they are expected to come up with instant answers.

In 2018, in a guest lecture at Anglia Ruskin University, I added two more:

- Political pressure and decisions.
- Alternative and fake facts.

Research has confirmed my original opinions about research findings were justified. But even when valid and reliable research is available, it is not always integrated into practice because getting research into practice involves not just lowering the barriers, but nearly always involves change. So how the initial decision that change is needed is taken is as important for its success – the 'problem-driven, bottom-up approach' being more effective than a knowledge-driven or 'top down' one.

That still seems very straightforward. In the past I would have said 'that's it!' Increasingly, however, I have concluded that it is not that simple and there are many more questions:

- **What** if sound evidence is available but is ignored or overridden?
- **What** about when evidence of harm is ignored, and tradition drives practice?
- **What** about unpublished evidence?
- **What** about falsified or biased evidence?
- **What** if policy makers and senior colleagues tell us 'to do or not to do' something not based on, or at variance, with the evidence?
- **What** is our personal and ethical responsibility?
- **What** does our regulatory code say?

Health policy decisions, including those about nursing and nurses, have a tremendous impact on what we do. Goldacre (2009) noted that few politicians have research experience and expertise and inevitably are influenced by ideology, economic constraints, party and public opinion and the ever-present next election. So, major changes, rather than being subject to the rigours required by clinical research, are driven by compromise, expedience, and the political climate.

I have thought about these issues more because of recent involvement in the safe nurse staffing campaign, where refusal to implement robust research evidence is only too evident, and more recently when observing nursing and medical care as a cancer patient's wife. Those experiences made me acutely aware of the major barriers emanating from ingrained attitudes, beliefs, high level policy and politics as well as the risks of ignoring, concealing or even fabricating evidence.

Today, nursing is more complex and more demanding than ever. More nurses can understand, undertake and use relevant research. However, barriers still hinder such activities now as they did then. I despair when senior managers, policy makers, politicians, other health care professionals, including nurses, say that degree-educated nurses are unnecessary and say they are not 'caring' as if education and empathy cannot exist together. If that were true, no healthcare professionals would be educated in universities. I wish too that more research was undertaken into hands-on practice and far more NICE guidelines included specifics on what nurses should do. I wish too that these are then universally adopted and implemented.

Current and future relevance

I have learned that even the most routine activity, like chairing a Nursing Procedure Committee, can result in something as important as the world-renowned Royal Marsden Manual – probably the thing of which I am proudest.

I have learned that like throwing a pebble into a pond, the ripples, a word, an action can reach out to places I never thought they would reach, and touch people I never knew and changed what they did or how they felt.

I have learned that help and support from mentors, friends and colleagues is essential and to be treasured. Some I know about and some I can only guess at, but I am grateful to them all. I have tried to follow their example in enabling and helping others and giving them credit whenever it is due.

I began my training with, and still hold, a passionate belief in the value of nursing and nurses to patients. I have been fortunate to help, through research, to justify those beliefs. Today nurses and nursing are more necessary than ever. What we do, even the most routine nursing action, is important to our patients. We are the web holding everything together. Too often, that web is invisible or thought to be unimportant and only noticed when it is no longer there. We must make that web visible to show others how important it is. Nursing research is a means to that end and not an end in itself.

Florence Nightingale is often remembered as the Lady with the Lamp: an iconic image indeed. But we should also remember Florence Nightingale was 'the passionate statistician' who challenged politicians, policy makers and doctors, questioned accepted practices, established nurse training schools, totally changed hospital design, sent her nurses the length and breadth of the country to spread her ideas and improve the care of patients

and so influenced policy at the highest level. Nursing research provides the foundation and the International Year of the Nurse and the Midwife the opportunity to take forward Florence Nightingale's legacy to implement evidence in our practice and use the resulting positive patient outcomes to shape future policy direction.

Yes, 50 years ago I was naïve in believing that, presented with good evidence, nurses would immediately change their practice to align it with the evidence base. The good news is there has been a huge expansion in nursing and medical research and there is now general acceptance of the need for evidence-based practice by all clinicians (Sackett et al 1996, Evans et al 2011). Certainly, barriers persist to the wish expressed so clearly in the Briggs Report (DHSS 1972). But, with the opportunities that the World Health Organization, State of the World Nursing Report (WHO 2020) provides, the potential to turn aspiration into reality, I hope and believe, can be delivered by those following in the footsteps of us early pioneers.

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