Editorial

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Linking evidence-based practice to clinical outcomes
Paul Fulbrook & Lynne Harrison

The evidence-based practice (EBP) movement is alive and well and arguably critical care nursing practice has benefited enormously from its application. This is particularly evident in the use of clinical practice guidelines and written policies and procedures that are now more strongly based on a critical appraisal of available evidence than, perhaps, they were in the past.

Whilst EBP has produced positive benefits for nursing, it is not without its challenges. For example, in our view, one of the major challenges is for nurses to develop the necessary academic skills that enable them to make informed decisions about research; in one Australian study, 42% of critical care nurses declared that they were not adequately prepared to evaluate research (Bucknall et al., 2001). If nurses are not able to make reasoned judgements about the quality of research evidence then there is huge potential for the findings of research to be applied unquestioningly – and in many cases inappropriately - to practice. And, given that most critical care nurses are frequently heard voicing complaints that they "do not have time for research," there is a real danger that the interpretive process of evidence-based practice is inadequately addressed. Thus, when nurses claim that their practices are evidence-based, whilst this might be the true, the evidence that they are referring to might (unknowingly) be either flawed or inappropriately generalised.

Another problem with the application of EBP is its currency. Almost as soon as an 'evidence-based' practice guideline is written it becomes history. For EBP to be effective in clinical practice constant updating is required. Again, the challenge is to find the time to do this. Rarely is a guideline reviewed more frequently than annually, and often policies and procedures can become regarded as 'tablets of stone' that are infrequently questioned. Because of this, when EBP is applied to practice, it may in fact be a hindrance – in terms of its ability to ensure up-to-date practice - rather than an asset.

The real problem with the application of EBP to clinical practice is in making the assumption that it has improved patient outcomes. Outcome assessment is perhaps the most important part of the classic triad of structure, process and outcome, which defines quality of care. Ultimately, outcomes are what patients care about (Berenholtz et al., 2002), and nearly two decades ago Relman (1988) was urging us to collect outcome data in order to achieve what he termed the 'third revolution' in medical care. It is not good enough for us to assume that simply because we have applied evidence to our practice that it has actually made a difference. We need to apply rigorous methods of data collection and analysis that enable us to identify clearly how effective our practice is. Essentially this means developing systems of audit that are implemented routinely, so that we can use our clinical data in a continuous way, to address the fundamental healthcare care improvement question, "How do we know that a change has led to an improvement?" (Batalden & Stoltz, 1993).

Finally, we need to understand that outcome assessment is multi-faceted. This means that our audit processes must capture all elements that contribute to the quality of patient care. Although, understandably, there is an emphasis in health care on the measurement of traditional outcomes such as patient ventilation days, infection rates, or discharge mortality, it is vital that we also gather information that informs us about other dimensions of quality. For example, using tools such as the Clinical Value Compass (Nelson et al., 1996); which addresses four outcome areas: clinical, functional, satisfaction, and costs, helps to ensure that we give our full attention, in equal measure, to all aspects.

If we can address all of these concerns about EBP, then we will be doing very well, and only then will we be able to say with any certainty that our practice is truly evidence-based.

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The World of Critical Care Nursing

2006 Volume 5 Number 1

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Connect: The World of Critical Care Nursing is published by Connect Healthcare Publishing Ltd., Crown House, 28 Winchester Road, Romsey, SO51 8AA, UK.

ISSN 1748-6254