

Nursing and Midwifery Practice Development Unit

Best Practice Statements

Report of the Impact Evaluation Study

N. Ring and A. Finnie

March 2004



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First published March 2004

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Acknowledgements

The research team would like to thank all those who participated in this project, particularly the interviewees and those within the NHS study sites who assisted with sampling and questionnaire distribution.

The team would also like to thank members of the Steering Group who provided support and encouragement whilst objectively reviewing project progress.

Finally, the team would like to acknowledge their colleagues within the Department of Nursing & Midwifery, University of Stirling for their support throughout this project.

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Project Funding

This evaluation was funded by the Nursing and Midwifery Practice Development Unit, NHSScotland.

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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 dependant on the skills and dedication of clinical practitioners and others who work with patients 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 those staff. Similarly, we have been dependant 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. As the attached report notes, the only other country to attempt anything similar to the Best Practice Statements in relation to nursing and midwifery practice, has been Australia through the Joanna Briggs institute. We were also delighted at the levels of support and participation at various levels, we enjoyed from colleagues across the multi-disciplinary team, at times medical and allied health professional staff were among our most enthusiastic and vocal supporters, and we want to continue to build on these high levels of collaboration in future work.

We were always aware of the existing body of literature - referred to in the report – attesting to the relatively low levels of implementation that guidelines, guidance and the like have traditionally been subject to and were keen to investigate how our statements were faring at an early stage, so as to learn lessons that would help us improve our processes as we went along. This report demonstrates that we have some way to go in ensuring we optimize the impact of the statements on practice and helpfully, makes recommendations about the development process and crucially about dissemination and implementation that will help us, along with our clinical colleagues to increase the uptake and use of the Best Practice Statements.

With hindsight and in relation to the findings of the report, we would not have 'treated' all of our Best Practice Statements in the same way in investigating their impact. For example, our Best Practice Statement on Home oxygen therapy for children being cared for in the community does not fare well next to others in relation to practitioners having heard of it; we would not have expected it to, because of the relatively very small numbers of staff and patients to whom this is relevant. However, we know from our clinical colleagues working with these children and their families, that this Best Practice Statement has had a widespread and at times dramatic effect on care.

While we did make attempts to involve patients and the public in our Best Practice Statements, we know we can and have to get much better at this; we know that patients and the public have much to contribute to building consensus about practice and that their involvement at all stages of our processes can only increase the likelihood of the relevance and uptake.

There are many valuable lessons to be learned if we are to make our Best Practice Statements even more effective. We look forward to working with our colleagues in the Service in putting what we have learned to good use and in ensuring that nursing and midwifery practice is evidence-based, safe, effective and continuously improving.

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March 2004

Executive Summary

Background

This evaluation investigated the dissemination, support and impact of the first five Best Practice Statements¹ (BPS) developed and launched by the Nursing and Midwifery Practice Development Unit (NMPDU), NHSScotland, in June 2002. The evaluation, funded by the NMPDU, was undertaken between March and August 2003. In recognition of the relatively short period between BPS launch and evaluation, this early investigation focused on the topic from the perspective of nurses and midwives working in Scotland.

Method

Two data collection methods were used; postal survey and interviews. The postal survey included a questionnaire about BPS knowledge, use and benefits to patients, nurses and midwives. The proforma requested information about local initiatives promoting BPS use. The survey sample consisted of 1278 nurses and midwives selected from clinical practice (n=1166), the NMPDU Network (n=82) and Directors of Nursing (n=30). Participants recruited from clinical practice were qualified nurses and midwives (grade C to I) working in seven NHS Trusts/Island Boards and a small group from the independent sector. Clinical participants were selected using stratified random sampling. Directors of Nursing, NMPDU Network members and nurses working in the independent sector were purposively selected. Fifteen nurses were selected for the telephone interviews, including five BPS project leaders and two members randomly selected from each BPS development group.

Questionnaire data were analysed using SPSS, a statistical software programme. Qualitative data were content analysed, manually and electronically using Nvivo software, to identify emergent themes and trends.

Results

Response rates

- The overall response rate for the questionnaires was 42% (n=539). Approximately three quarters of Director of Nursing and NMPDU Network participants responded. Amongst Clinical respondents the overall response rate was 39% (n=451), ranging from 25 – 51% in the different clinical sites.
- A total of 353 (28%) proforma were returned of which only 59 (17%) were completed detailing local initiatives promoting BPS use.
- All fifteen individuals selected for interview participated in the study.

BPS awareness

- Clinical participants were least aware of the BPS, with less than half (45%) being aware of the BPS prior to receiving the postal questionnaire.
- There was a statistically significant association between BPS awareness and clinical grade, the higher the grade, the greater the awareness of the BPS.

BPS usage

- Significant or key parts of the BPS were more likely to be used than the full documents. Overall, more respondents reported planning to use the BPS than were currently using the statements with *all* relevant patients.
- Amongst Clinical respondents, the BPS for pressure ulcer prevention, continence and nutrition (frail elderly) were currently being used the most with *all* relevant patients, by about a quarter of respondents.

¹ These were: Pressure ulcer prevention, Continence in adults with urinary dysfunction, Nutrition assessment and referral in the care of adults in hospital, Nutrition for physically frail older people and Home oxygen therapy for children being cared for in the community.

- When the BPS are being used, they are integrated into local clinical guidelines or standards, used in the development of care plans or used for audit and teaching purposes.
- From the survey and interviews, the most frequently cited barriers to BPS use included lack of resources; especially time, staff and training, perceived relevance of the BPS to practice, the huge number of other guidelines, the need for a structure for implementation, resistance to change, also lack of awareness and understanding of the BPS.

BPS benefits

- Many project participants noted that it was too early to evaluate benefits of the BPS. Nonetheless, amongst questionnaire respondents, less than 10% considered the BPS had produced no benefits to patients.
- From questionnaire data, the BPS were reported as benefiting patients through facilitating evidence based practice, standardising care, benchmarking and raising awareness of the topic amongst nurses and midwives.
- Interviewee participants reported that patients benefited from the BPS generally through increased emphasis on fundamental aspects of care and specifically through improved care, for example better assessment and discharge planning.
- Questionnaire respondents also reported that nurses and midwives benefited from the BPS through 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 BPS benefited nurses and midwives by facilitating care management and delivery, increasing knowledge and raising awareness, driving local change, and increasing accountability.

Support for BPS use

- Dissemination, practice development, training, the use of local groups, incorporating the BPS into clinical guidelines, measuring practice against the BPS, 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 BPS into the NHS Trusts/Board culture and enabled practice against the statements to be measured.
- All groups of questionnaire respondents and interviewees reported the existence of key drivers encouraging change and promoting local BPS use.
- Commonly cited drivers encouraging BPS use included specialist nurses, and local leaders, awareness raising and additional resources, including training.

Summary of recommendations

Full details of the recommendations are contained in Chapter 9.

- Development of the BPS should continue, but existing NHS Quality Improvement Scotland (NHS QIS) processes for BPS development and support should be systematically reviewed and action taken where appropriate.
- Consideration should be given to maximising links between the BPS and other national quality initiatives, especially NHS QIS standards and SIGN guidelines, as a means of encouraging their use.
- Topics for new BPS should be relevant to nurses and midwives, address national priorities and link to specialist groups and networks that can support local implementation.
- During BPS development, consideration should be given as to whether key parts of each statement should be identified as priorities for local implementation.
- The BPS require national and local clinical leaders. Project leaders should continue as national clinical leaders once their statement has been developed. If they are unable to continue in this role, NHS QIS should appoint another clinical leader.

- Awareness of, and access to, the BPS needs to be increased amongst clinical nurses and midwives, especially those in lower clinical grades and those working in the independent sector.
- BPS dissemination should be part of a strategy developed by the relevant bodies working with NHS QIS, and which includes opportunities for training and education. The dissemination strategy needs to include academic institutions and non-healthcare organisations such as local authorities.
- Quick Reference Guides should be developed for the BPS.
- Audit and/or benchmarking tools should be developed, and incorporated into the BPS. Consideration should also be given to establishing national reporting mechanisms to encourage local compliance with the BPS.
- Systems should be put in place across Scotland to actively share local resources developed to support BPS implementation, including posters, training packs, assessment and audit tools.
- Detailed evaluation focusing on clinical benefits to patients resulting from some, or all, of the first five BPS should be initiated within the next two to three years.

Conclusion

This evaluation was initiated less than a year after the first five BPS were launched. Nonetheless, there is early evidence from a range of sources that the BPS have benefited patients, nurses and midwives through increasing the consistent use of evidence-based clinical practice. As this evaluation focused on nurses and midwives, further research is required to investigate detailed impact of the BPS on patient care.

Chapter 1: Introduction

1.1 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 (NMPDU 2002a). Development of Best Practice Statements (BPS) was a key function of the NMPDU prior to it being incorporated into the new NHS Quality Improvement Scotland (NHS QIS) in January 2003. The BPS '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 (NMPDU 2002a). The first BPS were launched in June 2002.

This NMDPU funded evaluation was undertaken to gain insight into the initial impact of the first BPS. This evaluation explores impact from the perspective of nurses and midwives and focuses on the first five BPS:

- 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.

1. 2 Aims and objectives of the evaluation

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

Objectives

- To determine awareness of the first five BPS 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 BPS are currently being implemented including identification of benefits of the BPS on practice.
- To explore the benefits of the BPS 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 BPS.
- To make recommendations for maximising the impact of the BPS on future nursing and midwifery practice.

1.3 Study Design

This project was designed to meet the project objectives within the resources available. Time was a critical factor as the evaluation had to be completed within six months. As the BPS had been launched for less than a year at the start of the project, the priority for this evaluation was to obtain a snapshot picture of awareness and impact of the first five statements from a nursing and midwifery perspective. There is a need, however, to determine BPS impact over a longer period and from the patient's perspective, so this project should be regarded as the first in a series of evaluations.

Chapter 2: Literature Review

2.1 Background

Quality improvement is a vital part of the healthcare agenda and an important issue for all healthcare professionals, including nurses and midwives. The continual improvement of the delivery of healthcare can be facilitated, in part, by the utilisation of the best available evidence to inform clinical decision making, which in turn should lead to higher quality and cost effective care (Crane, 1995).

The advent of clinical governance has increased the emphasis on the evidence-base upon which decisions are made and on the demonstrable effectiveness of care (Rycroft-Malone and Duff, 2000). Clinical governance provides a framework for active dissemination of information and implementation of best practice (Rycroft-Malone and Duff, 2000). One means of achieving evidence-based practice and ensuring higher quality consistent care has been the development of guidelines and protocols, although it is not always possible to base these on published research evidence (Thomas et al, 1999).

McInnes et al (2001) identified four key barriers to research or evidence implementation: difficulty in accessing literature for practitioners, poor quality research with conflicting results; individuals lacking skills in searching for and appraising literature; and a lack of organisational and individual support to help practitioners implement research findings. Guidelines or best practice statements can help reduce these barriers by organising and summarising the evidence in specific, practice-focused, areas. They can also reduce the barriers to research implementation such as nurses not understanding research (Hunt, 1981).

Clinical guidelines are therefore important tools with which healthcare providers can improve clinical effectiveness. They support effective practice, enhancing the appropriateness of care and reducing unacceptable variations; as well as providing knowledge about care options, informing decision-making and providing benchmarks against which care can be measured (Rycroft-Malone and Duff, 2000). The consistent use of guidelines also provides a method by which individuals may be held accountable for their own practice and can limit clinical negligence and untoward incidents and complaints (Brooks and Anthony, 2000), albeit despite some concerns that guidelines may also constrain autonomy and choice (Mead, 2000).

2.2 NMPDU Best Practice Statements (BPS)

The BPS focus on specific aspects of clinical nursing and midwifery and provide broad statements aimed at improving practice and reducing variations in care. These statements were designed by the NMPDU to address areas of nursing and midwifery where research evidence was not always available, invariably areas of practice where the development of SIGN² guidelines is currently not possible. Where research evidence was not available, the NMPDU developed evidence for practice based on the consensus of expert opinion, evidence that was subsequently incorporated into the BPS.

Key aspects of the NMPDU BPS are:

- They are intended to guide practice and promote a consistent and cohesive approach to nursing and midwifery care across Scotland.
- Statements are derived from the best available evidence at the time of development, recognising that levels and types of evidence vary.

² SIGN, the Scottish Intercollegiate Guideline Network

- Evidence for BPS development is gathered from a broad range of sources including the identification of existing or previous initiatives at local or national level, qualitative and quantitative work, and by establishing consensus (NMPDU, 2002a)

Being a new initiative, there is no national research available within the UK about BPS dissemination, support and impact. However, guidelines similar to the BPS have been produced in Australia by the Joanna Briggs Institute, which has a programme to develop Best Practice Information Sheets (BPIS) based on systematic reviews of the literature. These BPIS are distributed via journal inserts and mailings to organisations linked to the Institute.

The Joanna Briggs Institute (2002) conducted an evaluation to determine the impact of their first six BPIS using a questionnaire approach. The study administered 1845 questionnaires to a random sample of registered nurses across Australia and obtained a 27% (n=499) response rate. Although only 25% (n=125) of respondents had read the BPIS, there was an 'encouraging level of implementation' amongst those that had read a BPIS (Joanna Briggs Institute, 2002). This study identified a number of issues relating to dissemination and implementation which are relevant to the NMPDU BPS; for example, how statements are made available to practitioners, the relevance of statements and the level/grade of nurse most likely to read them.

2.3 Guidelines

As the NMPDU BPS can be considered a form of clinical guideline, previous research on clinical guidelines was also examined.

Although there is agreement that guidelines can positively affect processes and outcomes in healthcare, there remains considerable debate regarding the 'best' approach to their development, implementation and monitoring (Clark, 2003). In Scotland, SIGN is responsible for the development of clinical guidelines.

SIGN was set up in 1993 to produce and disseminate multi-disciplinary evidence-based guidelines. To date, over seventy guidelines have been produced on a wide range of topics (SIGN, 2003). The overwhelming majority of recommendations in SIGN guidelines are based on robust research evidence as opposed to expert opinion (SIGN, 1999). SIGN regards well-conducted Randomised Controlled Trials (RCTs) as the 'gold standard', and the preferred evidence source. However, not all healthcare research questions, especially about nursing and midwifery practice, are appropriate to the RCT (Rycroft-Malone and Duff, 2000), and only a small proportion of what is done in healthcare has been tested in appropriate well-designed studies (Woolf et al, 1999). Until recently the majority of systematic reviews were medically focused, but increasingly nursing and midwifery have been engaging with evidence-based practice and conducting their own reviews (Mitchell, 1999). For example, a systematic review of guidelines in the developing academic professions of nursing, midwifery and the therapies noted difficulty in identifying whether guidelines were based on evidence (Thomas et al, 1999).

2.4 Dissemination

Guideline dissemination refers to the methods used to distribute and communicate guidelines to a target audience (Thomas et al, 1999). Dissemination is a key factor in achieving successful implementation. The success of guidelines in changing practice depends on active dissemination – including educational activities, patient specific reminders and recognition of local circumstances (Effective Health Care Bulletin 1994; Thomas et al, 1999).

In the UK, guideline dissemination tends to occur by distribution of printed materials, although the distribution methods are not always consistent (Brooks and Anthony, 2000; Thomas et al, 1999). Guidelines may also be available on the Internet, although some practitioners may have difficulty with Internet access (Brooks and Anthony, 2000). Passive dissemination of guidelines is largely ineffective and rarely leads to changes in behaviour (Feder et al, 1999). Despite this, mass distributions are still frequently the method of choice by many organisations (Cheater and Closs, 1997).

2.5 Implementation

The production of good quality guidelines do not ensure their implementation (Feder et al, 1999). Strategies are required to ensure that the knowledge contained within the guidelines results in changes to practice (Effective Health Care, 1994). The NHS Centre of Reviews and Dissemination (1999) showed that multi-faceted strategies for change were more successful than single interventions.

Humphris and Littlejohns (1996) consider successful guideline implementation requires strategic and operational planning whilst Harvey and Kitson (1996) state that integrated organisation-wide approaches are required. It also needs to be recognised that the size and complexity of the organisation can affect the feasibility of different implementation approaches (Feder et al, 1999).

Individual practitioners should also feel they have ownership of guidelines, although achieving this can be challenging, especially when guidelines are derived nationally and need to be implemented at local level (Young, 1999). As long ago as 1996, Harvey and Kitson identified the need to focus on teamwork, whilst encouraging practitioners to change their own practice.

Change strategies also need to be adequately resourced, including availability of people with the necessary knowledge, skills and abilities, to encourage change (Finnie, 2000). For example, face-to-face contact with a 'guideline facilitator' can have a positive impact on implementation (Feder et al, 1999; Marshall et al, 2001). Other resources, such as training and quality improvement processes, must also be built into any guideline implementation procedures (Marshall et al, 2001)

Clearly, there are resource implications associated with effective guideline implementation (Tong, 2001). The provision of appropriate resources including training may not always be feasible within some organisations. With finite resources, it therefore seems essential that healthcare organisations prioritise which guidelines they need to implement (Feder et al, 1999). This need for prioritisation and additional resources may explain why implementation of SIGN guidelines has been slow and widely variable within the NHS Trusts/Boards to date (CRAG, 2002).

2.6 Drivers and barriers to implementation

Within Scotland, although the implementation of specific guidelines and BPS are not mandatory, the development of NHS QIS generic clinical governance standards (NHS QIS, 2003) means healthcare providers are expected to be implementing guidelines generally and evaluating their use.

Successful guideline implementation requires multi-faceted interventions to address barriers to use (NHS Centre of Reviews and Dissemination 1999; Thomas, 1999; Thomson, 2000). Such strategies can include many activities. For example, Marshall et al (2001) reported that initially a needs analysis of 'hurdles and levers' should be undertaken within each area in which a guideline is to be implemented. Careful choice

of context is also important because, if ownership is to be encouraged, the guideline should be able to be appropriately applied to the context in which it will be implemented (Marshall et al, 2001). Planned action to address issues such as these will facilitate successful implementation. This action requires:

- The need for enthusiasm
- Targeting the context in which the impact is desired
- Ensuring credibility by providing strong evidence and endorsement from opinion leaders
- Strong and visible leadership to help promote organisational integration
- Financial, technical and emotional support
- Integration within organisational systems and involvement from all key stakeholders (Walter et al, 2003).

Another strong driver to guideline implementation occurs when practitioners believe that implementation would improve patient care (Marshall et al, 2001). Thus, the prospect of getting patients with long-term ulcers healed would be a strong driver for implementation of a venous ulcer guideline.

A short evaluation, conducted in 2001, of the implementation of SIGN guidelines (CRAG, 2002) was undertaken by distribution of questionnaires to NHS Boards and Trust Chief Executives and Clinical Audit / Effectiveness co-ordinators. The aim of this evaluation was to identify the extent of guideline implementation across Scotland including barriers and drivers encouraging use. Although the majority (54%) of Trusts had strategies for implementing SIGN guidelines, overall implementation of individual guidelines was highly variable and dependent on a variety of circumstances.

Within this evaluation, the following three factors were identified as key in supporting successful guideline implementation:

- The topic was considered a high local or national priority
- The guideline contained a high level of evidence or recommendations
- A local champion/clinical lead was available.

An additional barrier to successful implementation is difficulty in finding guidelines (Feder et al, 1999). Lack of awareness can be improved by educational approaches such as seminars and workshops. Clinical audit and feedback about performance can be useful where practitioners are unaware of the need to improve what might be considered sub-optimal practice. Culture and tradition can also impede such changes in practice. However, social influence such as consensus meetings, marketing, and education can be used to promote the need for change (Feder et al, 1999).

A perception that guidelines are being enforced on 'rank and file' professionals can also be a barrier to implementation; so, it is essential that a feeling of professional and practitioner ownership of guidelines be promoted (Harrison et al, 2002). Two additional barriers to implementation were also identified during the SIGN evaluation (CRAG, 2002); the need for extra investment and resources to support implementation, and guideline complexity, especially when implementation involved other organisations and sectors.

2.7 Impact

There has been little evaluation of the impact of guidelines (Tong, 2001). It is thought, however, that guidelines will result in greatest benefit to patients when they are focused on areas of greatest need and when the outcome of implementing the guideline will change and improve practice (McClarey and Duff, 1999).

Unfortunately, whilst changes in knowledge may be easily achievable, changes in attitudes and behaviour may be more difficult to achieve, especially in the wider context of a group or organisation (Humphris and Littlejohns, 1996). For example, the Scottish Leg Ulcer Project found there was no statistical difference in terms of healing rates of patients between nurses who received only the SIGN guidelines on chronic leg ulcer and those who received the guidelines and a formal training programme (Scottish Leg Ulcer Trial Participants, 2002).

Implementation strategies should be informed by relevant behavioural change theory (Thomas et al, 1999). It is not difficult to secure some change with the first flush of enthusiasm, but it is only in the long term that true outcomes become apparent (Humphris and Littlejohns, 1996). Working environments in which practitioners feel supported within a learning culture have been found to be effective (Rycroft-Malone et al, 2002). In particular, leaders have a key role in creating cultures conducive to transforming practice, and it has been found that change is easier to manage when clinical leadership is strong (Rycroft-Malone et al, 2002).

If practitioners perceive potential benefits, then practice may change despite little or no evidence being available. However, in the main, individuals do require more reasons to change clinical activity (Batstone and Edwards, 1996). Thomas et al (1999) found that a combined strategy of opinion leaders and education led to higher compliance with correct practice and therefore greater impact. This may imply that in areas where a specialist nurse (e.g. continence advisor) is employed to actively educate and encourage use of the guidelines, implementation may be more effective.

2.8 Summary

Even without evidence of the impact of the first five BPS, existing literature relating to the use of clinical guidelines indicates possible strategies and initiatives for developing BPS awareness, dissemination and impact.

Chapter 3: Study Design

During the planning stage, several design options were considered. As the evaluation commenced less than a year after the launch of the first BPS, the research team considered it appropriate to focus this initial exploration on the perspective of nurses and midwives rather than patients. The final choice of methods also reflected the need to complete the evaluation within six months, as required by the funding body.

3.1 Data collection

A multi-method approach was used to increase the potential for gathering reliable data of the necessary breadth and depth to meet project aims and objectives. The study consisted of two parts, quantitative and qualitative, conducted concurrently to gather as much information as possible within the time available.

3.1.1 Postal survey

This consisted of two elements, a questionnaire and a proforma, both developed by the research team. The questionnaire contained mainly forced choice questions but with some opportunities for free text comments (Appendix 1). In line with the NMPDU's philosophy of sharing good practice, a proforma was also developed to enable participants to report and recommend local initiatives promoting BPS use (Appendix 2). The questionnaire and proforma were designed to determine aspects such as:

- Awareness of, and access to, the BPS
- Current level of BPS implementation (i.e. full, partial or not at all)
- Benefits of the BPS to patients, nurses and midwives
- Provision of local initiatives to encourage implementation
- Barriers and drivers affecting implementation
- Suggestions for encouraging future implementation.

The questionnaires and proforma were tested in a pilot study. This involved 21 nurses and midwives working in clinical practice, practice development and management in an NHS Board area that had not been selected for inclusion in the study being asked to complete both questionnaire and proforma. The data collection tools were also distributed to research staff within the Department and representatives from the funding body to obtain feedback and suggestions for improvement. The questionnaire and proforma were both revised following the pilot and consultation process. The data analysis process was also pilot tested.

3.1.2 Telephone interviews

These were undertaken to gather richer, more detailed, qualitative information about use of the BPS which could not be obtained from the broader quantitative questionnaires. In recognition of their specialist insight into the topic and to ensure that pertinent data were collected within available resources, interviews focused on the perspective of BPS developers.

Interviewees were asked 13 questions about their BPS including the extent to which they thought it had benefited practice as well as barriers to use and suggestions for maximising future impact. Interviewees were also asked about their role, if any, in disseminating and supporting their BPS. These questions were incorporated into an interview schedule (Appendix 3).

Due to the short project timescales, data from interviews and questionnaires were collected simultaneously and it was not possible for the results of the questionnaire to influence development of the interview schedule. The interview schedule was refined

following consultation with the funding organisation and was piloted with an individual who had detailed knowledge of the five BPS but was not part of the evaluation.

3.2 Recruitment of participants and study sites

The relatively recent launch of the BPS, and the length of time taken to cascade information throughout nursing and midwifery, influenced project recruitment; as did awareness that different groups and grades of nurses and midwives must work together for the BPS to impact successfully. Qualified nurses and midwives from clinical practice therefore represented the largest group of participants because their use of the BPS directly impacts on patient care. Most of the clinical participants worked within the NHS, although a small group worked within the independent sector. In addition to those in clinical practice, the views of those with practice development and management remits were also sought because, although perhaps not directly involved in the clinical usage of the BPS, they have an essential role in promoting local change and implementation. This combined approach was designed to obtain greater insight into issues at a local and national perspective, as well as acting as a means of data triangulation.

3.2.1 Postal survey participants and study sites

To ensure clinical, practice development and management perspectives were obtained, random and purposive sampling techniques were used to select recipients of the questionnaire and proforma.

Clinical participants were selected by initially identifying a sample of seven NHS Trusts/Island Boards (23% of total NHS Trusts/Island Boards). To obtain this sample, all NHS Trusts/Island Boards were identified via the SHOW³ web site and sub-divided into providers of primary, secondary and integrated (acute and primary) care. Three acute and three primary care sites were then selected randomly from the acute and primary care sub-groups. A further site was selected from amongst the group of integrated health care providers. The sample of NHS clinical nursing and midwifery staff was obtained from these seven sites.

Independent sector participants were obtained by randomly selecting two of the seven NHS sites and identifying care homes or independent hospitals within those areas. All nurses in charge of the independent care homes in these two areas were invited to participate in the study. There were no independent hospitals in these sampled areas.

Once the seven NHS study sites were identified, their Directors of Nursing were informed about the study in writing and asked for written consent to include nurses and midwives in their area within the evaluation. All seven Directors of Nursing agreed to their site participating in the study. After local consent had been obtained, sampling of nurses and midwives was undertaken using stratified randomisation.

Each NHS site was asked to provide the total number of nurses and midwives employed and then to stratify staff according to their grade (C to I). Where an employee had more than one grade, they were included at their highest level.

As I grade nurses and midwives are a small group and could possibly be identified, H and I grade participants were amalgamated into one group. Sites were then asked to assign each nurse and midwife a unique study number starting from one and working upwards consecutively. The researchers then selected a proportion of nurses and midwives per grade, the number selected being dependent on the size of the NHS site (see Table 1). Individuals were selected from each NHS site using a random number generator to choose unique study numbers.

³ SHOW – Scottish Health on the Web (see Glossary for details)

Table 1: Description of clinical study sites and their sample sizes			
<i>Study site</i>	<i>Description of site</i>	<i>Sample (n=)</i>	<i>Sample as % of nurses & midwives employed in the site</i>
NHS site 1	Medium sized acute trust, mainly urban but also rural areas	175	13
NHS site 2	Medium sized acute trust, mainly urban but also rural areas	175	13
NHS site 3	Large sized acute trust, urban area	200	10
NHS site 4	Medium sized primary care trust, mixed urban and rural areas	175	15
NHS site 5	Small sized primary care trust, mainly rural	125	26
NHS site 6	Medium sized primary care trust, mainly rural	150	23
NHS site 7	Small sized primary and acute care provider, mainly rural	125	34
Independent sites	Care homes in two of the seven NHS sites	41	Not known
Total		1166	
NB: The total number of nurses & midwives employed in each NHS site determined the sample size. <500 nurses & midwives = sample of 125; 500-999 nurses & midwives = sample of 150; 1000-1999 nurses & midwives = sample of 175; >2000 nurses & midwives = sample of 200.			

A different approach was used to sample management and practice development participants. Participants with a management remit were purposively selected and consisted of all Directors of Nursing in Scotland (n=30). Nurses and midwives with a practice development remit were purposively selected from the Network of the former NMPDU. To ensure a clinical focus amongst this group, Network members working solely in education or research were excluded from the study. Eighty two Network members were eligible for inclusion in the evaluation.

Using these different sampling approaches, 1278 nurses and midwives from across Scotland were invited to participate in the postal survey. This number was considered large enough to ensure a satisfactory volume of data even if a poor response (less than 30%) was achieved. Those sampled from the NHS sites (n=1125) represented 15% of nurse and midwives employed within these NHS Trusts/Island Boards.

3.2.2 Telephone interview participants

A sample of 15 individuals involved in the development of the first five BPS were interviewed. These included the five BPS project leaders and two other members from each development team. Project leaders were purposively selected because of their unique role in the development process.

Other developers were selected by identifying all those listed within the BPS as being members of the steering or working groups. (For nutrition (assessment and referral) the wider reference group was also used, as the number of nurses in the steering group was small). From these lists, a sub-group of developers with nursing or midwifery job titles were identified as the population from which the sample was to be randomly selected, two per BPS. Developers listed as working in other healthcare disciplines, research or education, were excluded to ensure the interviews were clinically focused. The sample of 15 interviewees was 27% of the 56 eligible participants.

3.3 BPS included in the evaluation

All five of the first BPS launched simultaneously in 2002 were included in this evaluation. Of these five, four (continence, nutrition for physically frail older people,

nutrition assessment and referral in the care of adults in hospital and pressure ulcer prevention) had broad applicability to many areas of practice. The fifth BPS, home oxygen therapy for children being cared for in the community, was a specialist statement applying to a minority of practitioners across Scotland.

3.4 Process of data collection

All data were collected between May and July 2003.

3.4.1 Distribution of questionnaires and proforma

All participants were sent a pack containing a cover letter, project information leaflet, questionnaire, proforma and pre-paid return envelope.

Due to data protection constraints, the researchers could not access individual clinical participants directly. For clinical participants in the NHS sites, packs were sent to a local contact identified by the NHS Trust/Board, each pack was marked with the previously allocated study number. Using the study number to identify sampled individuals, the local contact was responsible for labelling the packs, ensuring that the correct employee details matched the study number on the pack.

Packs were sent directly to Directors of Nursing and Network members as their contact details are in the public domain. To ensure anonymity, the research team secretary (JC) allocated each of these individuals a random study number so researchers were unable to identify respondents. For participants working in the independent sector the addresses of care homes were obtained from the Care Commission and packs sent directly to the nurse in charge. Again, personal study numbers were randomly allocated to these participants.

3.4.2 Interviews

The selected individuals were sent a project pack containing a cover letter, information leaflet, copy of the interview schedule, consent form and a pre-paid reply envelope. Once individuals had given consent, they were contacted to arrange a suitable interview appointment. Interviewees were asked to consider the questions within the interview schedule in preparation for their session.

Interviews took place over a six week period and were undertaken by two members of the research team (NR and CM). Within the time available, it was not possible for the same researcher to undertake all interviews. Both interviewers used the same schedule to guide their questioning and other steps including observation of an interview and reflection were used to maximise consistency between the two interviewers.

Telephone interviews were tape-recorded and researchers made written notes on their interview schedule. Interviews were transcribed by NR and CM as soon as possible after recording. Transcripts were then checked by the researchers against interview tapes to ensure accuracy. Interviews were not time limited; however they had a natural length of between 20-30 minutes. Interview tapes and transcripts were coded to maintain anonymity of participants.

3.5 Maximising response rates

Several steps were taken to maximise the postal survey return,

(i) Before the project started, Rhona Hotchkiss, Director of the former NMPDU, wrote to all Directors of Nursing across Scotland to inform them about the study and to request their support.

(ii) Practical techniques to encourage participation were used. For example, where possible mailings were personalised, cover letters highlighting the relevance of the study were personally signed by the researchers and distributed with the questionnaires. Proforma and questionnaires were designed to be user-friendly with clear instructions, simple layout and were printed on coloured paper. Participants were provided with a pre-paid return envelope. For those seeking advice, contact details of the research team were included on all mailings and there was a dedicated project phone line and answer-phone.

A second mailing of a duplicate pack and a reminder letter were sent to non-respondents approximately four weeks following the initial distribution of questionnaires and proforma. The study was planned to avoid the main distribution of research materials during the summer school holidays when the return rate might be lowered. Between the first and second mailings, a letter was sent to Directors of Nursing at each NHS site to remind them the evaluation was on-going and request they continue to encourage local participation.

(iii) Other steps taken to promote a good response included a summary of the evaluation on the NMPDU web site and a presentation to Network members.

3.6 Ethical issues

Following advice from the Clerk of the Multi-centre Research Ethics Committee in Scotland during planning of the evaluation, ethical approval for the study was obtained from the Nursing and Midwifery Departmental Research Ethics Committee at the University of Stirling as soon as funding was awarded.

Consent: For the postal survey, consent to participate was required at NHS Trust/Board and individual levels. As already indicated Directors of Nursing for the NHS study sites provided written consent to include nurses and midwives in their area. For individuals selected to receive questionnaires and proforma, returning completed documentation implied consent to participate. Interviewees were requested to provide written consent. Prior to consenting, interviewees were informed interviews would be recorded.

Confidentiality and anonymity: Participants were assured that NHS Trusts/Island Boards included in the evaluation would not be named. Questionnaires and proforma were returned anonymously. The identities of clinical participants were never known to the research team, the personal study numbers allocated by the study sites were used to code these participants at all times.

The names of NMPDU Network members and Directors of Nursing were known to researchers at the start of the project. To protect their identity, JC randomly allocated them a study number. Researchers did not know which number corresponded to which individual and this information was kept in a password protected electronic file, which they could not access. A similar approach was used for nurses from the independent sector.

The identity of interviewees was restricted to the interviewers and JC. Interviewees were also allocated a study code, known only to the interviewers. All data (tape and electronic) were stored using these codes. Interviewees were assured no information, which could inadvertently reveal identities would be disclosed.

Data Protection: No member of the research team had access to personal data for clinical participants involved in the postal survey at any time during the study. All codes and contact details for Directors of Nursing and Network members required for the postal survey were kept in password protected databases accessible only by JC. Questionnaire and interview data were kept on password protected databases using

codes, not names and were only accessible to LM, NR, KH and CM who analysed the data. Interview tapes were not identified by respondent name. All data were stored securely in accordance with the Data Protection Act (1998).

3.7 Data analysis

A variety of data analysis methods were employed.

3.7.1 Questionnaires

Quantitative questionnaire data were entered by the research assistant (LM) using a statistical software programme (SPSS). Most data were categorical with the majority of analysis being descriptive, although Chi square tests were used where appropriate. Significance levels of five percent were used and categories were combined where necessary to ensure tests were valid. For free text data, coding frames were devised to enable responses to be categorised and subsequently analysed using SPSS. Coding frames were refined as the analysis process progressed. Analysis was undertaken by LM and KH.

3.7.2 Proforma

The content of the proforma was analysed manually by NR to identify the nature of initiatives, which BPS and staff groups were involved, and whether the respondent would recommend such initiatives to others. Initiatives were then grouped into similar types of activities and quantified.

3.7.3 Interviews

The content of interview transcripts were analysed by NR and CM manually, as well as electronically using the software programme NVivo. Preliminary data analysis of the transcripts was undertaken manually to help understand the 'mire' of data (Ross 1994). This involved reading the transcripts several times to enable the researchers to familiarise themselves with the content. Familiarisation with the transcripts enabled an initial coding system to be developed so that similar categories of data could then be identified. From these categories several connecting themes emerged enabling the different interview questions to be answered. To ensure quality within the manual data analysis process, NR and CM peer reviewed transcripts, coding, and the emergent themes, to ensure consensus. NVivo was then used to complete thematic analysis. The transcripts were then re-analysed and crosschecked to confirm reliability and validity of initial findings.

3.8 Limitations

Due to the short period between BPS launch and evaluation, this study focused on BPS impact from the perspective of nurses and midwives. Impact of the BPS from the perspective of clinical benefit to patients would need to be explored in a future study. This evaluation was also influenced by the six month timescale set by the funding body. This constrained the choice of methods and means of data collection, as the final selection had to be feasible within the time available.

3.9 Summary

The evaluation was designed to use interviews and a postal survey to gain insight into the initial dissemination, support and impact of the first five BPS from the perspective of nurses and midwives.

Chapter 4: Results of the Postal Survey

The postal survey tools focused on the BPS from the perspective of nurses and midwives working in clinical practice and management as well as those with a practice development remit. The tools generated a wealth of information about dissemination and use of the BPS as well as initial benefits of the BPS for patients, nurses and midwives. Barriers to BPS use and drivers encouraging implementation were also identified. Key findings from the questionnaire and proforma are presented in this chapter.

Part 1: Questionnaire

4. 1 Response rates

In total, 1,278 questionnaires were sent out to the eight clinical sites⁴, Directors of Nursing and NMPDU Network members. Overall, 539 questionnaires were returned completed, an overall response rate of 42% of those distributed. An additional 11 questionnaires were returned addressee unknown and 14 completed questionnaires were returned too late for inclusion in the study.

Staff in the clinical sites returned 451 completed questionnaires. The overall response rate was 39%, ranging from 25–51% between the different areas (Table 2). Network members and Directors of Nursing had the highest response rates with approximately three quarters responding.

Table 2: Response rates by study site and group			
Site or Study Group	Sent	Completed	% Completion
NHS Site 1	175	72	41.1%
NHS Site 2	175	57	32.6%
NHS Site 3	200	50	25.0%
NHS Site 4	175	74	42.3%
NHS Site 5	125	56	44.8%
NHS Site 6	150	63	42.0%
NHS Site 7	125	58	46.4%
Independent Sites	41	21	51.2%
Network Members	82	66	80.5%
Directors of Nursing	30	22	73.3%
Total	1278	539	42.2%

4.2 Demographic data of respondents

Clinical and Network participants were asked to provide certain demographic data including designation and area of practice. Directors of Nursing only needed to provide data on their type of Trust/Board area and whether they employed nurses and midwives.

⁴ NB: although there were two independent sites, due to small numbers they have been amalgamated into one for the purposes of data analysis and reporting.

4.2.1 Clinical and Network respondents

Designation: A total of 503 Clinical and Network respondents provided this information. There were 393 nurses, 55 midwives, eight health visitors, and nine respondents in joint clinical posts (Table 3). The designation of 38 respondents were categorised as 'other' and included nine in training/academic positions and 15 managers.

Table 3: Designation of Clinical and Network respondents						
	Health Visitor	Nurse	Midwife	Joint clinical post	Other	Total
Clinical Sites	8 1.8%	364 82.5%	37 8.4%	9 2.0%	23 5.3%	441 100.0%
Network Members	0 0%	29 46.8%	18 29.0%	0 0%	15 24.2%	62 100.0%
Total	8 1.6%	393 78.1%	55 10.9%	9 1.8%	38 7.6%	503 100.0%

Area of practice: Overall, 434 Clinical and Network respondents indicated their area of practice. Full details are contained in Table 4.1, Appendix 4.

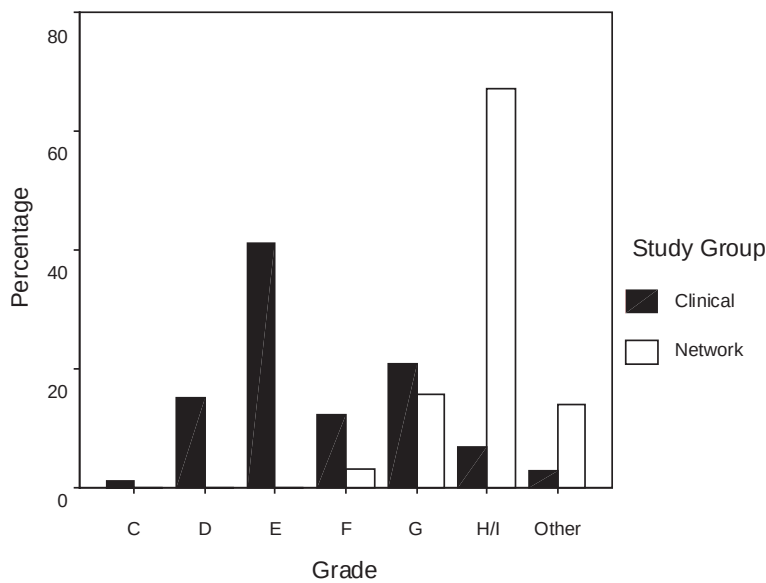
Amongst Clinical respondents, adult general nursing was the most common area of practice, reported by more than a third of respondents. Approximately 20% of Clinical respondents worked in the community with 11% working in mental health and 10% in continuing care. Learning disabilities and paediatrics had the least respondents, two percent or less.

Within the different clinical sites, mental health and learning disability respondents were employed in the primary care trusts (NHS sites 4-6). No midwives were employed in NHS site 4 or the independent sites.

Over 60% of Network respondents worked in support posts such as practice development.

Clinical grading: A total of 505 Clinical and Network respondents indicated their grade, of which 96% (n=484) were on the NHS clinical grading scale. The remainder reported other grading including senior management, administrative and clerical or private sector scales (Figure 1).

Figure 1. Clinical Grade of Clinical and Network Respondents

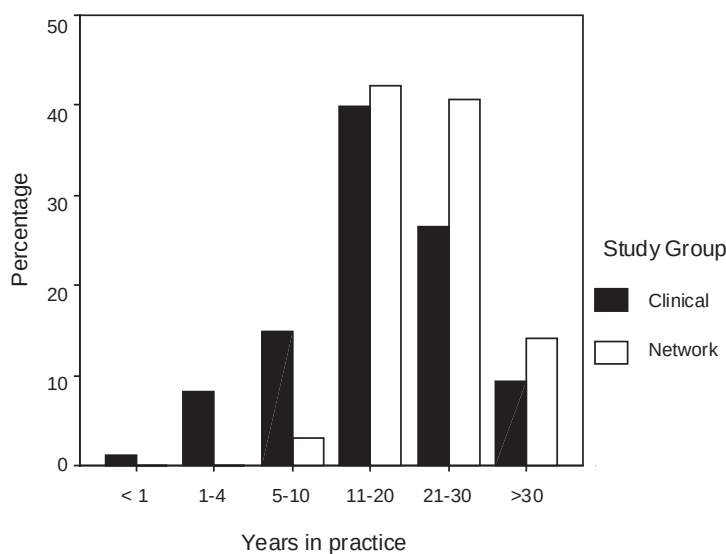


Of the 484 reporting clinical grades, one third were E grades, all of whom were Clinical respondents (Table 4.2, Appendix 4). G grade respondents were the second largest group (20%), all but ten of whom were Clinical respondents. Amongst Network respondents, the majority were graded H/I.

By comparing the clinical grade of respondents with those of the overall sample identified at the start of the project, respondents were very similar to the total sample group, although not wholly representative. This was because lower grade respondents (C and D grades) were under-represented from those within NHS sites 2 and 3 returning completed questionnaires.

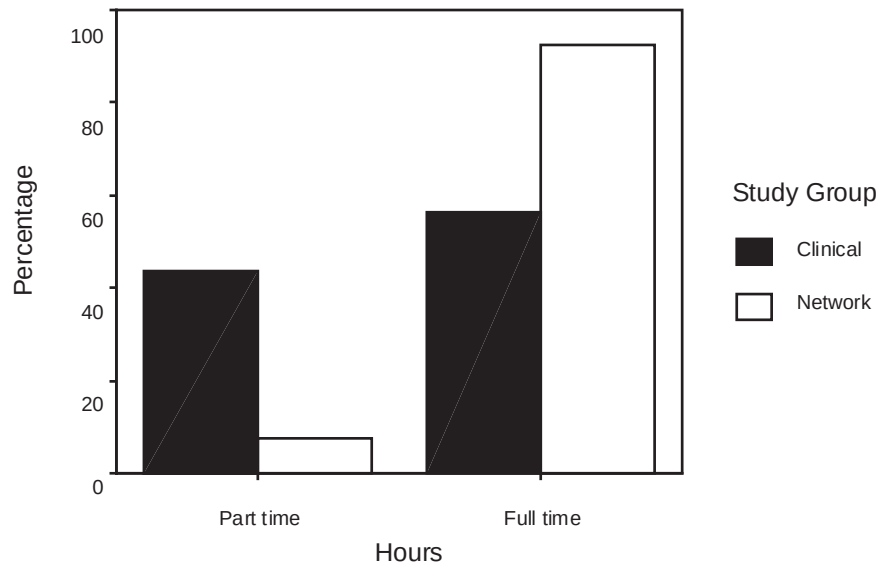
Years in practice: Three quarters of the 510 respondents had been practising for more than 10 years (Figure 2). Only five respondents had been in practice for less than a year, all Clinical respondents (Table 4.3, Appendix 4). Whilst only two Network respondents had been in practice for less than 11 years, a quarter (24%) of Clinical respondents had been in practice for that length of time.

Figure 2. Years in practice Clinical & Network respondents



Full-time or part-time employment: Of the 510 respondents who replied, 61% worked full-time with 39% working part-time (Table 4.4, Appendix 4). Only five Network respondents worked part-time compared to just under half of all Clinical respondents (Figure 3).

Figure 3. Part time and full time employment of Clinical and Network respondents



4.2.2 Directors of Nursing

To ensure Directors of Nursing were asked appropriate questions, they received a separate version of the questionnaire to Clinical and Network participants (Appendix 1B). For example, rather than asking if they were personally using the BPS, Directors were asked to indicate whether nurses and midwives in their area were using these statements. However, where possible, questions in the generic and Director of Nursing questionnaires were the same.

A total of 22 Director of Nursing questionnaires were returned (73%). From the replies, however, it appeared that in some cases the Director's deputy completed the questionnaire. It was not always possible to determine which respondents were Directors and which were deputies.

Only 19 respondents provided details of their areas. Of those, eleven worked in an acute NHS Trust, seven in a primary care Trust and one in an integrated acute and primary care NHS Trust/Island Board.

4.3 Questionnaire results

Results are presented in order of the questions asked within the questionnaires (Appendix 1). For clarity, the term 'study sites' refers specifically to the eight clinical sites and 'study group' refers to Director, Network and Clinical respondents. The BPS have been abbreviated to: home oxygen, continence, pressure ulcers, nutrition (assessment & referral) and nutrition (frail elderly).

4.3.1 Knowledge of the NMPDU BPS generally

There were 537 respondents who answered this question. Over half specifically reported knowing about the BPS prior to receiving the questionnaire. Less than half did not have knowledge of the statements prior to the evaluation (Table 4). All but one of the Director and Network respondents knew about the statements before the evaluation, however, half of the Clinical respondents were unaware of the BPS until receiving a questionnaire.

Table 4: General knowledge of the BPS by study group				
	Clinical	Network	Directors	Total
Yes	202 44.8%	65 98.5%	20 100.0%	287 53.4%
No	249 55.2%	1 1.5%	0 0%	250 46.6%
Total	451 100.0%	66 100.0%	20 100.0%	537 100.0%

Knowledge of the BPS varied between the clinical sites (Table 4.5, Appendix 4). For example, awareness was highest amongst NHS primary care sites 4 and 6 with 58% of respondents reporting prior knowledge of the BPS. The lowest rates of BPS awareness were in NHS acute site 3 (30%), the largest clinical site in the survey, and the independent sites (29%).

For respondents on NHS clinical grades (C to I), there was a statistically significant association between grade and knowledge of the BPS (Table 4.6, Appendix 4). That is, the higher the clinical grade, the greater the likelihood of the respondent being aware of the BPS before receiving the questionnaire. For example, whilst only 20% of C grade respondents had heard of the BPS, this figure increased to 50% of F grades and 90% H/I respondents.

Respondents working full-time and those who had been in practice for ten years or more were more likely to have heard of the BPS than their part-time colleagues working in practice for less than ten years (Table 4.7 and Table 4.8, Appendix 4).

4.3.2 Knowledge of specific BPS

Although 287 respondents knew about the BPS generally (see 4.3.1), not all had specific knowledge of the statements. A minority, 19 respondents, knew none of the five BPS by name (Table 5). More than three quarters of Director and Network respondents knew all five BPS, while only 16% of Clinical respondents did.

Table 5: Extent of knowledge of the BPS by study group

	None	Some	All Five	Total
Clinical	18 8.9%	151 74.8%	33 16.3%	202 100.0%
Network	1 1.6%	14 21.5%	50 76.9%	65 100.0%
Directors	0 0%	2 10.0%	18 90.0%	20 100.0%
Total	19 6.6%	167 58.2%	101 35.2%	287 100.0%

More than 70% of all respondents reporting specific knowledge were aware of the BPS for continence, pressure ulcer prevention and nutrition (frail elderly) (Table 6). Overall, knowledge was greatest for the pressure ulcer statement and lowest for home oxygen and nutrition (assessment and referral). For each BPS, knowledge was greatest amongst Director and Network respondents and lowest amongst Clinical respondents. Amongst respondents on clinical grades, awareness of all five BPS increased with grade.

Table 6: Specific knowledge of the BPS by study group

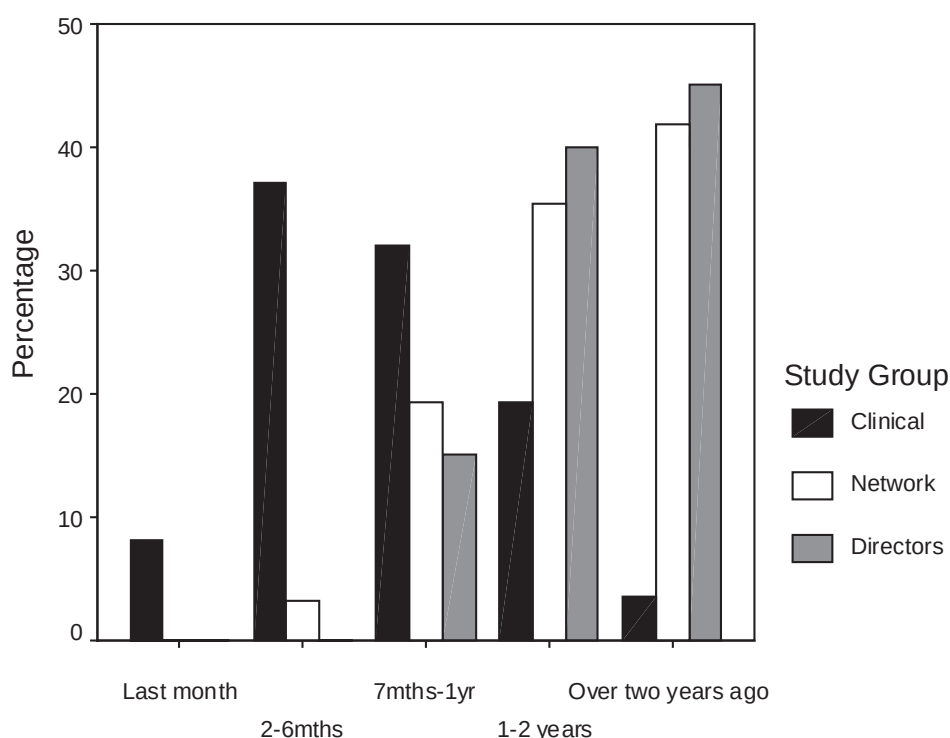
	Network members (n=65)	Directors of Nursing (n=20)	Clinical participants (n=202)	All groupings (n=287)
Continence	62 95.4%	19 95.0%	130 64.4%	211 73.5%
Pressure ulcer prevention	59 90.8%	20 100.0%	138 68.3%	217 75.6%
Nutrition (frail elderly)	60 92.3%	20 100.0%	123 60.9%	203 70.7%
Nutrition (assessment & referral)	57 87.7%	20 100.0%	114 56.4%	191 66.6%
Home oxygen	57 87.7%	19 95.0%	63 31.2%	139 48.4%

4.3.3 Length of BPS awareness

Although launched in 2002, work on identifying topics for BPS development started in April 2000, following establishment of the NMPDU. Respondents could therefore have been aware of the BPS for three years prior to the evaluation.

From the 279 participants who indicated how long they had been aware of the BPS, more than half (n=169, 61%) had been aware of the BPS for less than a year, with 8% only hearing about them within the last month (Table 4.9, Appendix 4). Director and Network respondents had been aware of the BPS for longer than Clinical respondents. Of those who reported becoming aware of the BPS within the past year, this group included less than a quarter of Director and Network respondents, but over three quarters of Clinical respondents (Figure 4). There were no statistically significant differences between the different clinical sites and length of awareness.

Figure 4. When respondents learned about the BPS



4.3.4 How respondents learned about the BPS

From the three study groups, 283 participants named 582 multiple sources for learning about the BPS.

Overall, the most popular routes for learning about the BPS were direct from employer (36%), receiving a personal copy (36%) and reading about them in a journal (31%) (Table 4.10, Appendix 4). Respondents were least likely to have heard about the BPS from a national (12%) or local launch (7%) or directly from the NMPDU (5%).

There were variations between how the different groups learned about the BPS. Whilst approximately a third of Director and Network participants had attended a national launch, only 3% of Clinical participants had. The majority of Network and Director respondents had personal copies of the BPS compared to less than a quarter of Clinical respondents. Amongst Network respondents, almost half had learned about the BPS via the NMPDU website, while less than 10% of Clinical respondents had used this route. Clinical respondents were most likely to hear about the BPS directly from their employer (43%), by reading about the BPS (35%) or from a colleague (26%).

Alternative sources for learning about the BPS included study days, specialist nurse workshops, the NMPDU newsletter and the Directors of Nursing group.

Within the different sites there were some variations in how respondents learned about the BPS. For example, primary care respondents were more likely to have a personal copy of the BPS than acute care respondents. Network members were more likely to have attended a national launch than other respondents.

4.3.5 Relevance of the BPS to practice

Respondents were asked to state whether the individual BPS were always relevant, sometimes relevant or not relevant to practice. Clinical and Network participants commented for their own practice, Directors of Nursing commented for nurses and midwives in their area. Respondents could also indicate if they were not sure about the relevance of the BPS.

More than half of all respondents to this question considered the BPS for pressure ulcer, continence and nutrition (frail elderly) to be always relevant to practice (Table 4.11, Appendix 4). Approximately a quarter of respondents also considered these statements to be sometimes relevant to practice. The BPS reported as least relevant to practice was home oxygen, with less than 30% of all respondents considering it always or sometimes relevant.

The BPS considered most relevant to practice by Clinical respondents were pressure ulcer, continence and nutrition (frail elderly) with more than half of all Clinical respondents reporting these statements always relevant to practice. There were some variations amongst the clinical sites. For example, within primary and integrated care NHS sites 4-7, more than half of respondents considered the continence BPS always relevant compared to a third of respondents from acute sites 1-3.

Whilst few Clinical respondents, less than 4%, were unsure if the BPS applied to them, greater numbers reported the BPS was not relevant to their practice. For example, 30% of Clinical respondents stated nutrition (assessment and referral) was not relevant to them.

For every BPS, Director of Nursing respondents were most likely to report statements were always relevant.

4.3.6 Current usage of the BPS in practice

Respondents were asked whether the BPS were being used with some or all patients. If not currently being used, respondents were asked to indicate if they were planning to use the BPS. Clinical and Network participants were asked about their practice and Directors about BPS use amongst their nurses and midwives.

Amongst the three groups, more than 40% of respondents reported using the BPS for pressure ulcer, continence and nutrition (frail elderly) with all or some relevant patients (Table 4.12, Appendix 4). The BPS for pressure ulcer prevention was reported as being used the most for all or some patients by 48% of respondents. The home oxygen BPS was being used least, with only 14% of respondents reporting any usage. For all BPS except pressure ulcer prevention, more respondents reported planning to use the statements than were currently using them with *all* relevant patients.

BPS usage amongst Clinical respondents is most important given they provide clinical care. From these respondents, the BPS cited as being used most with *all* relevant patients were pressure ulcer prevention (29%), continence (26%) and nutrition (frail elderly) (23%) (Table 4.12, Appendix 4). For every BPS more Clinical respondents reported using the statement with *all* relevant patients than with some. For the continence, nutrition (frail elderly) and pressure ulcer BPS, more than a quarter of Clinical respondents reported that although not currently using these BPS, they were planning to use them.

The BPS reported least applicable to practice by Clinical respondents were home oxygen (73%) and nutrition (assessment & referral) (32%).

There were 144 respondents who commented on their answers. The most frequent comment (n=27) was that the BPS were not always relevant to their practice. From respondents using the BPS, comments indicated that statements were integrated into local clinical guidelines, protocols or standards (n=6), care plans had been developed using the BPS (n=4) and the BPS were being used for audit purposes (n=5). An additional nine respondents also commented that they promoted the statements and used them for teaching purposes. Examples of specific comments are:

'I do not use these in practice as I am a manager – do however use them to inform others' (Manager).

'Use [the BPS] only as a basis for teaching and a resource for teaching' (Practice development nurse).

4.3.7 Extent of current usage of BPS

Respondents were asked to indicate if the BPS were being used in full, significant parts or a few key points only. Amongst the three study groups, the pressure ulcer and continence BPS were reported as being used the most either in full by around a quarter of respondents or significant parts by around a third of respondents (Table 4.13, Appendix 4). Excluding the specialist home oxygen BPS, the BPS used least, in full or a significant part, was nutrition (assessment and referral).

Significant parts of the BPS were more likely to be used than the full statement. Also, with the exception of the pressure ulcer BPS, respondents were likely to be using only key points of the BPS than the full statement.

Full use of the BPS was reported most by Director respondents. For example, whilst a third of Director respondents indicated the BPS for nutrition (frail elderly) was being fully used in their area, less than 20% of Clinical respondents reported such usage.

Amongst Clinical respondents specifically, the BPS for pressure ulcers and continence were most commonly reported as being used in full by over 20% (Table 4.13, Appendix 4). Within the different clinical sites, there were also some variations in BPS usage. For example, full use of the pressure ulcer BPS was highest in NHS primary care sites 4 and 6 (40%) and lowest in NHS acute site 1 (7%).

There were 64 respondents who commented on their answers. Relevant comments included statements that the BPS were already covered in existing local standards, the BPS complimented existing policies/practices and the BPS had been used to develop local guidelines and/or protocols

4.3.8 Benefits of the BPS for patients

Respondents were asked to indicate the extent to which the BPS impacted on patient care by identifying whether each statement was having major, minor or no benefits.

Amongst all groups, the BPS for pressure ulcer (42%) and continence (36%) were reported as having produced most major benefits to patients (Table 4.14, Appendix 4). Only a small minority of respondents, less than 10%, considered that the BPS had no benefits for patient care.

For Clinical respondents, the BPS most cited as producing major benefits for patients were pressure ulcers (45%), nutrition (frail elderly) (39%) and continence (38%). The

BPS reported by Clinical participants as producing least major benefits for patients were home oxygen (11%) and nutrition (assessment and referral) (31%).

There were 105 respondents who commented on their response. Of those, 12 respondents indicated it was too early to say whether the BPS had benefited patients and eight respondents reported that although too early to report benefits to patient care, these were anticipated. Another eight commented that patient care was already evidence based, so introduction of the BPS had only resulted in minor adjustments to patient care.

The largest overall category of responses (n=24) reported the BPS to have benefited patients by promoting quality improvement through facilitating evidence-based practice (n=6), standardising care (n=16) and enabling benchmarking (n=2). Patients were also reported to have benefited through raised awareness of the BPS topics amongst nurses and midwives (n=10). Specific comments include:

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

'Increased awareness of evidence - based practice for nurses - improving patient care' (Senior nurse).

'Raising maximum awareness - increasing quality of care' (Midwife).

4.3.9 Benefit of the BPS for nurses and midwives

Respondents were asked to indicate whether the BPS benefited nurses and/or midwives.

For all study groups, the BPS for pressure ulcers was considered to have had the most benefit to nurses and midwives, with 40% of respondents indicating major benefits for staff (Table 4.15, Appendix 4). A third of respondents ranked the BPS for continence and nutrition (frail elderly) as second or third in producing major benefits to nurses and midwives. The BPS considered to have resulted in the least major benefits was the specialist home oxygen statement (20%).

For each of the BPS there were differences in response between Clinical, Network and Director respondents. As a group, Director respondents rated each BPS higher in producing major benefits for nurses and midwives than nurses and midwives themselves (Table 4.15, Appendix 4). They also considered the continence BPS to have produced the most major benefits to nurses and midwives (62%) whereas Clinical (42%) and Network respondents (29%) considered nurses and midwives to have benefited most from the pressure ulcer BPS.

Most Clinical respondents reported the BPS had benefited nurses and midwives to some extent. For example, 72% considered that the continence BPS had either major or minor benefits. There were however a small minority who indicated that the statements had no benefits. This ranged from 3% for home oxygen to 12% for nutrition (assessment & referral).

Within the different clinical sites, there were some variations in response but these were not statistically significant.

Amongst the 107 comments provided for this question, the most frequent relevant response fell into the category of 'good evidence base to inform/guide practice' (n=25). Such comments include:

'The significance of professional care delivery underpinned by best practice' (Director).

'[Nurses and midwives] now have clear guidance on evidence based practice' (Director).

Nurses and midwives were also reported to have benefited from the BPS through raised awareness of clinical topics (n=11), positive reinforcement and affirmation of good practice (n=7), local discussion and agreement of good practice (n=7) and a standardised approach to care (n=6).

The following is an example of the 21 mixed responses coded as 'other':

'[It's a] challenge to make staff adopt [the BPS] in practice due to the volume of changes expected in the NHS' (Nurse).

4.3.10 Awareness of barriers to using the BPS

Respondents were asked to indicate barriers to BPS use. Overall, the pressure ulcer BPS was reported as having the least barriers (14%) and nutrition (assessment & referral) the most (22%) (Table 4.16, Appendix 4). There was no consensus within the different groups as to which single BPS had the most barriers. For Network, Director and Clinical respondents, the BPS with most barriers were nutrition (frail elderly), nutrition (assessment & referral) and home oxygen respectively.

More Director and Network respondents identified barriers than Clinical respondents (Table 4.16, Appendix 4). Within each of the NHS sites, barriers reported were generally less than 20%.

Where respondents indicated awareness of barriers to BPS use, they were asked to specify them; this generated 109 responses (Table 7). The most frequently cited barriers were lack of resources including time, staff and training (n=27), perceived relevance to practice (n=25), the huge number of other guidelines influencing practice (n=15), the need for a structure for implementation (n=12) and lack of understanding and awareness of the BPS (n=11).

Table 7: Reported barriers to BPS use						
	BPS Statement					
	Continence	Home Oxygen	Nutrition (A&R)	Nutrition (FE)	Pressure Ulcers	Total
Lack of resources including staff, money, equipment, time & training	9	1	5	6	6	27
Relevance of BPS	4	7	6	4	4	25
Huge number of guidelines	3	2	3	3	4	15
Need structure for implementation & maintenance	2	2	3	3	2	12
Lack of understanding & awareness	2	1	3	3	2	11
Other	1	3	1	3	2	10
Patient non compliance	2	0	1	1	0	4
Collaboration & communication	0	1	0	1	0	2
Other project in progress	0	0	1	1	0	2
Multi-disciplinary working	0	0	1	0	0	1
Total	23	17	24	25	20	109

There were 60 respondents who commented on their answers. The largest category related to lack of resources (n=16) including time constraints on clinical leaders and grass-roots staff.

The next most frequent category was lack of understanding and awareness of the BPS (n=9). Comments included:

‘Barriers to BPS can be fear of change - lack of understanding for change of practice’ (Health Visitor).

‘Only barrier is a lack of knowledge of the statements by some practitioners’ (Manager).

Other comments related to guideline overload, for example:

‘The overwhelming number of protocols/guidance/standards which are around. Staff are overloaded – unsure of which are priorities’ (Nurse).

4.3.11 Awareness of drivers encouraging BPS use

All groups reported awareness of drivers encouraging BPS use (Table 4.17, Appendix 4). Overall, the continence statement was identified as having most local drivers (39%), followed by pressure ulcer prevention (37%). The least number of drivers encouraging

use were identified for the home oxygen BPS (21%) and nutrition (assessment and referral) (27%).

Director and Network respondents were aware of more drivers than Clinical respondents. For example, more than half of Network and Director respondents reported drivers for the continence BPS however, less than a third of Clinical respondents did. Clinical respondents reported that continence (31%) and pressure ulcer prevention (29%) had the most drivers encouraging use. Within the NHS sites, the number of reported drivers varied, for example, ranging from 12 - 45% for the pressure ulcer BPS.

Where respondents reported awareness of local drivers encouraging BPS use, they were asked to specify these. This generated 274 multiple responses (Table 8). The most commonly cited drivers were specialist nurses (n=56) and key local individuals taking a lead role in facilitating change (n=42), for example a link nurse or Clinical Nurse Specialist. Such drivers were most frequently cited for the continence and pressure ulcer BPS.

Availability of the BPS (n=23), the wish and desire to change practice (n=21) as well as the need to change (n=11) were also identified as encouraging BPS use.

Amongst Clinical respondents, a specialist nurse encouraging use was rated as the primary driver for all BPS except nutrition (assessment & referral). For that BPS, Clinical respondents reported a local individual facilitating change, and availability of the BPS, as the primary drivers.

Table 8: Reported drivers encouraging BPS use						
	BPS Statement					
Type of Facilitator	Continenence	Home Oxygen	Nutrition (A&R)	Nutrition (FE)	Pressure Ulcers	Total
Member of specialist nursing group encouraging use	21	7	3	7	18	56
Other	12	2	10	10	11	45
Local leaders or key individuals promoting change	10	4	7	9	12	42
Availability of BPS	4	4	5	5	5	23
A wish/desire to change & apply BPS	10	1	2	3	5	21
Local initiatives to encourage change and raise awareness	4	2	5	4	5	20
Local steering group	2	0	4	6	1	13
Education	2	2	2	3	3	12
A need to change e.g. audits or complaints	4	0	3	2	2	11
Incorporate BPS into local guidelines including revision of existing guidelines	3	1	2	2	3	11
Implementation structure & support including leadership	3	1	2	1	2	9
Staff involvement	2	1	0	3	1	7
Additional resources	0	0	0	2	2	4
Total	77	25	45	57	70	274

4.3.12 Respondents with personal copies of the BPS

All Directors and approximately three quarters of Network respondents owned personal copies of the BPS (Table 4.18, Appendix 4). By comparison, only a minority of Clinical respondents owned personal copies of any of the BPS. The BPS most owned by Clinical respondents were continence and pressure ulcer prevention, owned by less than a third of respondents. The level of BPS ownership varied within the clinical sites. For example, only one (17%) independent sector respondent had a personal copy of the continence BPS whilst almost half (47%) of NHS site 4 respondents had a personal copy, the highest percentage of ownership.

4.3.13 Direct access to copies of the BPS

From the 275 respondents who answered this question, three quarters (74%) stated they could access copies of the BPS directly.

Most Network and Director respondents (94%) reported they could access the BPS directly (Table 4.19, Appendix 4), only two did not know how to access the statements. By comparison, whilst 65% of Clinical respondents stated they could access copies of the BPS directly, almost a third (30%) did not know how to access them. Amongst the eight clinical sites, independent sector respondents were least able to access the BPS directly, less than 20% (Table 4.20, Appendix 4).

4.3.14 How respondents access copies of the BPS

From the options provided, the most popular routes for accessing the BPS were via the NMPDU web site and from within the local working area (Table 4.21, Appendix 4). Only 46 respondents reported using a library to access the BPS.

Respondents provided eleven alternative sources for accessing the BPS. These included accessing the BPS within Local Health Care Co-operatives (LHCCs), directly from the NMPDU and from local clinical governance staff.

4.3.15 Ease of access to copies of the BPS

Only 6% of 246 respondents reported difficulties in accessing copies of the BPS, and all but one of these were Clinical respondents (Table 4.22, Appendix 4). Whilst more than three quarters (78%) of Network and Director respondents reported it was easy to access copies of the BPS, just over half (55%) of Clinical respondents agreed.

There were some variations within the clinical sites regarding ease of access to the BPS. For example, half of the independent sector respondents reported that accessing the BPS was difficult.

There were 21 respondents who commented on their response. Comments include:

‘IT access for all isn’t possible’ (Director).

‘[Access is] easy now that I am aware of the web-site’ (Nurse).

‘Independent care home sectors are not forwarding information relating to access of BPS’ (Care Home respondent).

4.3.16 Suggestions for improving dissemination of BPS to nurses and midwives

Respondents provided 64 free text suggestions for improving future dissemination (Table 9). The largest category of suggestions for improving BPS dissemination related to having a vast distribution of hard copies (n=13). Specific examples included, sending more copies of the BPS to link nurses/midwives who could advise on local distribution, and sending copies of relevant BPS to each hospital unit so information would be disseminated to wards.

Workshops, training sessions and seminars as well as dissemination via supervisor or line manager (n=9) were the second most cited options for improving future dissemination.

From the 13 responses categorised as ‘other’, comments included:

‘We need a more structured approach locally’ (Nurse)

‘Link [the BPS] to SIGN guidelines’ (Management respondent)

‘Only send out BPS to relevant areas’ (Midwife).

Table 9: Suggestions for improving dissemination of BPS

<i>Suggestion</i>	<i>Number of responses</i>
Vast distribution of hard copies	13
Other	13
Dissemination via supervisor/manager	9
Workshops, training sessions & seminars	9
Website access/e-mail	6
Launch events	4
Publicise (other media, posters)	4
More information on why they should be used	4
Journals/newsletters	2
Total	64

4.3.17 Suggestions for encouraging future BPS use by nurses and midwives

Respondents also offered 67 free text suggestions for encouraging future BPS use (Table 10). The largest category of suggestions (n=12) were coded as ‘other’, this included the following suggestions:

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

‘If the statements are not used, nurses and midwives should be asked to explain why they choose not to’ (Nurse).

The second largest category of response was increasing availability of the BPS in all relevant areas (n=10). For example:

‘Midwives may assume BPS are exclusively relevant to nurses. If they are relevant to midwives it would be worth circulating through midwifery channels’ (Midwife).

Smaller categories of suggestions included improved BPS dissemination through the hierarchies (n=7), increased publicity and advertising (n=7), increased support for implementation and an implementation strategy (n=6), more training and study days (n=6) and including the BPS in clinical guidelines and Clinical Standards Board (now NHS QIS) standards (n=5). Examples of such comments included:

‘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’ (Nurse).

‘Require good strategic leadership to take a co-ordinated approach [to implementation]’ (Practice development nurse).

Table 10: Suggestions for encouraging future BPS use	
<i>Suggestion</i>	<i>Number of responses</i>
Other	12
Make available in all relevant areas	10
Disseminated through hierarchy	7
Publicity/advertising	7
Increased implementation support/strategy	6
Training/study days etc	6
Include in clinical guidelines, CSBS/NHS QIS standards	5
Clinical champion including a nurse in charge of dissemination	4
Distribution around wards	4
Dissemination to students/new staff	3
Greater staff involvement	3
Total	67

4.3.18 Other comments about the BPS

This question generated 29 free text comments. The largest category, nine responses, were comments that fell into the 'other' category, for example:

'The focus of BPS is on best practice, rather than evidence like other guidelines - I think this has been confusing for some. Although I recognise they have a different purpose, including some more detailed audit suggestions may be useful' (Nurse).

'The problem is fitting in BPS with all the other clinical standards that we are having to adopt' (Nurse).

There were eight respondents who commented on the 'relevance and focus' of the BPS. These comments are exemplified by the following:

'Careful selection of topic required to ensure that [the BPS] can be broad based to meet the needs of the population without over generalisation and therefore limiting practical use' (Nurse manager).

Another category of seven responses related to the BPS being 'good and informative' for practitioners. For example:

'Absolutely excellent. Both home oxygen and naso-gastric feeding will be invaluable for those of us in paediatrics' (Director).

An additional five respondents made suggestions or comments regarding the 'credibility and status' of the BPS such as:

'Need to avoid developing BPS when other national [guidelines] exist as turns staff off and devalues the initiative and creates extra work for implementation' (Nurse).

'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 & risk management' (Practice development nurse).

Part 2: Proforma

4.4 Proforma results

Each questionnaire was issued with a proforma asking participants to provide details of local initiatives supporting BPS use. Participants were asked to return the proforma blank if they were unaware of any local initiatives.

From the 1278 proforma distributed with the questionnaires, 353 (28%) were returned of which only 59 (17%) were completed detailing local initiatives promoting BPS use. Such a low return rate suggests non-respondents were not aware of any initiatives to promote BPS use. Analysis is based on the 59 completed proforma (Table 11).

Table 11: Return rate of completed proforma per study site and group				
<i>Study site/group</i>	<i>Sample (n=)</i>	<i>Proforma returned</i>	<i>Number returned completed</i>	<i>Number returned recommending initiatives</i>
NHS site 1	175	40 (22.9%)	3	1
NHS site 2	175	41 (23.4%)	2	1
NHS site 3	200	37 (18.5%)	1	0
NHS site 4	175	53 (30.3%)	9	5
NHS site 5	125	37 (29.6%)	1	1
NHS site 6	150	36 (24%)	8	3
NHS site 7	125	32 (25.6%)	1	0
Independent sector	41	13 (31.2%)	1	1
Network members	82	47 (57.3%)	21	15
Directors of Nursing	30	17 (56.7%)	12	3
Total	1278	353 (27.6%)	59 (16.7%)	30

The 59 completed proforma highlighted a number of initiatives to support the BPS, and these fell into the following categories: use of local groups, link or lead nurses, training, incorporating BPS into Trust guidelines, protocols and/or policies, practice development initiatives, measuring performance against the BPS, and dissemination including presentations and seminars.

Initiatives to support BPS use were reported for all five BPS, although initiatives for home oxygen for children in the community were mentioned less often, reflecting its specialist nature.

The nursing and midwifery groups targeted by the different initiatives varied according to the BPS. Respondents reported a wide variety of disciplines and specialties from acute and community care had been involved in initiatives to promote BPS use. For example, district nurses, health visitors, practice nurses, midwives, specialist nurses, nurses from paediatrics, mental health and learning disabilities were all cited as having participated in local initiatives promoting BPS use. Some initiatives also included nurses from the independent sector, allied health professionals and medical staff.

From the 59 completed proforma, 22 respondents did not comment on the effectiveness of the initiatives they reported and seven reported it was too early to evaluate the effectiveness of local initiatives. For example:

‘[Effectiveness] too early to say – will demonstrate more once – re-audited after action plans implemented’ (Network member).

‘Local guidelines are not yet in practice so difficult to give evidence of [effectiveness] (Director of Nursing).

Nonetheless, there were a few instances where respondents did comment on the effectiveness of interventions, such as the following:

‘[The] incidence of pressure sores [has been] reduced’ (Independent site respondent).

Amongst those returning completed proforma, 30 recommended specific initiatives as being effective in encouraging local BPS use and this information is summarised in Table 12. Specific comments include:

‘Pressure ulcer [BPS] - useful. We now have leg ulcer specialists and clinics so healing rates more prevalent so enhancing patient care’ (NHS Clinical respondent).

‘Facilitate regular updates on progress on implementation Recommend to keep on agenda’ (Network member).

‘The most successful initiatives were the ones which targeted specialist interest groups e.g. pressure care management, nutritional link nurses’ (Network member).

From the 30 respondents recommending local initiatives, it would appear that whilst activities such as dissemination and training were effective, these initiatives worked best as part of an integrated approach to BPS use, which embedded the statements into the Trust/Board culture and enabled practice to be measured against the statements. Such an approach is illustrated below:

‘To put a raft of standards out to staff causes difficulties and is not encouraging. By incorporating [BPS] 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).

4.5 Summary

From all groups of nurses and midwives who participated in this postal survey, there was a high level of support for the BPS, although implementation of the statements was at an early stage. Results also indicate there is an urgent need to raise awareness of the concept and content of the BPS if the potential to benefit patient care from these statements is to be fully realised.

The results of the interviews are presented in Chapter 5.

Table 12: Initiatives recommended to promote BPS use identified via proforma

Type of initiative	Number of responses	BPS	Examples of some comments
Dissemination including local presentations and posters.	15	All five	'Every health centre was visited by the continence advisor who explained the BPS this was very effective' (NHS site respondent) 'Distributed to all clinical areas with attached flier of lead for each statement and contact person' (Network member) 'Development of a Quick Reference Guide to BPS and local launch' (Network member) 'Nurses presented 'real scenarios' of how [the BPS] can be used, [this] was very effective' (Network member) '[Study days are] effective in targeting key personnel who will use and/or should be aware of the statement' (NHS site respondent)
Practice development	8	All except Home Oxygen	'A new continence assessment form has had a definite effect on patient care' (NHS site respondent) 'A continence nurse .. has supported us in establishing a continence clinic' (NHS site respondent) 'Continue to look at resident's care needs supported by BPS' (Independent site) 'Multi-disciplinary working groups for agreeing nutrition charts' (Director of Nursing)
Training including induction	7	All	'Continence Awareness course run by specialist continence nurses' (NHS site respondent) 'Seminars from tissue viability nurse' (NHS site respondent)
Local groups e.g. working, implementation, practice development	6	All	'Practice development forum set up to encourage shared best practice including dissemination of the BPS' (Network member) 'Effectiveness lies in staff discussion as to how they could be used locally' (Network member)
Incorporate BPS into Trust guidelines, protocols or policies	6	All	'Recently nursing protocols have been updated and the BPS are referenced to this has been very effective [through] increased credibility' (NHS site respondent) 'Quality Improvement Group & Practice Development Group developed local guidelines to support practice ... this was helpful in enabling local implementation' (NHS site respondent) 'Has raised awareness, hope to encourage multi-professional approach i.e. involvement of dietitians' (Network member)
Measuring practice against the BPS	5	All except Home Oxygen	'Audit of care plans. Incidence of pressure sores reduced' (Independent site) 'Audit of continence assessments using BPS. Action plans to be developed' (Network member) 'Audit activity was useful to identify practice gaps for action' (Network member)
Local lead or link nurse identified	4	All	'The Quality & Effectiveness Dept. lead the process of implementation ... in partnership with clinicians' (NHS site respondent) 'Local champions identified to lead implementation' (Network member) 'Using the existing system of link nurses ... help the BPS drive local practice in the wards' (Network member)

Chapter 5: Results – Telephone Interviews

The telephone interviews focused on the perspective of nurses involved in BPS development. This chapter outlines the key results from the telephone interviews, including information about current BPS usage amongst interviewees and their role in disseminating their statement and promoting its use. Results are also provided for interviewee reported benefits of the BPS for patients, nurses and midwives.

5.1 Interviewees

All fifteen interviewees were nurses, 11 of whom had a specialist nursing role (for example in continence or tissue viability). With the exception of one, interviewees were still working in areas applicable to their BPS. Interviewees were employed within seven NHS Board areas, and two interviewees worked within Trusts/Island Boards included in the postal survey. The amount and type of data received from the interviewees varied depending on their BPS, current area of practice and level of involvement in implementation. Table 13 indicates which individuals were interviewed for each BPS.

Table 13: Interviewee codes	
<i>Best Practice Statement</i>	<i>Interviewee codes</i>
Continence	1, 2, 3
Pressure ulcer prevention	4, 5, 6
Home oxygen	7, 8, 9
Nutrition (assessment & referral)	10, 11, 12
Nutrition (frail elderly)	13, 14, 15
NB. To maintain anonymity of participants, BPS leaders and other developers have been grouped together. Work details of interviewees have not been described to protect identities.	

5.2 Responses to interview questions

Interviewees were asked 13 questions (Appendix 3). To enable better understanding and flow of reporting, the results of related questions have been presented together.

5.2.1 Extent to which interviewees were currently using their BPS

Fourteen of the interviewees were currently using their BPS, or at least part of it, in their practice. The exception was one interviewee who no longer worked in the area relating to their BPS.

Extent of usage varied depending on the nature of interviewees' current posts. As most interviewees held specialist nursing positions, their BPS use frequently related to training and education, participating in local roll out programmes, integrating the BPS into local guidelines and policies, and incorporating it into quality initiatives such as audit and benchmarking. Use of their BPS also included raising its awareness amongst nurses and midwives both locally and nationally. For example:

'Used [the BPS] as a basis for in-service training, for all levels of staff' (Interviewee 4, L7¹).

'In practice, it's me getting to as many people as possible to disseminate [it] (Interviewee 6, L26).

'From [the BPS] developed local policies of best practice for children and neonates for home oxygen' (Interviewee 7, L2-3).

¹ L = Line number(s).

'We are using it to look at the nutrition pathway across the Trustit's allowing us to use these standards to develop our pathway' (Interviewee 14, L7-11).

Nine interviewees, at least one per BPS, specifically reported that use of their statement by themselves and their colleagues was partial. For example,

'We are aiming to use it in full but there are still one or two areas that need action' (Interviewee 1, L5-6).

The following statement reflected current usage of the BPS by many of the interviewees:

'We are in the early stage of implementing it' (Interviewee 15, L52).

5.2.2 Benefits to patient care from the BPS

All interviewees, except the one no longer working in a relevant area, reported benefits to patients. Benefits varied between the different statements with a mix of broad and specific examples. Details are shown in Appendix 5.

Broad benefits included general statements such as:

'Patients have benefited locally ... through better teaching' (Interviewee 3, L13-15).

'Pressure ulcers in Scotland have never been taken so seriously and treated so professionally' (Interviewee 4, L56-57).

'It has definitely benefited patient care because everybody is getting the same' (Interviewee 9, L14-15).

'BPS benefited patient care nationally through raising awareness of specific nursing issues' (Interviewee 10, L8).

Interviewees indicated the home oxygen and both nutrition BPS produced more specific local benefits to patients than the statements for continence and pressure ulcer prevention. Specific benefits included, the introduction of new documentation such as screening tools, improved care and discharge planning, an increase in appropriate dietetic referrals, dietary changes, policy changes, team working, as well as increased supervision and monitoring of patients.

Interviewees from the specialist areas of continence and pressure ulcer prevention reported the least specific benefits to patient care. One reason for this was that their practice was often reported as being evidence based prior to the launch of the BPS. The arrival of the statement therefore produced little additional benefit for their patients. For example:

'A large chunk of what was presented as best practice was already going on here' (Interviewee 4, L7-8).

'I can't say there has been a great change in benefit because we didn't have that much to implement. Our practice was already fairly good ... we were already doing most of [the statement]' (Interviewee 5, L9-15).

In such cases, the BPS consolidated existing good practice rather than changing it as exemplified by the following:

‘Locally [the BPS] allowed us to formalise practice’ (Interviewee 4, L29).

‘We’re re-affirming to patients and telling [them] that we are actually carrying out best practice’ (Interviewee 6, L9).

Interviewees also reported that patients had benefited from the various BPS because of the emphasis placed on fundamental aspects of care, especially re-focusing on areas previously over-looked. For example:

‘[The BPS has] helped raise the profile of nutrition, it’s become much more of a clinical priority’ (Interviewee 10, L77-84).

‘People are addressing the subject and not just passing it over’ (Interviewee 13, L12-16).

‘It’s put nutrition on the agenda at a local level’ (Interviewee 14, L12-14).

‘It has raised the profile of continence care as something that can have best practice’ (Interviewee 2, L20-21).

‘Locally, it’s allowed us to re-focus on pressure ulcers ‘cos it’s not a major issue in most people’s heads’ (Interviewee 2, L29-31).

5.2.3 How the BPS benefits nurses and midwives

Benefits to staff resulting from the BPS were categorised into four themes:

- Facilitating care management and delivery
- Increasing knowledge and awareness
- Driving local change
- Increased accountability.

Facilitating care management and delivery

This was the most significant theme emerging from the interview data. Eleven interviewees believed the BPS benefited staff in relation to care management and delivery. They reported the BPS benefited staff by encouraging the consistent use of best practice, acting as a resource to guide care planning and delivery, improving communication, and teamworking. Specific quotes include:

‘Ward nurses who’ve said how good [the BPS] was, how helpful it was in developing their continence care planning’ (Interviewee 2, L15-18).

‘Nurses who didn’t quite have an understanding of the incontinent patients, it would lead them in the right direction, like a care pathway’ (Interviewee 1, L14-20).

‘The [statement] is a good framework for nursing homes and ... areas that don’t have a tissue viability nurse’ (Interviewee 5, L13-15).

‘It does encourage everybody to do the same practice and I think that’s important for staff and parents’ (Interviewee 9, L95-98).

‘As a multi-disciplinary team it has brought us all closer together’ (Interviewee 15, L8).

Increased awareness and knowledge

This theme related to the BPS increasing the clinical knowledge of individual nurses thereby improving the quality of care. Five interviewees specifically reported staff benefiting from increased awareness and knowledge, their comments are exemplified by the following:

‘[The BPS] it’s updated us and ... made us stop and think about quite a few things that we hadn’t thought about before it certainly benefits us making us more aware of what we need to look for’ (Interviewee 9, L16-29).

‘Better awareness [of health and safety], for example, carrying oxygen in your car, something I wouldn’t have through twice about before, now are more aware of the dangers’ (Interviewee 7, L24-26).

Importantly, this increased knowledge was considered to make staff:

‘Feel confident and competent in [their] own practice’ (Interviewee 7, L28).

Driving local change

Although only three interviewees highlighted instances of staff using the BPS to drive forward local change, the content of quotes, such as those below, were considered sufficiently important to justify inclusion of this theme.

‘A lot of your G grades will still say ‘soap and water’ ... so, I quote ... the BPS and I think it has helped some of the staff nurses. They can take [the BPS] to the Sister and say, ‘look, it’s down here, it’s recommended that we use the spray and get away from the soap and water’ (Interviewee 5, L54-66).

‘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 outpatient departments’ (Interviewee 3, L75-82).

Increased accountability

Two interviewees reported that the BPS benefited nurses through increased accountability as illustrated by the following:

‘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’ (Interviewee 4, L110-114).

‘We’ve just implemented new turning charts a few nurses have been able to use this when complaints have come in that maybe position hadn’t been changed or patients had been neglected and the Sister has been able to say ... ‘it’s been signed for that the patient’s ... position was changed 3 hourly’. They have that documentation’ (Interviewee 5, L27-33).

5.2.4 Barriers to BPS implementation

All interviewees reported at least one barrier to the implementation of their BPS (Appendix 6). The statement with the least reported barriers was home oxygen.

Lack of resources was the most frequently cited barrier (eight interviewees) including lack of time, specialist nurses, access to equipment and appropriate tools. No interviewees from the home oxygen BPS, reported lack of resources as a barrier.

Access to training, particularly the ability of clinical staff to attend training events, along with resistance to change, were the second most commonly reported barriers (six interviewees each). The following comments exemplify these:

‘It’s time for me to devote to [the BPS], to come up with the training packages and time for the staff to be released to do the training’ (Interviewee 3, L32-33).

‘Local and ... national, the most common problem is this ... ‘we’ve been nursing for years and we know all there is to know about continence’ ... [so] where there’s local training ... [it] tends to be auxiliaries and care assistants that get sent ... they go back to a ward area where the staff are like ‘we’ve been doing it our way for years and we’re not interested’ (Interviewee 2, L44-51).

‘Pressure ulcers ... they’re not some area that people are particularly interested in and people don’t know what they don’t know so they don’t see the point of picking something up [a BPS] because they think their care is perfectly alright, yet things have changed and moved on’ (Interviewee 6, L69-80).

Another significant barrier, reported by five interviewees, was the comment that the BPS are not always seen as important or as a priority for implementation within the Trusts/Island Boards. For example, as guidelines are not policy they do not have to be implemented in full.

Less frequently reported barriers, included access to the BPS, the need for local champions to support the statements, and guideline overload within the clinical area. There was also recognition that barriers to implementation may relate to other professionals and the need to raise awareness of relevant BPS amongst local authority employees. A few interviewees reported very specific difficulties relating to their particular BPS. For example, one interviewee (Interviewee 14) reported that assessing the nutritional status of *all* patients within 24-48 hours of admission was particularly difficult to achieve in practice due to lack of time.

5.2.5 Benefits of BPS

Interviewees were asked to provide comments about potential and actual benefits resulting from the BPS. Ten interviewees reported potential benefits. These could be categorised as better patient care, raising awareness and the profile of particular topics and benefits for staff.

Four interviewees reported multiple ways in which the BPS had the potential to improve patient care including better assessment and management, consistent evidence based practice, and support for obtaining additional resources such as specialist nurses. Raising the awareness and profile of clinical issues could also be considered a means for improving patient care. The following quote summarises how the BPS has the potential to raise awareness of particular topics:

‘Bring[ing] forward again common sense issues that were still being over-looked ... and patient care would improve again as people were addressing that subject and not just passing it over’ (Interviewee 13, L10-16).

Four individuals also reported the potential for the BPS to benefit staff through providing them with a ‘sensible guideline’ to follow (Interviewee 4, L54) which ‘nurses could focus on and identify with’ (Interviewee 10, L82), re-assuring staff that they were providing best practice and reinforcing existing messages of good practice at a local level. Overall, interviewees considered the BPS as having a potential to be ‘a force for good’ (Interviewee 3 L75).

When asked about actual benefits of their BPS, interviewees often responded with multiple answers. Five reported the BPS had actually improved patient care through better assessment, continuity of care and consistent evidence based practice nationally. Four interviewees considered the BPS had improved patient care through raised awareness of their topic:

‘[It] has raised the profile and status of continence care as something that can have a best practice’ (Interviewee 2, L20-21).

‘It has helped raise awareness of nutrition, it’s become much more of a clinical priority’ (Interviewee 10, L77-78).

Three also reported that their BPS had benefited team working. For example:

‘[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’ (Interviewee 10, L 69-76).

Six interviewees specifically reported their BPS had met or exceeded their expectations for benefit. This group included all interviewees from the home oxygen BPS but none from pressure ulcer prevention. This may reflect differences between these statements. In particular, home oxygen applies to a very small group of children whereas pressure ulcer prevention applies to most nursing specialties and midwifery. Also, in some areas good practice in pressure ulcer prevention already existed locally, explaining why some interviewees reported little benefit in their areas post BPS launch.

The remaining interviewees reported that actual benefit had been minimal, often localised to specific units rather than Trust wide, or that it was too early to assess benefits. The following quote illustrates these views:

‘It didn’t make an initial huge impact but I don’t think these things generally do. I think it’s coming through but it’s gradual’ (Interviewee 12, L65-67).

There was specific acknowledgement by five interviewees that future impact depended upon keeping the BPS ‘live’ (Interviewee 3, L73) otherwise ‘people [would] just let things slide’ (Interviewee 13, L38-39), especially as ‘effectively they don’t have any teeth’ (Interviewee 10, L116-117) and ‘there is no compliance mechanism ... [to give the BPS] real power’ (Interviewee 4, L19-22).

5.2.6 Participation of interviewees in initiatives to encourage BPS use

Thirteen interviewees reported participating in local or national initiatives to promote use of their BPS. The nature of initiatives participated in and frequency of response are shown in Table 14.

For those interviewees who had participated in initiatives to encourage BPS use, seven reported multiple roles, for example, participation in dissemination, training and/or quality initiatives. Project leaders reported disproportionately participating in more initiatives than other developers. Although it is possible other developers under-reported such work, it seems those with a lead role during the development phase continued to have a lead role in encouraging BPS use post development.

Table 14: Participation of interviewees in initiatives to promote use of their BPS	
Distribution & dissemination	6/13 interviewees
Training	4/13 interviewees
Quality initiatives e.g. audit, benchmarking, standard setting, developed policy of best practice, re-design, review of existing services	4/13 interviewees
Rolled out use of the BPS in local areas	2/13 interviewees
Participated in local meetings to discuss or oversee implementation	2/13 interviewees
Developed an abbreviated A4 sized summary for local use	1/13 interviewees
Set up a nutritional link nurse network	1/13 interviewees

5.2.7 Role of interviewees in disseminating their BPS

All interviewees reported having a role in the dissemination of their BPS, although the extent and nature of this varied considerably (Table 15). Project leaders were again disproportionately more active than other developers in disseminating their BPS. For example, project leaders participated in all but one of the national events, and wrote all the publications raising awareness of the BPS.

Table 15: Role of interviewees in dissemination of their BPS	
Oral presentations excluding launches: National Local	7/15 interviewees (7) (4)
Local training	6/15 interviewees
Distributed to specific nursing groups locally or nationally e.g. link nurses or specialist groups	4/15 interviewees
Publications	4/15 interviewees
National NMPDU launches	3/15 interviewees
General awareness raising at local level	2/15 interviewees
Poster presentations: National Local	2/15 interviewees (1) (1)
Lectures to student nurses	2/15 interviewees
Acted as a local point of contact for the BPS	2/15 interviewees

Local presentations included Trust nursing or clinical effectiveness events. National presentations included specialist events, such as a national wound care conference, and generic events, such as NT Live. Two interviewees presented outwith Scotland.

Articles publicising the BPS were reported as being published in the Nursing Times, an RCN specialist newsletter and the British Journal of Community Nursing. One interviewee had written a chapter in a book, which included reference to the BPS. Interviewee comments about their role in dissemination included:

‘I haven’t had the time to roll it out more and raise awareness’
(Interviewee 3 L59-61).

‘I’m going through the LHCCs and the practice development nurses and I’ve worked really hard to get them to then disseminate it further’
(Interviewee 6, L114-117).

‘[I’m] ensuring every clinical area has a [copy of the] statement’
(Interviewee 5, L74).

‘[I] send the BPS to [district nurses and health visitors] if they’ve got a baby going home on oxygen’ (Interviewee 8, L73-76).

5.2.8 Suggestions for encouraging future use of the BPS

All interviewees provided suggestions for encouraging future use of their BPS. The nature and frequency of these are shown in Appendix 7.

Raising awareness of the BPS was the most common suggestion, cited by eight interviews across all five statements. Although some interviewees suggested awareness raising generally, others gave specific suggestions. Additional resources including training and education were the second most common suggestions, cited by seven interviewees. Amongst those interviewed, only those representing the home oxygen BPS did not suggest training or education.

5.2.9 General comments about the BPS

For general comments about the BPS not already mentioned, see Appendix 8. Overall comments about the BPS were extremely supportive, for example:

‘I think they are a good thing, they’re a very good thing for nursing’
(Interviewee 8, L170).

5.3 Summary

The telephone interviewees were enthusiastic supporters of the BPS and their specialist role in BPS development nationally and local implementation gave them additional insight into the dissemination, support and impact of these statements. Although interviewees acknowledged that BPS implementation was in its early stages they were able to report actual benefits of the statements for patients, nurses and midwives.

In Chapter 6, results from the postal survey and interviews are used to answer the research objectives.

Chapter 6: Relating Results to Research Objectives

In this chapter, data from the questionnaires, proforma and telephone interviews have been used to answer the research objectives. The objectives relate to awareness of the BPS, extent of usage, benefits to patients, nurses and midwives as well as systems for dissemination and support.

6.1 Objective: To determine awareness of the first five BPS amongst a representative sample of nurses and midwives working in clinical practice, practice development and management across Scotland.

General awareness

- Almost all (99%) Director of Nursing and Network respondents were aware of the BPS prior to the evaluation, but less than half (45%) of all Clinical respondents were.
- The level of BPS awareness varied between the eight clinical sites from 29-58%. The lowest level of awareness was in the independent site and the largest NHS site.
- 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 BPS.
- Clinical respondents in part-time employment and in practice for less than ten years were least likely to be aware of the BPS.

Specific awareness

- Amongst all respondents, knowledge of the pressure ulcer and continence BPS was highest (approximately 75%) and lowest for home oxygen (48%) and nutrition (assessment and referral) (67%).
- More than three quarters of all Director and Network respondents knew of all five BPS but only a minority of Clinical respondents did, less than 20%.

How and when respondents became aware

- Three quarters of Clinical respondents (77%) had known of the BPS for less than a year, that is, since their launch. Three quarters of Director and Network respondents (79%) had known about the BPS for over a year, that is, prior to their launch.
- Amongst all respondents, the most popular routes for learning about the BPS were from employers (36%), receiving a personal copy (36%), and reading about them in a journal (31%).
- Respondents were least likely to have heard about the BPS from a national (12%) or local (7%) launch or directly from the NMPDU (5%).

6.2 Objective: To determine within this sample the extent to which the BPS are currently being implemented, including identification of benefits of the BPS on practice.

Usage:

- Significant or key parts of the BPS were more likely to be used than the full document.
- For all BPS, except pressure ulcer prevention, more respondents reported planning to use the statements than were currently using them with *all* relevant patients.
- Where the BPS were being used, pressure ulcer prevention was reported as being used the most with all or some relevant patients (by 48% of respondents).

- Amongst Clinical respondents, the BPS for pressure ulcer prevention, continence and nutrition (frail elderly) were currently being used the most with all relevant patients, although, this was only by a quarter of respondents.
- From questionnaire data, when the BPS are being used, they are integrated into local clinical guidelines or standards, used in the development of care plans or used for audit and teaching purposes.

Benefits for patients:

- For those indicating the BPS applied to their area, only a small minority considered the BPS to have no benefits for patients, less than 10% of questionnaire respondents.
- The BPS most cited by respondents as producing major benefits to patients were pressure ulcer prevention (42%) and continence (36%).
- Where survey respondents specified how the BPS benefited patients (n=24), the largest category of responses related to quality improvement, including facilitation of evidence-based practice, standardised care, benchmarking and raised awareness of the topic amongst nurses and midwives.
- A small minority of questionnaire respondents, (n=8), reported their care was evidence based prior to the BPS. In such cases, introduction of the BPS resulted in only minor adjustments to local patient care.

Benefits for nurses and midwives:

- For those replying to this question, the majority reported the BPS resulted in major or minor benefits to nurses and midwives.
- Overall, the BPS for pressure ulcer prevention was considered to have most benefit for nurses and midwives with 40% indicating major benefits. The BPS for continence and nutrition (frail elderly) were ranked second and third for producing major benefits to nurses and midwives by over a third of respondents.
- Where questionnaire respondents specified how nurses and midwives benefited from the BPS, the largest categories of responses related to the availability of good evidence on which to guide practice (n=25), raised awareness of the topic (n=11), positive reinforcement of existing good practice (n=7), and from local discussion and agreement of good practice (n=7).

Barriers to BPS use:

- Overall, the pressure ulcer BPS had the least barriers reported, and nutrition (assessment and referral) the most.
- Director and Network respondents reported more barriers to BPS use than Clinical respondents.
- From the survey, the most frequently cited barriers to BPS use were lack of resources; especially time, staff and training, perceived relevance of the BPS to practice, the huge number of other guidelines, the need for a structure for implementation, and lack of awareness and understanding of the BPS.

6.3 Objective: To explore the benefits of the BPS on practice from the perspective of a sample of nurses and midwives from the five BPS development groups.

Benefits to patients:

- All but one interviewee reported that the BPS had benefited patient care.
- Interviewees reported patients benefited generally through raised awareness of particular topics and increased emphasis on fundamental aspects of care. As a result, nurses re-focused on previously overlooked topics, regarding them as clinical priorities.
- Patients also benefited through consistent practice, better trained nurses and midwives, integration of the BPS into local guidelines and policies, and incorporation of the BPS into audit and benchmarking activities.
- Specific patient benefits included new documentation, improved care and discharge planning, policy changes, and increased supervision and monitoring of patients.
- Interviewees for the continence and pressure ulcer BPS reported the least specific benefits to patient care, indicating their BPS often served to consolidate existing good practice rather than change practice.

Benefits to nurses and midwives:

- From the accounts of interviewees, the BPS benefited nurses and midwives by facilitating care management and delivery, increasing knowledge and raising awareness, driving local change, and increasing accountability.

Maximising benefits from the BPS:

- The most commonly cited interviewee suggestions for encouraging BPS use were awareness raising, additional resources including training and specialist nurses, local champions and leaders, improved dissemination and feedback on performance

6.4 Objective: To identify and review systems for BPS dissemination and support.

- Whilst the majority of Director and Network respondents owned copies of the BPS, most Clinical respondents did not. The highest clinical ownership of any of the BPS was for continence (32%).
- The majority of Network, Director respondents and Clinical respondents could access the BPS directly.
- Less than 6% of all respondents reported that it was difficult to access the BPS but an additional 30% of Clinical respondents did not know how to access the statements.
- Once aware of the BPS, the most popular routes for accessing the BPS were within the local working area or via the NMPDU web site.
- Key suggestions for improving future BPS dissemination from the postal survey were increasing the distribution of hard copies (n=13), education including workshops (n=9), and increased dissemination of BPS via line managers and supervisors (n=9).
- Interviewee suggestions for improving dissemination included poster versions of the BPS, A4 sized BPS Quick Reference Guides and more hard copies of the statements. Specific suggestions for BPS awareness raising included ensuring all relevant libraries had copies of the BPS and using others, such as academic staff, to promote the BPS.

6.5 Objective: To identify local examples of good practices which have maximised use of the BPS.

Recommended initiatives:

- From the 353 returned proforma, 59 respondents (17%) reported local initiatives to support BPS use. Nevertheless, only 30 respondents recommended initiatives considered effective in encouraging local use of the BPS.
- Dissemination, practice development, training, the use of local groups, incorporating the BPS into clinical guidelines, measuring practice against the BPS, and having local leads identified were all recommended as effective. Such initiatives worked best as part of an integrated approach, which embedded the BPS into the NHS Trust/Board culture and enabled practice against the statements to be measured.

Drivers encouraging BPS use:

- All questionnaire groups reported drivers encouraging BPS use. Most drivers were reported for continence and pressure ulcer prevention.
- From the postal survey, the most commonly cited drivers promoting change were specialist nurses and local leaders.
- Interviewees most commonly considered additional resources, including training and specialist nurses, awareness raising, local champions and improved dissemination as key drivers encouraging BPS use.

6.6 Objective: To make recommendations for maximising the impact of the BPS on future nursing and midwifery practice

Recommendations for future practice are shown in Chapter 9.

Chapter 7: Discussion

Results of this evaluation raise several points about the study and the BPS, which are considered within this chapter. In relation to the study, the response rate and limitations are discussed. Key points relating to the BPS, that is awareness of and access to the statements, benefits to patients, nurses and midwives, drivers and barriers to BPS use, are also discussed.

7.1 Response rate - postal survey

The postal survey returned 539 (42%) questionnaires and 353 (28%) proforma. Whilst these rates are acceptable, return rates would have been higher if the evaluation had been conducted over a longer period, as there would have been time to actively promote the project within the clinical sites. Also questionnaires and proforma returned after the closing date would have been included in the data.

Network and Director respondents returned the most questionnaires (79%) and proforma (55%). This was to be expected given their close connection with the former NMPDU and their greater awareness of the BPS. The much lower clinical response for questionnaires (39%) and proforma (25%) might also have been expected for several reasons. Firstly, an earlier evaluation of the Australian equivalent to the BPS reported only a 27% response rate (Joanna Briggs Institute, 2002). Secondly, the relatively recent launch of the BPS (June 2002) and the time taken for information to cascade down the clinical hierarchy and across Scotland, would suggest lower clinical awareness of the statements and therefore lower participation in the study. Thirdly, the diverse nature of the five BPS being evaluated meant it was not possible to target the postal survey to particular nursing or midwifery specialties. As NHS clinical participants were randomly selected it was therefore possible that some recipients did not respond because they considered that these BPS did not apply to their area.

As regards the proforma, which asked about local initiatives, a higher response rate could have been expected since, where respondents were unaware of initiatives; they were asked to return a blank proforma. Nonetheless, it is likely that where respondents had nothing to report, some of them chose not to return the proforma. Regardless, although 353 proforma were returned, only 59 of these detailed local initiatives to support BPS use, and 30 recommended any of these initiatives as effective in encouraging BPS use locally. Such low figures suggest that the current level of local activities to encourage BPS use, or at least awareness of them, is very low.

The overall return rate for the questionnaire and proforma were reasonable given the circumstances in which the evaluation was conducted and the experience of the similar study previously undertaken by the Joanna Briggs Institute.

7.2 Limitations of the study

This evaluation was an exploratory study undertaken within a relatively short period following the launch of these first five BPS. The study was therefore designed to gather a breadth of information from the clinical sites, Network members and Directors of Nursing about all five statements. Results reveal there is a need to investigate the impact of the individual BPS in more detail at a later stage.

Within this initial study, the postal survey was not targeted to recipients in particular disciplines because the BPS being evaluated were diverse in nature, potentially relevant to many nursing specialties and midwifery. If future evaluations focus exclusively on individual BPS, such a focused approach should facilitate the gathering of more detailed data on dissemination, support and implementation, providing more depth of insight, especially in relation to clinical outcome.

This evaluation also focused on BPS impact from the perspective of nurses and midwives. Such a focus was adopted in recognition of the relatively recent launch of the BPS and the length of time taken for information to cascade down the clinical hierarchy. In these circumstances it was considered by the research team too early to investigate the topic from the patient perspective. However, it would be appropriate to include this aspect in any future evaluations.

All of the first five BPS launched in 2002 were included in this evaluation. Of these five statements, four had broad applicability but one, home oxygen therapy for children being cared for in the community, was very specialist in nature and was only relevant to a small minority of nurses and midwives participating in this study. It is therefore not surprising that knowledge and use of this statement was reported to be low amongst questionnaire participants. Nonetheless, from the interviewees and the few questionnaire respondents who were using this statement, considerable benefits to patient care were reported resulting from this BPS.

7.3 BPS awareness

It takes considerable time for information to be disseminated down a hierarchy and across the many nursing specialties and midwifery. It was therefore not surprising that only half (53%) of all respondents were aware of the BPS prior to receiving the questionnaire. Neither was it unexpected that awareness would be greatest amongst Director and Network respondents, nor that there would be a significant association between clinical grade and BPS awareness (Tables 4.5 and 4.6). While the distribution of questionnaires and information leaflets to over 1000 clinical staff, may itself have had a role in raising awareness of the BPS, it seems that more must be done both locally and nationally to continue to raise awareness of the BPS especially amongst the lower clinical grades and the independent sector.

Director and Network respondents were more likely to have heard about the BPS from receiving personal copies or attending national launches, whilst Clinical respondents learned about the BPS from their employers, journals and colleagues (Table 4.10). The importance of dissemination is underlined by the variations in knowledge between the NHS clinical sites. For example, NHS site 6 had the highest level of BPS awareness (59%) whereas NHS site 3 reported lowest awareness (30%) (Table 4.5). There may be local explanations for such difference, for example disseminating BPS information would be harder in NHS site 3 as it was the largest site. The completed proforma also suggest a lower rate of initiatives to promote BPS use in this site compared to the other sites, which would affect local dissemination and awareness.

This evaluation suggests that nurses and midwives need to be aware of both the existence and content of the BPS. Amongst those aware of the BPS as a concept, many were unaware of the specific content. When asked, large numbers of respondents indicated the BPS did not apply to their practice. However, other data would suggest that some respondents choosing this option were unable to recognise the possible application of the BPS to their practice. For example, two labour ward midwives indicated the pressure ulcer statement did not apply to them; a cardiac rehabilitation nurse stated none of the BPS applied; and some respondents working in out-patient Departments were not aware that the BPS, such as continence, could apply to patients attending clinics.

Informing clinical practitioners about the existence and, just as importantly, content of new and existing BPS is essential if the statements are to benefit patients. The results of this evaluation indicate that multiple methods are required to inform the different groups of nurses and midwives about the BPS. As with previous research on the dissemination of guidelines, for example Thomas et al (1999), to be effective, distribution needs to be active and linked to other mechanisms such as educational initiatives.

The four BPS with the widest applicability to practitioners are pressure ulcers, continence and the two nutrition statements. Data from this evaluation also indicate that awareness of these BPS is greater where there is a close association between the statement and a specialist clinical area or grouping. The BPS for pressure ulcers and continence are affiliated to specialist tissue viability and continence nurses. Nutrition (frail elderly) is associated with the specialty of elderly continuing care. Specialist networks for continence, tissue viability and continuing care have acted as clinical champions, raising awareness of these statements and driving forward implementation. By comparison, nutrition (assessment and referral) is not specifically associated with any clinical specialty, which may explain why it is the least known of the four mainstream BPS. If BPS awareness is greater where statements are clearly associated with particular clinical specialties and networks, this has implications for the choice of future BPS topics and project leaders.

Since the launch of the BPS, project leaders (with the exception of one no longer working in an area relevant to their BPS) have taken a lead role in promoting awareness and use of their statement locally and nationally. These individuals have therefore continued with their role as clinical leader for their BPS beyond the development phase. Taking on a role as champion, the developers have been promoting use through specific initiatives and raising awareness through presentations and publications. This suggests that when future BPS developers are appointed, consideration should be given as to how these individuals will continue to lead on their statements after development. Importantly, given the key role of the project leaders in promoting their BPS post development, when a leader is unable to continue in such a role, a replacement should be formally appointed.

7.4. Access to the BPS

Although clinical practitioners do not need to own a personal copy of a BPS to implement it, increased access to statements is essential if their use is to be encouraged. Access to the BPS was easiest for Director and Network respondents as the majority had their own copies of the statements unlike Clinical respondents, where less than a third of respondents had a copy (Table 4.18). Also, direct access to the BPS was greater for Director and Network respondents (94%) than Clinical respondents (65%) (Table 4.19).

For Clinical respondents who knew of the BPS, the most frequently reported routes for accessing the statements were through the work place and the NMPDU website (Table 4.21). Ironically, only 9% used the website to first learn about the BPS (Table 4.10). It therefore seems that whilst Clinical respondents are unlikely to use the website to initially find out about the BPS, once aware of the BPS they do use this route to obtain specific information, if they have IT access.

The majority of respondents suggested increasing the distribution of hard copies and increasing dissemination both horizontally and vertically. To achieve this, NHS QIS and NHS Trusts/Boards must work together to develop a strategy for dissemination, addressing the information needs of nurses and midwives working in the NHS and independent sector. Such a strategy could include full copies of the BPS, Quick Reference Guides and Internet access. Messages informing staff of new BPS, and directing them to the NHS QIS website, might also be included in pay slips and updates in local newsletters.

Some questionnaire respondents and interviewees also identified the need to inform other groups about the BPS and to ensure they also have access to the statements. Other groups identified included student nurses and midwives as well as academic staff. In response to the Joint Futures agenda, local authority employees were also identified as another group requiring knowledge of and access to the BPS.

7.5 Benefits for patients

Given that three quarters (77%) of Clinical respondents had only heard of the BPS, since the launch of the statements, and 8% within the last month before the evaluation, awareness of the BPS amongst nurses and midwives is at a relatively early stage (Table 4.9). As a result, it is not surprising that the reported benefits to patient care from the BPS were limited (Tables 4.14).

As with SIGN guidelines, the potential for the BPS to benefit patient care is also dependent on them being considered a priority for implementation within the NHS Boards and the Independent sector (CRAAG 2002). From the interviews and questionnaires, it is apparent that BPS implementation is not always considered to be a priority. It is possible that the variable level of BPS awareness and of initiatives to promote local use within clinical sites may be a reflection of the different levels of priority assigned to BPS implementation.

Throughout the evaluation, participants reported it was too premature to specifically comment on the benefits of BPS to patients. Interviewee 4 summarised this by comparing the BPS with SIGN guidelines:

‘This question is two years too early for me. If you look at the SIGN leg ulcer guidelines, within a year, it hadn’t made much of an impact’ (L64-65).

Although BPS use in clinical practice is in its infancy, there was evidence from questionnaire respondents and interviewees that all statements had improved patient care. These improvements included facilitating evidence based practice and standardising care usually through integration into local guidelines and protocols as well as enabling measurement of performance through benchmarking and auditing. Patient care was also reported as benefiting from increased awareness of the topic, which enabled nurses and midwives to re-focus on aspects of care which had previously been overlooked, making them clinical priorities.

Importantly some interviewees, and a minority of respondents reported that availability of the statements had done little to improve patient care because existing practice was already good. These participants reported that their practice, especially in pressure ulcer prevention and continence care, had been predominantly evidence based prior to the BPS. As a result, the BPS had only benefited patients in these areas through minor adjustments to existing services. Availability of the BPS, in such instances, had therefore served to re-affirm existing good practice rather than introduce significant levels of new practice.

Amongst all study groups, the BPS for pressure ulcers, continence and nutrition (frail elderly) were reported most frequently as having major benefits to patient care (Table 4.14). This perception may reflect greater awareness of the content of these BPS, and their close association with specific areas of practice. For pressure ulcer and continence, greater recognition of the perceived benefits of the BPS may also reflect the role of specialist nurses in raising awareness and training. This recognition also seemed to be shared by those participants who identified specialist nurses as a primary driver encouraging local BPS use.

Overall, the number of respondents reporting the BPS had no benefits to patient care were small, less than ten percent, although two or three times this number of respondents reported the BPS did not apply to their area of practice (Table 4.14). As questionnaires were sent out randomly, it is possible the BPS did not apply to large numbers of respondents. From the data, however, it seems that lack of detailed knowledge about the BPS meant some respondents simply assumed from the title that the statements did not apply to them.

If the future potential of the BPS to benefit patient care is to be realised, it is essential that awareness of the statements be raised amongst those within nursing and midwifery who are currently unaware of the BPS applicable to their practice. Encouraging use of the BPS amongst this group, combined with the 19-29% of Clinical respondents *planning* to use the BPS for continence, pressure ulcer and nutrition (frail elderly) (Table 4.12), suggests the BPS have real potential for maximising benefits to patients in the coming years. Most importantly, actual benefits to patients resulting from the BPS needs to be determined through patient focused evaluation at a later date.

7.6 Benefits to nurses and midwives

In addition to the early benefits to patients from the BPS, the statements were also reported as having a positive effect on nurses and midwives. The BPS most frequently cited as benefiting professionals were; pressure ulcer prevention, continence and nutrition (frail elderly) (Table 4.15). Although primarily developed to benefit patients, within this evaluation the BPS are also personally benefiting nurses and midwives. Such benefits are important, particularly as a means for encouraging greater use of the BPS in future.

From the interviewees, nurses and midwives benefited as the BPS facilitated care management and delivery; increased knowledge and awareness; acted as drivers for local change and increased accountability. These themes were also supported by questionnaire and proforma data. In the main, the availability of good practice within the BPS benefited nurses and midwives by encouraging consistent evidence based practice in areas where it did not previously exist. In areas where good practice existed prior to the BPS, the statements served to re-affirm good practice, increasing the confidence and credibility of those practitioners.

7.7 Drivers and barriers to BPS use

If maximum benefits are to be derived from BPS use, it is essential that barriers to their implementation are overcome. The barrier most frequently cited by questionnaire respondents and interviewees was resources, including time and training (Table 7). Other barriers reported via the questionnaires and interviews included perceived relevance of the BPS to practice, guideline overload, lack of understanding and awareness of the BPS and resistance to change (Table 7 and Appendix 6). These findings are similar to barriers previously identified for the implementation of clinical guidelines and research (Feder et al 1999, Marshall et al 2001, McInnes 2001, CRAG 2002).

As Walter et al (2003) identified, such barriers can be overcome by planned actions including targeting the context in which the impact is desired; ensuring credibility through strong evidence and endorsement from clinical leaders; financial and technical support and integration into organisational systems. All data indicated that planned actions were used to facilitate use of the BPS. Data from the evaluation also supports the recent SIGN guidelines evaluation (CRAG 2002), which identified the availability of local champions or clinical leads and the need for topics to be considered high local and national priority as factors required for successful implementation.

The drive for evidence-based practice has resulted in the availability of many clinical guidelines and national standards, and the introduction of the BPS has added to this wealth of data. Unfortunately, this appears to have often confused some within nursing and midwifery as to the priorities for implementation. If benefits to patients and professionals from the BPS are to be maximised in the future, it is vital these statements are regarded as a priority not just by nurses and midwives, but also by the health service generally. It is therefore essential that links between the BPS and other national quality initiatives, especially NHS QIS standards and SIGN guidelines, are maximised as a means of raising the profile of the BPS and reinforcing their priority for implementation.

Where clinical champions and leaders are concerned, this evaluation shows such individuals exist at two levels, locally and nationally. Nationally, the BPS project leaders, with the exception of one, are still continuing to act as clinical leaders during this initial dissemination and implementation stage. They are continuing to take a lead role in promoting their BPS across the UK, as well as adopting a central role in local implementation through training and other initiatives.

In addition to the national clinical leader, where the BPS relates to a particular specialty, local specialists have taken on a role as clinical champion, again promoting awareness and supporting implementation locally. As a result, the specialist BPS relating to pressure ulcer prevention and continence appear to lead the field amongst these first five BPS, facilitated by tissue viability nurses and continence advisors working within the NHS Boards and independent sector. Of the five BPS evaluated, nutrition (assessment & referral) is not closely associated with any clinical specialty and as a result its awareness and implementation appears to be at a lower level than the other mainstream BPS, that is continence, pressure ulcer prevention and nutrition (frail elderly). The role of clinical leaders in maximising future BPS impact therefore appears to be very important, and has implications particularly when a new BPS is not closely associated with a clinical specialty or where specialist nurses are not employed, for example in the independent sector.

Finally, the BPS are a new initiative and as such resistance to change and adoption of these statements is to be expected. The desire and need to change at local level could be encouraged if audit and/or benchmarking tools were developed as part of the BPS. Use of such tools locally would clearly identify sub-optimal performance, and which could be improved through BPS use. At the moment, some areas are spending time developing audit tools, time which could be saved if these tools had been incorporated into the BPS by the NMPDU and NHS QIS at the time of development. Standardised audit and/or benchmarking tools would also enable future BPS use to be measured consistently across the country. Such an approach could also facilitate future evaluation of the BPS, both process and outcome.

7.8 Summary

This evaluation was initiated less than a year after the launch of the BPS and was undertaken within a short six months time period. Time therefore influenced and constrained what was feasible within this exploratory study. It would therefore be appropriate to investigate the findings of this study, such as barriers and drivers influencing BPS use, at a later date. It is also important that a detailed examination of the impact of the BPS from the perspective of patient benefit is also undertaken.

Chapter 8: Conclusion

This evaluation was commissioned less than a year after the launch of the first five BPS. As such, the capacity of these statements to benefit patient care during this short period was always likely to be limited. Nonetheless, from the nursing and midwifery participants in this evaluation, there is early evidence that the BPS have benefited patients, nurses and midwives. In particular, the BPS are starting to achieve what they were designed to do; that is, increase quality improvement through the consistent use of evidence based practice amongst nurses and midwives working in Scotland.

Such clinical benefits can, however, only be achieved if nurses and midwives are aware of the BPS and able to access them. From this evaluation, the majority of clinical respondents, especially those in lower grades, are currently not fully aware of the BPS applicable to their area of practice. Awareness of the BPS amongst clinical staff therefore needs to be raised, as a matter of urgency, by appropriate local and national bodies working together.

Although it was too early for this evaluation to capture detailed clinical outcome data, it seems that the BPS do have the potential to considerably benefit patients 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.

Based on this evaluation, the full potential for the BPS 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 evaluation focusing on clinical impact from the patient perspective.

Chapter 9: Recommendations for Future Practice

Just as the BPS should act as a 'basis for developing and improving care' (NMPDU 2002b), it is hoped this evaluation has a similar role in encouraging future BPS use. To that end, based on data from the different elements of this nursing and midwifery focused study, the following recommendations have been identified.

9.1: Continuation of the BPS programme

- 9.1.1 The development of BPS for nurses and midwives should continue. However existing NHS QIS processes for BPS development and support should be systematically reviewed in the light of this evaluation and action taken where appropriate.
- 9.1.2 Consideration should be given to maximising links between the BPS and other national quality initiatives, especially NHS QIS standards and SIGN guidelines, as a means of encouraging their use.
- 9.1.3 The process for selecting BPS topics needs to be reviewed to ensure that new BPS are relevant to nurses and midwives, address national priorities and integrate clearly with any other relevant national quality initiatives. Where possible, consideration should be given to ensuring that future BPS topics are linked to specialist groups and networks that can support local implementation.
- 9.1.4 Careful consideration should be given to the choice of future BPS titles as readers appear to make assumptions about the relevance of each statement based on title alone.
- 9.1.5 Future BPS project leaders should be selected not just on their ability to complete development, but also on their ability to function as a clinical leader after the launch of their BPS and to participate in relevant specialist groups and networks. Systems should be put in place to ensure project leaders continue to formally liaise and work with NHS QIS, post BPS launch.
- 9.1.6 Each new BPS should clearly state to which nursing and midwifery disciplines and specialties it applies as well as to which care sectors.
- 9.1.7 During development of the BPS consideration should be given as to whether key parts of each BPS should be identified as priorities for local implementation.
- 9.1.8 A Quick Reference Guide should be developed alongside the full statement.
- 9.1.9 Where possible, systems should be put in place to share local good practice in BPS implementation nationally. Consideration should be given to actively sharing resources such as training packs, posters and assessment tools that have been developed within clinical areas.
- 9.1.10 Audit and/or benchmarking tools should be developed, and incorporated into the BPS. Consideration should also be given to establishing national reporting mechanisms to encourage local compliance with the BPS.

9.2: Review of the first five BPS

- 9.2.1 Nurses and midwives working at all levels of clinical practice in the NHS and the independent sector, along with local authority employees, need to be better informed of these BPS.
- 9.2.2 Quick Reference Guides should be developed summarising key BPS points.

- 9.2.3 Each of the BPS should have an identified clinical leader who liaises regularly with NHS QIS. Where project leaders are no longer able to continue in such a role, a new clinical leader should be formally appointed by NHS QIS.
- 9.2.4 Within each existing BPS the type of nurses and midwives, along with the care sectors, to which the statement applies, should be clearly identified in the document.
- 9.2.5 The title of each existing BPS should be reviewed to ensure it is not preventing clinical staff seeing the relevance of its content.
- 9.2.6 Where possible, systems should be put in place to share local good practice in BPS implementation nationally. Consideration should be given to actively sharing resources such as training packs, posters, assessment and audit tools that have been developed within clinical areas.
- 9.2.7 Audit and/or benchmarking tools should be developed, and incorporated into the BPS during any revision process. Consideration should also be given to establishing national reporting mechanisms to encourage local compliance with the BPS.

9.3: Awareness raising

- 9.3.1 Better procedures need to be put in place to ensure that nurses and midwives working clinically within the NHS and the independent sector are informed about existing and new BPS as soon as possible, especially those working in lower grades.
- 9.3.2 Disseminating information about the BPS requires local and national bodies to work in partnership, particularly NHS QIS, NHS Boards and the independent sector. Such bodies should work together to develop a strategy for BPS dissemination.
- 9.3.3 Awareness raising needs to involve a variety of approaches, including greater dissemination of hard copies targeted to appropriate staff groups, fliers promoting the BPS website, and local options for disseminating information such as newsletters and pay slip messages.
- 9.3.4 Steps should be taken to include student nurses and midwives, academic staff and local authority employees working in care homes in the dissemination process.
- 9.3.5 Short articles on each new and revised BPS should continue to be published in mainstream journals accessible to clinical nurses and midwives.
- 9.3.6 Consideration should also be given to providing updates within the news section of national newsletters and bulletins such as those produced by the Royal Colleges of Nursing and Midwives.
- 9.3.7 Consideration should be given as to whether the national launches should continue in the present format or whether resources could be used more effectively on alternative promotional events. For example, printing more hard copies, producing posters and/or fliers promoting the BPS and NHS QIS website.

9.4: Implementation

- 9.4.1 Implementation of the BPS needs to be seen as a local and national priority. Links between the BPS and other national quality initiatives, especially NHS QIS standards, should be maximised as a means of raising the profile of the BPS and reinforcing their priority for implementation.
- 9.4.2 The process for selecting BPS topics needs to be reviewed to ensure that new BPS are relevant to nurses and midwives and address national priorities thereby maximising the potential for implementation.
- 9.4.3 Consideration should be given as to how other national bodies, such as the Centre for Change and Innovation, could support BPS implementation.
- 9.4.4 Consideration should be given to prioritising the content of future BPS to clearly identify points, which should be implemented as a matter of priority.
- 9.4.5 An audit tool should be included in all BPS to assist local and national implementation through the measurement of performance.

9.5: Future benefits to patients

- 9.5.1 Detailed evaluation focusing specifically on clinical benefits to patients resulting from some, or all, of the first five BPS should be initiated within the next two to three years.

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Glossary

Best Practice Statement (BPS)	A national statement to describe best and achievable practice in a specific area of nursing and midwifery (NMPDU 2002b).
Guideline	Systematically developed statements which assist in decision making about appropriate health care for specific clinical conditions (CSBS 2001).
NHS Quality Improvement Scotland (NHS QIS)	NHS QIS was established in January 2003 as a result of bringing together former national bodies including the Clinical Standards Board for Scotland and the Nursing & Midwifery Practice Development Unit. The purpose of NHS QIS is to improve the quality of healthcare in Scotland by setting standards and monitoring performance and providing NHSScotland with advice, guidance and support on effective clinical practice and service developments (NHS QIS 2003).
Nursing & Midwifery Practice Development Unit (NMPDU)	This national unit had a broad remit which included identifying and sharing good practice within nursing and midwifery across Scotland. This included development of the BPS.
NMPDU Network	A network of 'link' nurses and midwives across Scotland set up to help disseminate information from local to national and national to local level. There are network representatives from every Trust in Scotland, every academic department, NHS related bodies and the independent sector (NMPDU 2003).
Scottish Inter-collegiate Guideline Network (SIGN)	SIGN is responsible for systematically developing multi-professional national clinical guidelines based on systematic reviews.
SHOW	On line health information provided by NHSScotland available at: www.show.scot.nhs.uk

☐☐☐☐☐

Study of the Impact of the NMPDU Best Practice Statements

Please complete the following questions.

Section 1: Some Information about the Best Practice Statements

1. Before receiving this questionnaire, did you know the Nursing & Midwifery Practice Development Unit (NMPDU) had produced Best Practice Statements (BPSs) to guide nurses and midwives working in Scotland with specific areas of their practice? (tick one box)

Yes ☐

No ☐

If no, please go to section 2, page 5. If yes, please continue.

2. Which of the following BPS do you know of? (tick all that apply)

Continence in adults with urinary dysfunction

Yes ☐

Home oxygen therapy for children being cared for in the community

☐

Nutrition assessment & referral in the care of adults in hospital

☐

Nutrition for physically frail older people

☐

Pressure ulcer prevention

☐

NB: Statements will now be abbreviated to continence, home oxygen (children), nutrition (adults in hospital), nutrition (physically frail), and pressure ulcers.

3. When did you first learn about the BPSs? (tick one box)

Within the last month

☐

Within the last 2 - 6 months

☐

Within the last 7 months to 1 year

☐

Between 1 to 2 years ago

☐

Over 2 years ago

☐

4. How did you learn about the BPSs? (tick all that apply)

Read about them e.g. in a journal

☐

Read about them on the NMPDU web site

☐

Received a personal copy

☐

Attended a national BPS launch event

☐

Attended a local BPS launch event or training session

☐

Direct information from local NMPDU Link Nurse/Midwife

☐

Direct information from employer e.g. line manager

☐

Heard about them from a nursing or midwifery colleague

☐

Other (please state): _____

5. How relevant are the BPSs to *your* practice? (tick one box for each BPS)

	Always relevant	Sometimes relevant	Not relevant	Not sure if relevant
Continence	☐	☐	☐	☐
Home oxygen (children)	☐	☐	☐	☐
Nutrition (adults in hospital)	☐	☐	☐	☐
Nutrition (physically frail)	☐	☐	☐	☐
Pressure ulcers	☐	☐	☐	☐

6. Are you currently using the BPSs in your practice? (tick one box for each BPS)

Title of BPS	Currently using with <i>all</i> relevant patients	Currently using with <i>some</i> relevant patients	Not using but planning to use for relevant patients	Not using & NOT planning to use	This BPS doesn't apply to my area
Continence					
Home oxygen (children)					
Nutrition (adults in hospital)					
Nutrition (physically frail)					
Pressure ulcers					

Please comment on your answer:

7. If you are currently using the BPSs, please indicate to what extent? (tick one box for each BPS)

Title of BPS	Using the statement in full	Using a significant part of the statement	Using only a few key points	This BPS doesn't apply to my area
Continence				
Home oxygen (children)				
Nutrition (adults in hospital)				
Nutrition (physically frail)				
Pressure ulcers				

Please comment on your answer:

8. What benefit, if any, do you think the patients/clients in your area have had as a result of the development and launch of the BPSs? (tick one box for each BPS)

Title of BPS	Major benefit	Minor benefit	No benefits	This BPS doesn't help my area
Continence				
Home oxygen (children)				
Nutrition (adults in hospital)				
Nutrition (physically frail)				
Pressure ulcers				

Please comment on your response: _____

9. What benefit, if any, do you think the nurses and/or midwives in your area have had as a result of the development and launch of the BPSs? (tick one box for each BPS)

Title of BPS	Major benefit	Minor benefit	No benefits	This BPS doesn't help my area
Continence				
Home oxygen (children)				
Nutrition (adults in hospital)				
Nutrition (physically frail)				
Pressure ulcers				

Please comment on your response: _____

10. Are you aware of there being any barriers to using the BPSs in your area of practice? (tick one box for each BPS)

Title of BPS	No	Yes	If you ticked 'yes' there are barriers, what are these write in boxes below
Continence			
Home oxygen (children)			
Nutrition (adults in hospital)			
Nutrition (physically frail)			
Pressure ulcers			

Please comment on your response: _____

11. Are you aware of anything in your area that has helped encourage the use of the BPSs? (tick one box for each BPS)

Title of BPS	No	Yes	If you ticked 'yes', what has helped encourage BPS use (write in boxes below)
Continence	☐	☐	
Home oxygen (children)	☐	☐	
Nutrition (adults in hospital)	☐	☐	
Nutrition (physically frail)	☐	☐	
Pressure ulcers	☐	☐	

NB: Those ticking yes, should also fill in the blue proforma at the end.

12. Do you have a personal copy of the BPSs? (tick one box for each BPS)

	Yes	No
Continence	☐	☐
Home oxygen (children)	☐	☐
Nutrition (adults in hospital)	☐	☐
Nutrition (physically frail)	☐	☐
Pressure ulcers	☐	☐

13. Can you access copies of the BPS directly? (tick one box)

Yes ☐ No ☐ Don't know ☐

14. If you can access copies of the BPSs, how? (tick all that apply)

Copies in your local working area e.g. ward or health centre ☐

Copies in the library you use ☐

Download copies from the NMPDU web site ☐

Other (please specify) _____

15. How easy is it for you to access copies of the BPSs? (tick one box)

Easy ☐ Neither easy nor difficult ☐ Difficult ☐

If difficult, please comment on your answer:

16. If you have any suggestions for improving dissemination of BPSs to nurses and midwives in the future, please write them here:

17. If you have any suggestions for encouraging the future use of BPSs in practice by nurses and midwives, please write them here: _____

18. If you have any other comments about the BPS, please write them here:
(continue overleaf, if necessary) _____

Section 2: Information about You

19. Are you currently working as a:

Health Visitor ☐
Midwife ☐

Nurse ☐
Other? (state) _____

20. Please specify your main area of practice e.g. District Nursing, Day Surgery, Labour Ward, Learning Disabilities, Management, Practice Development:

21. What grade are you currently employed at? (tick one box)

C ☐
F ☐

D ☐
G ☐

E ☐
H or I ☐

Other (please specify) _____

22. Are you currently working (tick one box):

Part-time ☐

Full time? ☐

23. How many years in practice have you had since qualification? (tick one box)

Less than 1 year ☐
11-20 years ☐

1 to 4 years ☐
21-30 years ☐

5 to 10 years ☐
30 plus years ☐

If you have any details about local initiatives to support the use of the BPSs in practice, please complete the accompanying blue proforma.

Thank you for your assistance

Please return this questionnaire in the envelope provided to the: BPS Research Team, Department of Nursing & Midwifery, University of Stirling, Stirling, FK9 4LA by the _____ 2003

Appendix 1B - Questionnaire to Directors of Nursing

☐☐☐☐☐

Study of the Impact of the NMPDU Best Practice Statements

(Questionnaire for Directors of Nursing)

Please complete the following questions.

Section 1: Some Information about the Best Practice Statements

1. Before receiving this questionnaire, did you know the Nursing & Midwifery Practice Development Unit (NMPDU) had produced Best Practice Statements (BPSs) to guide nurses and midwives working in Scotland with specific areas of their practice? (tick one box)

Yes ☐

No ☐

If no, please go to section 2, page 5. If yes, please continue.

2. Which of the following BPS do you know of? (tick all that apply)

Continence in adults with urinary dysfunction

Yes

☐

Home oxygen therapy for children being cared for in the community

☐

Nutrition assessment & referral in the care of adults in hospital

☐

Nutrition for physically frail older people

☐

Pressure ulcer prevention

☐

NB: Statements will now be abbreviated to continence, home oxygen (children), nutrition (adults in hospital), nutrition (physically frail), and pressure ulcers.

3. When did you first learn about the BPSs? (tick one box)

Within the last month

☐

Within the last 2 - 6 months

☐

Within the last 7 months to 1 year

☐

1 to 2 years ago

☐

Over 2 years ago

☐

4. How did you learn about the BPSs? (tick all that apply)

Read about them e.g. in a journal

☐

Read about them on the NMPDU web site

☐

Received a personal copy

☐

Attended a national BPS launch event

☐

Attended a local BPS launch event or training session

☐

Direct information from the NMPDU nationally

☐

Direct information from local NMPDU Link Nurse/Midwife

☐

Heard about them from a nursing or midwifery colleague

☐

Other (please state): _____

5. How relevant are the BPSs to the nurses or midwives in *your* area? (tick one box for each BPS)

	Always relevant	Sometimes relevant	Not relevant	Not sure if relevant
Continence	☐	☐	☐	☐
Home oxygen (children)	☐	☐	☐	☐
Nutrition (adults in hospital)	☐	☐	☐	☐
Nutrition (physically frail)	☐	☐	☐	☐
Pressure ulcers	☐	☐	☐	☐

6. Are the nurses or midwives in your area currently using the BPSs in their practice? (tick one box for each BPS)

Title of BPS	Currently using with patients	Currently using some relevant	Not using but to use for re patients	Not using & No to use	This BPS doesn't apply to my
Continence					
Home oxygen (children)					
Nutrition (adults in hospital)					
Nutrition (physically frail)					
Pressure ulcers					

Please comment on your answer: _____

7. If the nurses or midwives in your area are currently using the BPSs, please indicate to what extent? (tick one box for each BPS)

Title of BPS	Using the statement full	Using a significant the statement	Using only a few points	This BPS doesn't my area
Continence				
Home oxygen (children)				
Nutrition (adults in hospital)				
Nutrition (physically frail)				
Pressure ulcers				

Please comment on your answer: _____

8. What benefit, if any, do you think the patients/clients in your area have had as a result of the development and launch of the BPSs? (tick one box for each BPS)

Title of BPS	Major benefits	Minor benefits	No benefits	This BPS doesn't apply to my area
Continence				
Home oxygen (children)				
Nutrition (adults in hospital)				
Nutrition (physically frail)				
Pressure ulcers				

Please comment on your response: _____

9. What benefit, if any, do you think the nurses and/or midwives in your area have had as a result of the development and launch of the BPSs? (tick one box for each BPS)

Title of BPS	Major benefits	Minor benefits	No benefits	This BPS doesn't apply to my area
Continence				
Home oxygen (children)				
Nutrition (adults in hospital)				
Nutrition (physically frail)				
Pressure ulcers				

Please comment on your response: _____

10. Are you aware of there being any barriers to using the BPSs in your area? (tick one box for each BPS)

Title of BPS	No	Yes	If you ticked 'yes' there are barriers, what are these? (please write in boxes below)
Continence			
Home oxygen (children)			
Nutrition (adults in hospital)			
Nutrition (physically frail)			
Pressure ulcers			

Please comment on your response: _____

11. Are you aware of anything in your area that has helped encourage the use of the BPSs? (tick one box for each BPS)

Title of BPS	No	Yes	If you ticked 'yes', what has helped encourage BPS use? (please write in boxes below)
Continence	☐	☐	
Home oxygen (children)	☐	☐	
Nutrition (adults in hospital)	☐	☐	
Nutrition (physically frail)	☐	☐	
Pressure ulcers	☐	☐	

NB: Those ticking yes, should also fill in the blue proforma at the end.

12. Do you have a personal copy of the BPSs? (tick one box for each BPS)

	Yes	No
Continence	☐	☐
Home oxygen (children)	☐	☐
Nutrition (adults in hospital)	☐	☐
Nutrition (physically frail)	☐	☐
Pressure ulcers	☐	☐

13. Can you access copies of the BPS directly? (tick one box)

Yes ☐ No ☐ Don't know ☐

14. If you can access copies of the BPSs, how? (tick all that apply)

Copies in your local working area e.g. ward or health centre ☐

Copies in the library you use ☐

Download copies from the NMPDU web site ☐

Other (please specify) ☐

15. How easy is it for you to access copies of the BPSs? (tick one box)

Easy ☐ Neither easy nor difficult ☐ Difficult ☐

If difficult, please comment on your answer: _____

16. If you have any suggestions for improving dissemination of BPSs to nurses and midwives in the future, please write them here: _____

17. If you have any suggestions for encouraging the future use of BPSs by nurses and midwives in your area, please write them below:

18. If you have any other comments about the BPSs, please write them below (continue overleaf, if necessary):

Section 2: Information about Your Area

19. Is your area an (tick one box)

Acute Care NHS Trust

☐

Primary Care NHS Trust

☐

Acute and Primary Care NHS Trust/Island Board

☐

20. Does your area employ (tick one box)

Nurses only

☐

Nurses and Midwives

☐

If you have any details about local initiatives to support the use of the BPSs in practice, please complete the accompanying blue proforma.

Thank you for your assistance

***Please return this questionnaire in the envelope provided to the:
BPS Research Team, Department of Nursing & Midwifery, University of
Stirling, Stirling, FK9 4LA by the _____ 2003***

Study of the Impact of the NMPDU Best Practice Statements (BPSs)

Proforma to identify local BPS initiatives

Please complete the boxes on pages 1 & 2, if you have organised, participated in or attended any local initiatives to maximise the use of the BPSs. If you are not aware of any such initiatives, please return this form blank, with the questionnaire, to the BPS Research Team.

Give details of any local initiative(s) to promote the dissemination & use of BPSs in your area i.e. what was the initiative(s) and what was involved? This could include promotional events e.g. roadshows & seminars.	Which BPSs were included in this initiative(s)?	Which group of nurses or midwives was the local initiative(s) targeted towards?

Please Turn Over

In your opinion, how effective was this initiative(s) in promoting the use of the BPSs amongst nurses and midwives in your area? Did the initiative work? Did it encourage use of any of the BPSs in nursing or midwifery practice?	Based on your experience, would you recommend this initiative(s) as being helpful in encouraging the use of BPSs?

Thank you for your assistance.

Please return this proforma in the envelope provided to the:
BPS Research Team, Department of Nursing & Midwifery, University of Stirling, Stirling, FK9 4LA
 by the _____ 2003

Study of the Impact of the NMPDU Best Practice Statements (BPS)

Interview schedule for BPS developers

During the telephone interview you will be asked the following questions. In advance of the interview, you are asked to read these questions and note any answers you may want to give the researcher on the form. Please note your identity will be protected at all stages of the research. You do NOT need to answer every question.

1. Name of the BPS you developed: _____
2. What was your role in the BPS development process?
Project Lead ☐ Member of the development team ☐
3. To what extent are you currently using the BPS you developed in your practice? (For example, are you using your BPS in full? If not, which specific parts, if any, are you using?).
4. Can you give examples, either local or national, of how your BPS has benefited patient care?
5. Can you give examples, either local or national, of how your BPS has benefited nurses and midwives?

6. Are you aware of any parts of your statement that are difficult for either you or others to implement in practice? If so, what are these difficulties?

7. When you started developing your BPS, how much impact did you think it would have on patient care and in what way?

8. Since the launch of your BPS, how much impact do you think it has had on patient care? How does this compare with the impact you expected it to have?

9. Are you aware of any barriers, local or national, to the use of your BPS in practice? If so, what are these barriers?

10. Have you participated in any local or national initiatives to encourage the use of your BPS in practice? If yes, what and how effective do you think this initiative(s) was in promoting the use of your BPS?

11. Have you had a role in disseminating your BPS to nurses & midwives? For example, writing papers, presentations, poster displays. If yes, please give details.

12. Have you any suggestions for encouraging the use of your BPS in future?

13. Do you have any other comments about the use of your BPS specifically or BPS statements generally?

Thank you for your help

Appendix 4 - Questionnaire data: Tables 4.1 – 4.22

Table 4.1: Area of practice Clinical & Network respondents			
	Clinical	Network	Total
Community	82 21.8%	4 7.0%	86 19.8%
Midwifery	22 5.8%	6 10.5%	28 6.5%
Mental health	41 10.9%	2 3.5%	43 9.9%
Learning disabilities	8 2.1%	1 1.8%	9 2.1%
Adult nursing general	142 37.7%	2 3.5%	144 33.1%
Adult nursing specialist	10 2.7%	1 1.8%	11 2.5%
Continuing care	36 9.5%	2 3.5%	38 8.8%
Paediatrics	5 1.3%	0 0%	5 1.2%
Support posts	25 6.6%	38 66.6%	63 14.5%
Others	6 1.6%	1 1.8%	7 1.6%
Total	377 100.0%	57 100.0%	434 100.0%

Table 4.2: Grade of Clinical and Network respondents			
Grade	Clinical	Network	Total
C	5 1.1%	0 0%	5 1.0%
D	67 15.2%	0 0%	67 13.3%
E	181 41.0%	0 0%	181 35.8%
F	54 12.2%	2 3.1%	56 11.1%
G	92 20.9%	10 15.6%	102 20.2%
H/I	30 6.8%	43 67.2%	73 14.5%
Other	12 2.8%	9 14.1%	21 4.1%
Total	441 100.0%	64 100.0%	505 100.0%

Table 4.3: Years in practice of Clinical and Network respondents			
Years in practice?	Clinical	Network	Total
Less than a year	5 1.1%	0 0%	5 1.0%
1-4 years	37 8.3%	0 0%	37 7.3%
5-10 years	66 14.8%	2 3.1%	68 13.3%
11-20 years	178 39.9%	27 42.2%	205 40.2%
21-30 years	118 26.5%	26 40.6%	144 28.2%
30 plus years	42 9.4%	9 14.1%	51 10.0%
Total	446 100.0%	64 100.0%	510 100.0%

Table 4.4: Full or part-time employment of Clinical and Network respondents			
Hours	Clinical	Network	Total
Part time	195 43.8%	5 7.7%	200 39.2%
Full time	250 56.2%	60 92.3%	310 60.8%
Total	445 100.0%	65 100.0%	510 100.0%

Table 4.5: General knowledge of the BPS by study site and group			
	Yes	No	Total
NHS Site 1	29 40.3%	43 59.7%	72 100.0%
NHS Site 2	26 45.6%	31 54.4%	57 100.0%
NHS Site 3	15 30.0%	35 70.0%	50 100.0%
NHS Site 4	43 58.1%	31 41.9%	74 100.0%
NHS Site 5	23 41.1%	33 58.9%	56 100.0%
NHS Site 6	37 58.7%	26 41.3%	63 100.0%
NHS Site 7	23 39.7%	35 60.3%	58 100.0%
Independent Sites	6 28.6%	15 71.4%	21 100.0%
Network Members	65 98.5%	1 1.5%	66 100.0%
Directors of Nursing	20 100.0%	0 0%	20 100.0%
Total	287 53.4%	250 46.6%	537 100.0%

Table 4.6: General knowledge of the BPS by clinical grade			
	Yes	No	Total
C	1 20.0%	4 80.0%	5 100.0%
D	15 22.4%	52 77.6%	67 100.0%
E	62 34.3%	119 65.7%	181 100.0%
F	28 50.0%	28 50.0%	56 100.0%
G	74 72.5%	28 27.5%	102 100.0%
H/I	66 90.4%	7 9.6%	73 100.0%
Other	14 66.7%	7 33.3%	21 100.0%
Total	260 51.5%	245 48.5%	505 100.0%
Note: $X^2=110.599$, $df=6$, $p<0.001$			

Table 4.7: BP awareness and part and full-time employment			
Hours	Yes	No	Total
Part time	77 38.5%	123 61.5%	200 100%
Full time	188 60.6%	122 39.4%	310 100%
Total	265 52.0%	245 48.0%	510 100.0%

Table 4.8: BP awareness and length of practice			
Hours	Yes	No	Total
Less than 10 years	32 29.1%	78 70.9%	110 100%
More than 10 years	231 57.8%	169 42.2%	400 100%
Total	263 51.6%	247 48.4%	510 100.0%

Table 4.9: When respondents first learned about the BPS by study group						
	Last month	2-6mths	7mths-1yr	1-2 years	Over two years ago	Total
Clinical	16 8.1%	73 37.1%	63 32.0%	38 19.2%	7 3.6%	197 100.0%
Network	0 0%	2 3.2%	12 19.4%	22 35.5%	26 41.9%	62 100.0%
Directors	0 0%	0 0%	3 15.0%	8 40.0%	9 45.0%	20 100.0%
Total	16 5.7%	75 26.9%	78 28.0%	68 24.3%	42 15.1%	279 100.0%

Table 4.10: How respondents learnt about the BPS				
	Clinical	Network	Directors	Total
Read about them e.g. in a journal	70 34.8%	12 19.4%	6 30.0%	88 31.1%
Read about them on NMPDU web site	18 9.0%	27 43.5%	5 25.0%	50 17.7%
Received a personal copy	45 22.4%	40 64.5%	17 85.0%	102 36.0%
National BPS launch event	6 3.0%	23 37.1%	6 30.0%	35 12.4%
Local BPS launch event	9 4.5%	7 11.3%	4 20.0%	20 7.1%
Local NMPDU Network Nurse	32 15.9%	25 40.3%	13 65.05%	70 24.7%
Direct information from employer	87 43.3%	14 22.6%	0 0%	101 35.7%
Direct from NMPDU nationally	0 0%	3 4.8%	12 60.0%	15 5.3%
Heard about them from colleague	53 26.4%	10 16.1%	2 10.0%	65 23.0%
Other	25 21.4%	9 14.5%	2 10.0%	36 12.7%
Total	201	62	20	582

Table 4.11: Relevance of the BPS to practice						
		Always relevant	Sometimes relevant	Not relevant	Not sure	Total
Contenance	Clinical	107 56.6%	45 23.8%	31 16.4%	6 3.2%	189 100.0%
	Network	28 47.5%	21 35.6%	9 15.2%	1 1.7%	59 100.0%
	Directors	15 78.8%	2 10.6%	2 10.6%	0 0%	19 100.0%
	Total	150 56.2%	68 25.5%	42 15.7%	7 2.6%	267 100.0%
Home Oxygen	Clinical	9 5.5%	20 12.1%	129 78.7%	6 3.7%	164 100.0%
	Network	8 13.8%	17 29.3%	33 56.9%	0 0%	58 100.0%
	Directors	7 41.2%	7 41.2%	3 17.6%	0 0%	17 100.0%
	Total	24 10.0%	44 18.4%	165 69.1%	6 2.5%	239 100.0%
Nutrition (A&R)	Clinical	78 46.2%	34 20.1%	51 30.1%	6 3.6%	169 100.0%
	Network	24 40.7%	14 23.7%	19 32.2%	2 3.4%	59 100.0%
	Directors	15 78.8%	2 10.6%	2 10.6%	0 0%	19 100.0%
	Total	117 47.4%	50 20.2%	72 29.2%	8 3.2%	247 100.0%
Nutrition (FE)	Clinical	102 56.3%	41 22.7%	32 17.7%	6 3.3%	181 100.0%
	Network	25 42.4%	13 22.0%	21 35.6%	0 0%	59 100.0%
	Directors	15 78.8%	2 10.6%	2 10.6%	0 0%	19 100.0%
	Total	142 54.8%	56 21.6%	55 21.3%	6 2.3%	259 100.0%
Pressure Ulcers	Clinical	113 60.8%	40 21.5%	28 15.1%	5 2.6%	186 100.0%
	Network	30 50.8%	14 23.8%	13 22.0%	2 3.4%	59 100.0%
	Directors	15 78.8%	3 15.8%	1 5.4%	0 0%	19 100.0%
	Total	158 59.8%	57 21.6%	42 15.9%	7 2.7%	264 100.0%

Table 4.12: Current usage of the BPS

		With ALL relevant patients	With SOME relevant patients	Not using but planning to use	Not using & not planning to use	Doesn't apply to may area	Total
Continence	Clinical	44 25.9%	30 17.6%	49 28.8%	20 11.8%	27 15.9%	170 100.0%
	Network	8 15.1%	10 18.9%	20 37.7%	4 7.5%	11 20.8%	53 100.0%
	Directors	3 17.6%	11 64.7%	2 11.8%	0 0%	1 5.9%	17 100.0%
	Total	55 22.9%	51 21.3%	71 29.6%	24 10.0%	39 16.2%	240 100.0%

Home Oxygen	Clinical	4 2.9%	3 2.2%	11 7.9%	20 14.4%	101 72.6%	139 100.0%
	Network	4 8.3%	8 16.7%	5 10.4%	2 4.2%	29 60.4%	48 100.0%
	Directors	2 15.4%	6 46.1%	3 23.1%	0 0%	2 15.4%	13 100.0%
	Total	10 5.0%	17 8.5%	19 9.5%	22 11.0%	132 66.0%	200 100.0%

Nutrition (A&R)	Clinical	29 19.3%	26 17.4%	29 19.3%	19 12.7%	47 31.3%	150 100.0%
	Network	8 15.1%	9 17.0%	12 22.6%	6 11.3%	18 34.0%	53 100.0%
	Directors	2 12.4%	12 75.0%	1 6.3%	0 0%	1 6.3%	16 100.0%
	Total	39 17.8%	47 21.5%	42 19.2%	25 11.4%	66 30.1%	219 100.0%

Nutrition (FE)	Clinical	38 23.2%	34 20.7%	44 26.8%	17 10.4%	31 18.9%	164 100.0%
	Network	9 17.6%	8 15.7%	11 21.6%	2 3.9%	21 41.2%	51 100.0%
	Directors	2 12.4%	11 68.9%	1 6.3%	0 0%	2 12.4%	16 100.0%
	Total	49 21.3%	53 22.9%	56 24.2%	19 8.2%	54 23.4%	231 100.0%

Pressure Ulcers	Clinical	49 29.0%	31 18.3%	44 26.1%	20 11.8%	25 14.8%	169 100.0%
	Network	12 22.2%	10 18.5%	13 24.1%	3 5.6%	16 29.6%	54 100.0%
	Directors	4 25.0%	9 56.3%	2 12.4%	0 0%	1 6.3%	16 100.0%
	Total	65 27.2%	50 20.9%	59 24.7%	23 9.6%	42 17.6%	239 100.0%

Table 4.13: Extent of current BPS usage						
		Full Statement	Significant Part	Few key points	Doesn't apply to my area	Total
Continence	Clinical	23 21.5%	38 35.5%	23 21.5%	23 21.5%	107 100.0%
	Network	5 14.7%	11 32.4%	12 35.3%	6 17.6%	34 100.0%
	Directors	3 21.5%	9 64.3%	1 7.1%	1 7.1%	14 100.0%
	Total	31 20.0%	58 37.4%	36 23.2%	30 19.4%	155 100.0%
Home Oxygen	Clinical	2 2.2%	4 4.5%	2 2.2%	81 91.1%	89 100.0%
	Network	4 12.9%	6 19.4%	5 16.1%	16 51.6%	31 100.0%
	Directors	3 27.3%	4 36.3%	3 27.3%	1 9.1%	11 100.0%
	Total	9 6.9%	14 10.7%	10 7.6%	98 74.8%	131 100.0%
Nutrition (A&R)	Clinical	11 11.6%	29 30.5%	19 20.0%	36 37.9%	95 100.0%
	Network	5 14.7%	8 23.5%	13 38.3%	8 23.5%	34 100.0%
	Directors	3 20.0%	10 66.6%	1 6.7%	1 6.7%	15 100.0%
	Total	19 13.2%	47 32.6%	33 22.9%	45 31.3%	144 100.0%
Nutrition (FE)	Clinical	16 16.2%	35 35.4%	24 24.2%	24 24.2%	99 100.0%
	Network	8 23.5%	7 20.6%	8 23.5%	11 32.4%	34 100.0%
	Directors	5 33.3%	7 46.7%	1 6.7%	2 13.3%	15 100.0%
	Total	29 19.6%	49 33.1%	33 22.3%	37 25.0%	148 100.0%
Pressure Ulcers	Clinical	23 22.4%	41 39.8%	20 19.4%	19 18.4%	103 100.0%
	Network	9 25.0%	11 30.6%	9 25.0%	7 19.4%	36 100.0%
	Directors	4 28.6%	9 64.3%	0 0%	1 7.1%	14 100.0%
	Total	36 23.5%	61 39.9%	29 19.0%	27 17.6%	153 100.0%

Table 4.14: Benefits of the BPS for patients						
		Major Benefits	Minor Benefits	No Benefits	Doesn't apply to my area	Total
Continence	Clinical	52 37.7%	49 35.5%	9 6.5%	28 20.3%	138 100.0%
	Network	11 25.6%	20 46.5%	5 11.6%	7 16.3%	43 100.0%
	Directors	6 46.2%	6 46.2%	0 0%	1 7.6%	13 100.0%
	Total	69 35.6%	75 38.7%	14 7.1%	36 18.6%	194 100.0%
Home Oxygen	Clinical	11 10.7%	3 2.9%	2 1.9%	87 84.5%	103 100.0%
	Network	10 25.0%	7 17.5%	3 7.5%	20 50.0%	40 100.0%
	Directors	3 30.0%	5 50.0%	0 0%	2 20.0%	10 100.0%
	Total	24 15.7%	15 9.8%	5 3.3%	109 71.2%	153 100.0%
Nutrition (A&R)	Clinical	37 30.8%	26 21.7%	10 8.3%	47 39.2%	120 100.0%
	Network	9 23.1%	14 35.9%	5 12.8%	11 28.2%	39 100.0%
	Directors	5 38.6 %	7 53.8%	0 0%	1 7.6%	13 100.0%
	Total	51 29.7%	47 27.3%	15 8.7%	59 34.3%	172 100.0%
Nutrition (FE)	Clinical	49 38.9%	35 27.8%	8 6.3%	34 27.0%	126 100.0%
	Network	12 28.6%	11 26.2%	5 11.9%	14 33.3%	42 100.0%
	Directors	6 46.2%	5 38.6%	0 0%	2 15.2%	13 100.0%
	Total	67 37.0%	51 28.2%	13 7.2%	50 27.6%	181 100.0%
Pressure Ulcers	Clinical	60 45.1%	36 27.1%	9 6.7%	28 21.1%	133 100.0%
	Network	14 31.2%	18 40.0%	2 4.4%	11 24.4%	45 100.0%
	Directors	6 50.0%	5 41.7%	0 0%	1 8.3%	12 100.0%
	Total	80 42.1%	59 31.1%	11 5.7%	40 21.1%	190 100.0%

Table 4.15: Benefits of the BPS for nurses and midwives						
		Major Benefits	Minor Benefits	No Benefits	Doesn't apply to my area	Total
Continence	Clinical	50 37.6%	46 34.6%	13 9.8%	24 18.0%	133 100.0%
	Network	11 25.5%	22 51.2%	4 9.3%	6 14.0%	43 100.0%
	Directors	8 61.5%	3 23.1%	1 7.7%	1 7.7%	13 100.0%
	Total	69 36.5%	71 37.6%	18 9.5%	31 16.4%	189 100.0%
Home Oxygen	Clinical	15 14.5%	4 3.8%	3 2.9%	82 78.8%	104 100.0%
	Network	10 26.3%	6 15.8%	2 5.3%	20 52.6%	38 100.0%
	Directors	6 54.5%	4 36.4%	0 0%	1 9.1%	11 100.0%
	Total	31 20.3%	14 9.2%	5 3.3%	103 67.2%	153 100.0%
Nutrition (A&R)	Clinical	34 28.8%	29 24.6%	14 11.9%	41 34.7%	118 100.0%
	Network	8 20.5%	17 43.6%	3 7.7%	11 28.2%	39 100.0%
	Directors	7 50.0%	5 35.8%	1 7.1%	1 7.1%	14 100.0%
	Total	49 28.7%	51 29.8%	18 10.5%	53 31.0%	171 100.0%
Nutrition (FE)	Clinical	43 35.0%	42 34.1%	11 8.9%	27 22.0%	123 100.0%
	Network	12 28.6%	15 35.7%	3 7.1%	12 28.6%	42 100.0%
	Directors	7 50.0%	4 28.6%	1 7.1%	2 14.3%	14 100.0%
	Total	62 34.6%	61 34.1%	15 8.4%	41 22.9%	179 100.0%
Pressure Ulcers	Clinical	53 41.4%	42 32.8%	11 8.6%	22 17.2%	128 100.0%
	Network	13 28.9%	20 44.4%	2 4.4%	10 22.3%	45 100.0%
	Directors	8 57.1%	5 35.8%	0 0%	1 7.1%	14 100.0%
	Total	74 39.6%	67 35.8%	13 7.0%	33 17.6%	187 100.0%

Table 4.16: Awareness of barriers to BPS use by study group

		Clinical	Network	Directors	Total
Continence	Yes	13 9.0%	13 35.1%	4 33.3%	30 15.5%
	No	131 91.0%	24 64.9%	8 66.7%	163 84.5%
	Total	144 100.0%	37 100.0%	12 100.0%	193 100.0%

Home Oxygen	Yes	11 15.5%	10 37.0%	2 20.0%	23 21.3%
	No	60 84.5%	17 63.0%	8 80.0%	85 78.7%
	Total	71 100.0%	27 100.0%	10 100.0%	108 100.0%

Nutrition (A&R)	Yes	13 11.5%	14 43.8%	7 53.8%	34 21.5%
	No	100 88.5%	18 56.2%	6 46.2%	124 78.5%
	Total	113 100.0%	32 100.0%	13 100.0%	158 100.0%

Nutrition (FE)	Yes	14 10.8%	16 47.1%	6 50.0%	36 20.5%
	No	116 89.2%	18 52.9%	6 50.0%	140 79.5%
	Total	130 100.0%	34 100.0%	12 100.0%	176 100.0%

Pressure Ulcers	Yes	13 9.2%	12 34.3%	2 16.7%	27 14.3%
	No	129 90.8%	23 65.7%	10 83.3%	162 85.7%
	Total	142 100.0%	35 100.0%	12 100.0%	189 100.0%

Table 4.17: Awareness of drivers by study group

		Clinical	Network	Directors	
Continence	Yes	44 31.2%	24 53.3%	10 83.3%	78 39.4%
	No	97 68.8%	21 46.7%	2 16.7%	120 60.6%
	Total	141 100.0%	45 100.0%	12 100.0%	198 100.0%

Home Oxygen	Yes	7 8.4%	12 37.5%	7 63.6%	26 20.6%
	No	76 91.6%	20 62.5%	4 36.4%	100 79.4%
	Total	83 100.0%	32 100.0%	11 100.0%	126 100.0%

Nutrition (A&R)	Yes	19 17.3%	15 38.5%	10 83.3%	44 27.3%
	No	91 82.7%	24 61.5%	2 16.7%	117 72.7%
	Total	110 100.0%	39 100.0%	12 100.0%	161 100.0%

Nutrition (FE)	Yes	31 24.6%	19 46.3%	9 81.8%	59 33.1%
	No	95 75.4%	22 53.7%	2 18.2%	119 66.9%
	Total	126 100.0%	41 100.0%	11 100.0%	178 100.0%

Pressure Ulcers	Yes	39 29.1%	22 48.9%	11 78.6%	72 37.3%
	No	95 70.9%	23 51.1%	3 21.4%	121 62.7%
	Total	134 100.0%	45 100.0%	14 100.0%	193 100.0%

Table 4.18: Ownership of personal copies of the BPS by study group					
Continence		Clinical	Network	Directors	Total
	Yes	59 32.1%	48 78.7%	14 100.0%	121 46.7%
	No	125 67.9%	13 21.3%	0 0%	138 53.3%
	Total	184 100.0%	61 100.0%	14 100.0%	259 100.0%
Home Oxygen	Yes	26 17.1%	40 70.2%	14 100.0%	80 35.9%
	No	126 82.9%	17 29.8%	0 0%	143 64.1%
	Total	152 100.0%	57 100.0%	14 100.0%	223 100.0%
Nutrition (A&R)	Yes	41 24.3%	41 70.7%	15 100.0%	97 40.1%
	No	128 75.7%	17 29.3%	0 0%	145 59.9%
	Total	169 100.0%	58 100.0%	15 100.0%	242 100.0%
Nutrition (FE)	Yes	50 28.6%	43 75.4%	15 100.0%	108 43.7%
	No	125 71.4%	14 24.6%	0 0%	139 56.3%
	Total	175 100.0%	57 100.0%	15 100.0%	247 100.0%
Pressure Ulcers	Yes	54 29.8%	44 74.6%	14 100.0%	112 44.1%
	No	127 70.2%	15 25.4%	0 0%	142 55.9%
	Total	181 100.0%	59 100.0%	14 100.0%	254 100.0%

Table 4.19: Direct access to copies of the BPS				
	Clinical	Network	Directors	Total
Yes	126 64.9%	58 93.5%	18 94.7%	202 73.5%
No	10 5.2%	3 4.8%	0 0%	13 4.7%
Don't know	58 29.9%	1 1.7%	1 5.3%	60 21.8%
Total	194 100.0%	62 100.0%	19 100.0%	275 100.0%

Table 4.20: Direct access to BPS by clinical sites			
Site	Yes	No/Don't know	Total
NHS Site 1	20 69.0%	9 31.0%	29 100.0%
NHS Site 2	13 52.0%	12 48.0%	25 100.0%
NHS Site 3	9 64.3%	5 35.7%	14 100.0%
NHS Site 4	32 74.4%	11 25.6%	43 100.0%
NHS Site 5	12 57.1%	9 42.9%	21 100.0%
NHS Site 6	29 82.9%	6 17.1%	35 100.0%
NHS Site 7	10 47.6%	11 52.4%	21 100.0%
Independent Sites	1 16.7%	5 83.3%	6 100.0%
Total	126 64.9%	68 35.1%	194 100.0%

Table 4.21: How respondents access the BPS				
	Working Area?	Library?	NMPDU website?	Other source
Clinical	83 64.8%	27 58.7%	92 58.6%	7 63.6%
Network	33 25.8%	13 28.3%	51 32.5%	4 36.4%
Directors	12 9.4%	6 13.0%	14 8.9%	0 0%
Total	128 100%	46 100%	157 100%	11 100%

Table 4.22: Ease of access to copies of the BPS				
	Clinical	Network	Directors	Total
Easy	92 55.1%	48 78.7%	14 77.8%	154 62.6%
Neither easy nor difficult	62 37.1%	12 19.7%	4 22.2%	78 31.7%
Difficult	13 7.8%	1 1.6%	0 0%	14 5.7%
Total	167 100.0%	61 100.0%	18 100.0%	246 100.0%

Benefits to Patients from the BPS reported by interviewees

Continence BPS e.g.

- [BPS] 'used for the basis of continence training' (Interviewee 2, L9-11)
- '[Patients] ... all get assessed individually' (Interviewee 1, L11-12)
- 'Patients have benefited locally ... through better teaching' (Interviewee 3, L13-15)

Pressure ulcers BPS e.g.

- 'Pressure ulcers have never been taken so seriously and treated so professionally' (Interviewee 4, L56-57)
- '[The BPS] is a good framework for nursing homes and ... areas that don't have a tissue viability nurse' (Interviewee 5, L13-15)
- 'We've just implemented new turning charts' (Interviewee 5, L27)
- 'Consensus management of patient care .. it benefits them in that way that we're trying to get everybody speaking the same language and doing the same thing' (Interviewee 6, L13-16)

Home oxygen e.g.

- 'Biggest [benefit] nationally is about the decanting of oxygen from a larger cylinder ... this is practice that shouldn't be happening .. best practice should be [someone] licensed to decant ... know now that [some areas] have changed their practice, have changed policies' (Interviewee 7, L12-17)
- 'Care plans in implementation, stops the Chinese whispers so you know exactly what the consultant said' (Interviewee 7, L18-19)
- 'Health and safety awareness – dangers of oxygen, knew about this before but communicating this to parents and other professionals' (Interviewee 7, L20-21)
- 'Promoted need for ambulatory oxygen across Scotland, that children can't just be sat in their bedrooms attached to an oxygen cylinder' (Interviewee 7, L22-23)
- [BPS] 'has improved discharge planning phenomenally from the neonatal unit into the community' (Interviewee 8, L15-16)
- 'All the children that are oxygen dependent from my end now have direct access to the local paediatric unit should they have a problem out of hours it was done ad hoc before' (Interviewee 8, L33-49)
- 'It has definitely benefited patient care cause everybody is getting the same' (Interviewee 9, L14-15)
- '[The BPS] really does encourage everybody to do the same practice ... so if that child .. moved elsewhere, then the care they should be getting should really be the same' (Interviewee 9, L95-98)

Nutrition (frail elderly)

- 'BPS benefited patient care nationally through raising awareness of specific nursing issues but [locally] ... there's been huge changes that have come about as a result of the BPS, as an example we now have whole milk provided .. rather than semi-skimmed milk ... a range of finger foods which are now available across the service ... highlighting the importance of suppertime and something very substantial .. rather than just a biscuit. These sorts of things which have actually changed delivery of patient care' (Interviewee 10, L8-17)
- 'Able to use this BPS to influence certain changes to the new menus that we've made for our care group, to make sure things are appropriate to the needs of elderly people in continuing care environment' (Interviewee 10, L26-29)
- 'BPS has helped us with improving the patient centredness of the care that we deliver, it is very individually focused, and does concentrate at the individual level, so I think that that has really helped nurses to think about the needs of the individual' (Interviewee 10, L65-68)
- '[BPS] gave much more of a team ownership of nutrition, making sure it's right for the residents, that has come about as a direct result of the BPS' (Interviewee 10, L80-84)
- '[The BPS] it's just making the staff aware of the need to supervise patients, make sure they have the right implements to eat with, table height' (Interviewee 11, L4-6)
- 'Audit ... showed that we were making more appropriate referrals to the dietitians and it also improved our weighing the patients more often and made us more conscious of monitoring patient weights and heights' (Interviewee 12, L21-27)

Nutrition (assessment & referral)

- 'Along with the [NHS] QIS standards we are using [the BPS] to look at the nutrition pathway across the Trust ... it's allowing us to use these standards to develop our pathway to make sure that we're doing everything as thoroughly as we can' (Interviewee 13, L7-11)
- 'These documents [the BPS] are encouraging staff at a lower level to ensure that patients are getting either referral to the dietitian or things like high protein drinks' (Interviewee 13, L15-18)
- 'As a multi-disciplinary team it has brought us all closer together and we are able to develop a good service for the patients' (Interviewee 14, L8-11)
- '[The BPS] is good for continuity of care and education' (Interviewee 15, L13-15)
- 'Because there was no screening tool a lot of people were not aware of malnourished patients and ... [patients] used to lie around in the ward for weeks on end before you thought 'oh that patient's getting a bit thin, whereas now the screening tool is up and running' (Interviewee 15, L29-37)

Appendix 6 - Barriers to BPS implementation reported by interviewees

Barriers	Number of interviewees	Examples of interviewee comments
Resources: • Time • Lack of specialist nurses e.g. continence advisors • Access to equipment • Better facilities	8	• 'Toilet accessibility, where staff groups were required to help' (Interviewee 2, L23) • 'Nationally, what I'm picking up is where there are no specialists, who's going to do this, who's task is this?' (Interviewee 4, L72-72) • 'I would see changes in patient's skin if we had a continence advisor and the staff would be using the appropriate products' (Interviewee 5, L42-44) • '[What] we won't be able to put into practice in the majority of our wards is separate dining facilities because a lot of the wards don't even have day rooms so the patients have to sit at their bedside to have their meals' (Interviewee 11, L25-27) • 'There is always the restriction of time' (Interviewee 11, L43-44) • 'There's been a lot of comments about the difficulties weighing patients, making sure that scales are accurate and they have proper tools for doing the job' (Interviewee 13, L4-6)
Accessing training • Releasing staff to attend training • Specialist nurses finding time to train others	6	• 'It doesn't matter how much education you do, you can't get everybody in a place this size ... and with turnover of staff' (Interviewee 5, L67-69) • 'One other thing which will continue to pose problems, is providing education on an on-going basis. Although education is available, we've got a big service and making sure that everyone has access to it, can be quite challenging' (Interviewee 10, L57-59) • 'I've distributed 44 [training packs] for trained staff and I think 10 have taken it up [we've] said they would be paid a couple of extra hours if they complete the pack and that hasn't really enticed them That's disappointing but I think that's the reality, it's difficult for nurses to take time out' (Interviewee 15, L46-52) • 'Time and finance is a barrier because you have to get staff away from wards and it's very difficult to get them away for a full day's training' (Interviewee 15, L42-44)
Resistance to change • Reluctance of staff to change • Failure to recognise the need for change • Ability to influence change	6	• 'The most common problem is this 'we've been nursing for years and we know all there is to know about continence' where the staff are like 'we've been doing it our way for years and we're not interested' (Interviewee 2, L44-51) • '[Staff] think their care is perfectly alright yet, things have changed and moved forward' (Interviewee 6, L69-75) • 'The most difficult part is the management side and influencing the likes of menus and catering and choice' (Interviewee 12, L29-30) • 'Lots of staff don't actually use the BMI so although it's a good indicator in many occasions, trying to get clinical staff .. to use BMI is a bit more challenging' (Interviewee 14, L19-24)

Barriers	Number of interviewees	Examples of interviewee comments
BPS are not always seen as important - Guidelines are not policy - Competing priorities - No compliance	5	'Because they're clinical guidelines they're not necessarily policy, not everybody is prepared to recognise their importance' (Interviewee 10, L107-109) 'These are guidelines so Trusts can choose Trusts do have the opportunity to implement partially or not at all' (Interviewee 14, L40-44) 'It's trying to get people to stop and really prioritise ... this is amongst all their other priorities as something they have to go back to and look at again Trying to get as many people as possible who ... have got umpteen priorities of their own and say this is important' (Interviewee 6, L69-84) 'I've heard of other areas where they don't necessarily see them as important because effectively they don't have any teeth or don't appear to have at the moment' (Interviewee 10, L113-117) 'At the moment, [the BPS] has been launched and there is no compliance mechanism' (Interviewee 4, L18-19) 'Because it's primary care and it's a joint future, we've got non-nursing people, carers, social work, they're going in to see patients and we need to access them to get preventative care going' (Interviewee 6, L28-30) 'At one point [during development] we said we would expect the fire safety office to visit and provide advice, we can't say you're going to do that, that depends on the fire safety office for that area. Can't say for all professions what they should be doing, especially if multi-agency' (Interviewee 7, L33-37) 'People from other disciplines mayn't agree with everything that's written within the BPS' (Interviewee 10, L111) 'We've got a medium sized Trust so trying to get the dietitians to .. see the patients within the timescale is difficult' (Interviewee 14, L19-27)
Multi-disciplinary issues	4	'Who's going to do this, who's task is this?' (Interviewee 5, L73) 'To make sure you get to as many people as possible and get as many champions for the cause to carry it through' (Interviewee 6, L33-34) 'There weren't enough hard copies and like or not, folk like a hard copy' (Interviewee 2, L75) 'Although it's online... there are lots of nurses who don't get access to the computers to download [copies]' (Interviewee 6, L26-28) 'We haven't tended to do [dysphasia assessment] ... it's more applicable to ... acute areas ...it's not something which is commonly seen in our area so that's been difficult for us to implement' (Interviewee 10, L52-56) 'There's an awful lot of guidelines that impact on nursing, we can get guideline overload... with nutrition there are 5 sets [of guidelines] ...[but] they don't all say exactly the same thing and sometimes it can be a little bit too much trying to implement all these clinical guidelines people just get a little bit jaded sometimes with the amount of guidelines we're being bombarded with' (Interviewee 10, L95-106)
The need for local champions	3	
Access to the statements	2	
Difficulties relating to specific BPS	1	
Guideline overload	1	

Appendix 7- Interviewee suggestions for encouraging future use of the BPS

Suggestion	Number of interviewees suggested by	Examples of interviewee comments
Awareness raising: General & specific suggestions	8	'Could a letter have gone out to all the wards?' (Interviewee 5, L89-90) 'We really need to get the university lecturers on board .. to get them saying these are things that the nurses should be working from' (Interviewee 6, L128-133) 'Somebody to write to local newsletters .. a lot of it is through the media. You almost wish you'd a wee slot on a television programme to raise awareness publicly that these things [the BPS] are out there' (Interviewee 6, L81-85) 'Get even the reps that go around the nurses .. to say ...' have you seen these?' (Interviewee 6, L122-123) 'Every library should have one' (Interviewee 7, L79) 'You just have to keep plugging at it over and over again Keeping the awareness, keeping it at the forefront' (Interviewee 12, L82-84) 'It would have been nice to have followed it through [post launch] and done some local presentations [across the country] and disseminated it a bit more' (Interviewee 13, L34-36)
Resources: - Training & education - More continence advisors - Better toilet facilities	7	'We need better disabled toilets, we need better signage, we need more toilets around out-patient departments' (Interviewee 3, L80-82) 'I'd see changes in the patient's skin if we had a continence advisor and the staff would be using appropriate products' (Interviewee 5, L43-44) 'Although education is available, we've got a big service and making sure that everyone has access to it can be quite challenging' (Interviewee 10, L57-60) 'More study days' (Interviewee 15, L68)
Have someone locally tasked to lead each BPS: - Clinical champions - Local leaders	4	'The whole statement would be difficult to implement if you don't have someone tasked with it' (Interviewee 4, L36-37) 'Get as many champions for the cause to carry it through' (Interviewee 6, L33-34) 'Well in this situation, having somebody at a higher level, if they had more clout to sort of initiate it more' (Interviewee 9, L83-85)

Suggestion	Number of interviewees suggested by	Examples of comments
Improved dissemination: • Poster version • A4 sized version (Quick reference guides) • More copies	4	• 'It's all very well to say it's on the website ... but if people have [a hard copy] they are much more likely to use it rather than just a wee piece of [downloaded] paper' (Interviewee 2, L75-80) • 'Sometimes ... folders just get filed away ... a poster maybe would benefit (Interviewee 5, L82-83) • 'Quick guides like the SIGN guidelines which can be laminated' (Interviewee 10, L152-155)
Feedback on performance: • Clinical audit • Incorporate into the Performance Assessment Framework • Use for benchmarking	4	• 'In Scotland, there needs to be a point 3-4 years after it's published at which we do a clinical audit of patient careand say ... how are your getting on with these statements, you've had them a couple of years, what's happening?' (Interviewee 4, L66-70) • '[The BPS] could be used as a tool for monitoring, could be incorporated into the Performance Assessment Framework' (Interviewee 7, L81-82) • 'The process of benchmarking has been incredibly interesting never tried that approach before but it's been highly effective because it involved clinicians, it really helped them to see what they were doing and how they needed to change' (Interviewee 10, L128-137).
Targeted roll out & implementation	2	• 'Target some of the wards who would perhaps use it more. like the urology wards and care of the elderly' (Interviewee 3, L62-63)
Adapt BPS content to local use	2	• 'The entire document was given out and an A4 abstract which covers all the main topics with some local issues put in for example [the BPS] say use a foam cleanser, our local policy is to use Clinisan ... so we've put [in the abstract] Clinisan as that reflects local policy' (Interviewee 4 L76-83)

Appendix 8 - General comments about the BPS from the interviewees

'It was nice that ... whoever it was who suggested the topics, picked *nursing* topics rather than high tech, fancy almost moving into mini doctor type work which is where there always seems to be a push. It's lovely that the areas they came back to were areas that would be viewed as basic nursing which we clearly need to get right before we start faffing about on anything else' (Interviewee 2, L87-92)

'The BPS] is very user friendly and easy to let the nurse know what she's meant to be doing' (Interviewee 1, L19-20)

'It was very good to be involved in it [during development] (Interviewee 1, L59)

'I'm glad they're being followed up because I'm worried that they'll just sit on a shelf like a lot of other statements and that we really need to keep them live and keep using them and refer to them' (Interviewee 3, L72-74)

'I think the BPS are a brilliant idea and very brave' (Interviewee 4, L107)

I think they are like any statement, they are only of any value if they are used and it's all down to how we get them out there' (Interviewee 6, L136-137)

'I feel really, really proud of the document, [it] looks so good. Individuals on their own couldn't have produced that quality. Good quality piece of work, just produced by a bunch of nurses it's made me go out and encouraged me to do more stuff' (Interviewee 7, 83-86)

'[The BPS] has shown that you can all get together, there's a wealth of knowledge and enthusiasm in Scotland and a willingness to work together and that really came through. Nobody was in it for their own kind of benefit, it was how do we make things better for the child?' (Interviewee 7, L87-90)

'I think it's been a very useful exercise for me' (Interviewee 8, L81)

'The fact that it's research based and it benefits the patients, I think that's excellent' (Interviewee 9, L98-99)

'I think they are a good thing, they're a very good thing for nursing' (Interviewee 10, L170)

'I think they're a good thing and we need more of them ... in specific areas, issues which are of relevance to nursing, that's why these are good because they're about things which matter and which are of relevance to nurses rather than specific medical conditions' (Interviewee 10, L177-180)

'I think they are excellent and we know that they are well founded in research so that you feel quite confident using them' (Interviewee 12, L85-86)

Continued

'I think they are a great thing to do, I do think they need to be kept on top of as people do just let things slide so, it would be good to keep the ball rolling' (Interviewee 13, L38-39)

I thoroughly enjoyed working on the statement and would certainly love to be involved in something like that again' (Interviewee 13, L40-41)

'I think they are a good idea and they are evidence based practice so, whether or not people are happy with you, you always have it backed up with evidence and references so therefore people that are set in their ways, stand up and take note ... so, it gives us food for thought I think they are a very good idea' (Interviewee 15, L70-75)

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- Electronic
- Audio cassette
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