



Elizabeth Papathanassoglou



Sek Ying Chair



## EDITORIAL

Elizabeth Papathanassoglou, Sek Ying Chair

### Excellence in critical care nursing practice: more than guidelines

Evidence accumulates that many critically ill patients may not be receiving guideline-based care (Kahn, 2017). In this issue, three articles explore issues pertaining to the implementation of clinical practice guidelines (CPG). Two articles address issues surrounding implementation of CPGs for the management and prevention of sepsis, and one article explores effectiveness and nursing implications pertaining to the use of prone positioning for patients with Acute Respiratory Distress Syndrome. Moreover, Mpouzika and colleagues address issues of inter-professional collaboration in critical care nurses, which has been shown to be a pivotal factor in CPG implementation (Kim et al., 2016).

CPGs are based on vigorous syntheses of research evidence and are central to improving quality of care. Ample evidence supports improvements in critically ill patients' outcomes after their implementation (Damiani et al., 2015). As CPGs are lengthy, detailed documents, they often cannot be readily implemented by clinicians at the point of care. A final translation step is needed, often in the form of care bundles and care management protocols for nurses. Knowledge translation (KT) in critical care is fairly recent, and there is ambiguity surrounding optimal KT strategies

Nurses' knowledge of clinical practice guidelines has been overall less than optimal (Jansson et al., 2013), and poor knowledge may be a barrier towards CPG adherence. Many other factors have been associated with low adherence, including periods of increased workload (Weismann et al., 2015). In this issue, Ibrahim and colleagues report low levels of awareness and implementation of ventilator and central venous catheter bundles among critical care nurses in Nigeria and they propose that vigorous staff education and development of unit-based protocols should be undertaken. To promote CPG implementation, multifaceted strategies addressing both healthcare professionals and healthcare systems appear to be more effective (Graham et al., 2011). For example, the addition of reminders to educational interventions appears to be more effective than education alone, whereas intensive educational efforts (including face-to-face education of clinicians in their unit) seem to be more effective than simple education.

Institutional factors may determine the success of implementation. For example, the type (e.g. public versus private hospital) and resources of healthcare organizations influence adoption of CPGs in critical care, with implementation being more challenging in lower income countries and limited resource environments (Machado et al., 2017). Furthermore, characteristics such as inter-professional collaboration, autonomy of units, large organizations, leadership support and low level of formalisation promote uptake and maintenance of CPGs (Graham et al., 2011). Moreover, Baker et al. (2010) have shown that tailored interventions to overcome barriers to change are effective in implementation efforts. This approach requires an in-depth understanding of the gaps, needs, system mechanisms, behaviors and barriers at an institution, and often calls for meaningful engagement of end-users, and identification of ways to facilitate change.

Implementation science supports multifaceted, multidisciplinary approaches that focus directly on clinical practices. Kahn et al. (2014) have shown that a nurse-led program of screening ICU patients for best practices was associated with higher quality of care and decreased duration of mechanical ventilation and

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length of stay. Knowledge translation and implementation science in critical care can largely benefit from nursing research and nurse-led initiatives.

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### EDITORS

**Prof Sek Ying Chair** (Hong Kong),  
E-mail: sychair@cuhk.edu.hk

**A/Prof Elizabeth Papathanassoglou**  
(Canada), E-mail: papathan@ualberta.ca

### EMERITUS EDITOR

**Prof Paul Fulbrook** (Australia),  
E-mail: paul.fulbrook@acu.edu.au

### ASSOCIATE EDITORS

**Ms Laura Alberto** (Argentina), E-mail:  
lauramalbert@yahoo.com

**A/Prof Sandra Goldsworthy**  
(Canada), E-mail: sandra.goldsworthy@ucalgary.ca

**Dr Esther Wong Yee Hing** (Hong Kong), E-mail: wongyh@ha.org.hk

**Prof Violeta Lopez** (Singapore),  
E-mail: violeta\_lopez@nuhs.edu.sg

### Dr Shelley Schmolgruber

(South Africa), E-mail: shelley.schmolgruber@wits.ac.za

**Prof Janet Wing Hung Sit** (Hong Kong), E-mail: janet.sit@cuhk.edu.hk

**Prof Colleen Norris** (Canada),  
E-mail: colleen.norris@ualberta.ca

**Ms Kathleen Vollman** (USA), E-mail:  
kvollman@comcast.net

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