



Report of the consultation on the development of the strategy 'Making Evidence work for Community Nursing'



Institute of Community Health Nursing

NOVEMBER 2013

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*'Good evidence makes work easier,
safer for the client and practitioner,
conserves resources and
is a very useful means of accessing resources.'*

[Participant, Focus Group]

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We would like to thank all the people who contributed to this consultation process, which has supported the development of the strategy 'Making Evidence work for Community Nursing'.

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Background

A multi-methods, consultative approach, using primary and secondary sources of information, was adopted to the development of this strategy to support the implementation of evidence-informed policy and practice on community nursing. All members of the Institute of Community Health Nursing (ICHN) were invited to take part in the development: 49 individuals participated in focus group discussions and 80 responded to the survey questionnaire. This report presents the findings emerging from the focus group discussions and the survey. The data were collected between June and August 2013.

Focus groups

Qualitative data were collected from Public Health and Community Nurses using a focus group method (n=3 groups). In total, 49 members participated in this approach. Those taking part included public health nurses, registered general nurses, specialist nurses and managers, all of whom were currently working in community settings. The focus of the discussions were on:

- main challenges currently facing front-line practitioners and managers;
- current mechanisms for identifying relevant evidence;
- information that is currently collected;
- sources of evidence (e.g. key databases accessed, other sources of information);
- supports in place to facilitate the use of evidence;
- challenges arising in the use of evidence.

A thematic analysis was conducted and key areas emerging related to challenges and barriers arising; current practices and experiences; and potential mechanisms for supporting decision-makers to use evidence. The findings from the focus groups, along with information emerging through desk research, formed the basis for the survey instrumentation and they were, therefore, critically important in identifying areas for inclusion in the survey. The findings from the focus groups were also very helpful in gaining a more in-depth understanding of the key issues arising for nurses working in community settings in Ireland.

Survey

A survey questionnaire provided an opportunity for Public Health and Community Nurses to contribute to the development of the strategy. As indicated above, key themes arising from the focus groups and other issues from desk research were used as the basis for an initial pilot questionnaire. This instrument also included some pre-tested questions that had been used in a previous study relating to nurses' knowledge, skills and attitudes related to evidence-based practice (Munroe *et al*, 2008).^{*} The pilot survey was conducted with 10 ICHN members and the findings from this analysis were used to inform the final questionnaire. The questionnaire was made available online through the ICHN and arrangements were also made for those who wished to complete the survey in hard copy.

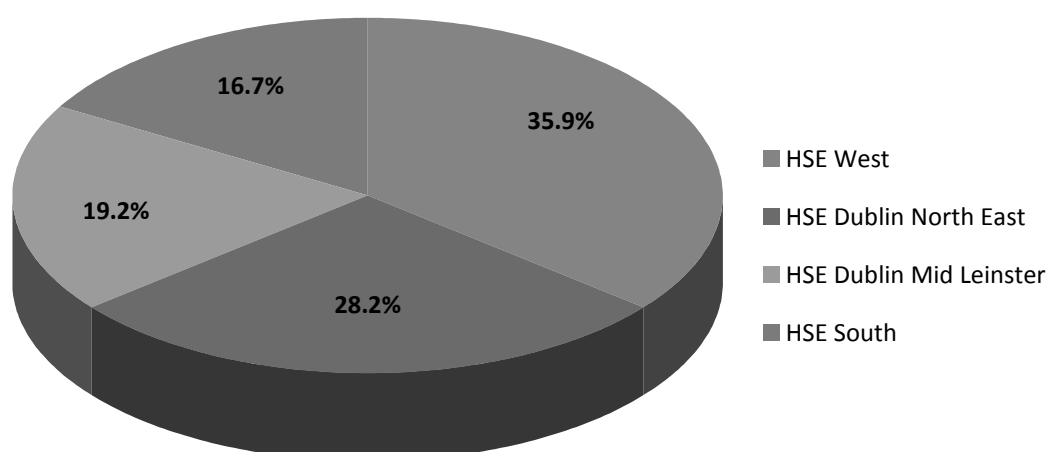
^{*} Munroe, D., Duffy, P. and Fisher, C. (2008) 'Nurse knowledge, skills, and attitudes related to evidence-based practice: Before and after organisational supports', *MEDSURG Nursing*, Vol. 17, No. 1, pp. 55-60.

Response rate

In total, 80 people responded to the questionnaire. Of those, 67 completed the survey online and 13 completed hard copies. All respondents (100%) were female. In terms of age, 41.6% were aged 50-59; 36.4% were aged 40-49; 15.6% were aged 30-39; 5.2% were aged 60 or over; and 1.3% were aged 20-29.

In terms of HSE areas, as can be seen from Figure 1, 35.9% of respondents were from HSE West; 28.2% were from HSE Dublin North East; 19.2% were from HSE Dublin Mid Leinster; and 16.7% were from HSE South.

Figure 1: HSE areas of respondents



Respondents' roles

As seen in Table 1, the majority of respondents (59.5%) were public health nurses, followed by registered general nurses (11.4%), specialist nurses (10.1%), Assistant Directors of public health nursing (8.9%), Directors of public health nursing (6.3%), agency nurses (2.5%), school nurses (2.5%), student nurses (2.5%) and academics (1.3%). Other roles mentioned by 11.4% of respondents included audiology screening in schools, nurse tutor, project officer, advanced nurse practitioner and a number of posts concerned with child health and protection. Several respondents chose more than one role from the list provided.

Table 1: Roles of respondents

Role	No.	%*
Public health nurses	47	59.5
Registered general nurses	9	11.4
Other	9	11.4
Specialist nurses	8	10.1
Assistant Directors of public health nursing	7	8.9
Directors of public health nursing	5	6.3
Agency nurses	2	2.5
School nurses	2	2.5
Student nurses	2	2.5
Academics	1	1.3

* Percentages do not add up to 100% since respondents were allowed to tick more than one role.

Findings

Findings from the survey and focus groups are presented in this section. The findings are organised according to areas relating to:

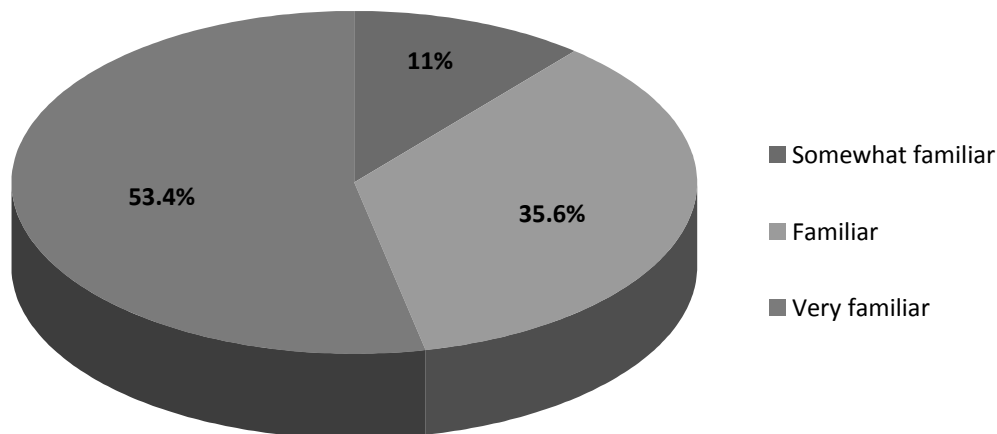
1. familiarity and confidence with evidence-based practice;
2. continuous professional development;
3. resources available;
4. challenges, enablers and sources of evidence;
5. data and research;
6. mechanisms to support ICHN members;
7. priority topic areas.

Area 1: Familiarity and confidence with evidence-based practice

Familiarity with evidence-based practice

The questionnaire asked respondents how familiar they were with the concept of evidence-based practice in their work. As can be seen in Figure 2, over half of respondents (53.4%) stated they were 'very familiar' with evidence-based practice in their work, 35.6% stated that they were 'familiar' with it and 11% stated they were 'somewhat familiar' with it. No respondents stated they were not familiar with the concept.

Figure 2: Respondent's familiarity with concept of evidence-based practice in work



Examples of using evidence

Those who completed the survey were asked to give examples of where they use evidence in their day-to-day work. The example most frequently mentioned by respondents was wound care, which was cited by almost half of all those who answered the question. Other examples of using evidence in their daily work included:

- evidence-based local/national/international policies, procedures, protocols and guidelines;
- maternal and infant health (e.g. breastfeeding, weaning, post-natal depression such as use of Edinburgh Post-natal Depression Scale);
- child health and development (e.g. percentile charts);

- parenting (e.g. Child Safety Awareness Programme, early intervention, the Incredible Years Programme);
- health promotion (e.g. smoking cessation, continence promotion, child health promotion, head lice treatment);
- diabetic management (e.g. the administration of insulin);
- assessments (e.g. pressure relief assessments, falls risk assessments, clinical risk assessments);
- hygiene (e.g. hand washing practice);
- health screening (e.g. audiology screening, vision screening using the LogMAR chart);
- enuresis assessment/treatment (e.g. the three systems model, NICE guidelines);
- patient care delivery (e.g. stoma care, leg ulcer care);
- compression bandaging (e.g. the ankle-brachial pressure index);
- infection control
- education and training (e.g. teaching strategies, curriculum planning);
- elderly care;
- palliative care.

The following quotes from the survey highlight further examples of using evidence in day-to-day work:

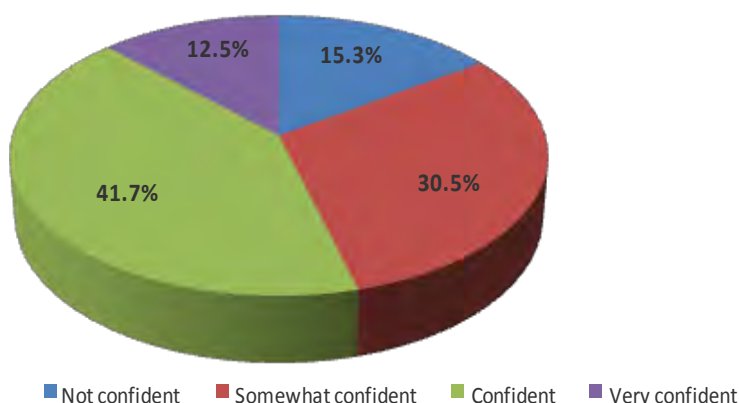
'As Assistant Director, I would use evidence on a regular basis, giving advice in relation to complex issues and also in relation to reviewing work practices, and policies, procedures and guidelines.'

'Enuresis – I use guidelines published by international bodies, NICE and the International Children's Continence Society (ICCS).'

Confidence in searching research evidence

Respondents were asked how confident they were in their capacity to word questions when searching research evidence. As can be seen in Figure 3, 12.5% described themselves as 'very confident', 41.7% as 'confident', 30.5% as 'somewhat confident' and 15.3% as 'not confident'.

Figure 3: Confidence to word questions when searching research evidence



Confidence in searching literature/databases

Similarly, with regard to searching the research literature and/or databases to answer questions about research evidence, 12.5% felt 'very confident', 41.7% felt 'confident', 36.1% felt 'somewhat confident' and 9.7% were 'not confident'.

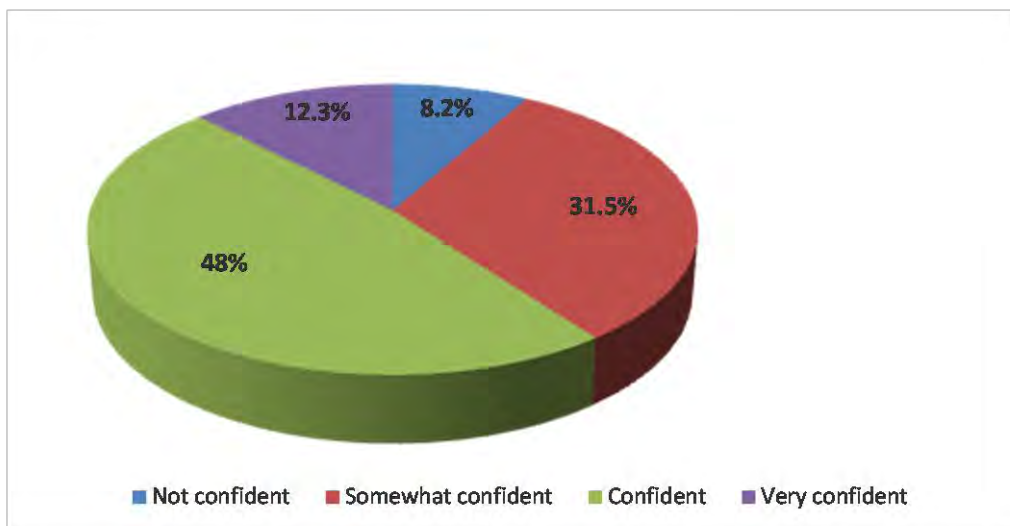
One participant in a focus group discussion noted the importance of being able to access the right information quickly because of time constraints:

'It's the ability to access fairly quickly relevant information in your health centre and to have the websites that you want to get into. Sometimes you're going in and you're only trawling. They don't have the time to trawl through everything.' [Focus Group 1]

Confidence in capacity to read/interpret research papers

Respondents were asked to rate their confidence level in relation to their capacity to read and interpret research papers. Almost half of respondents (48%) felt 'confident' in their abilities, 31.5% felt 'somewhat confident', 12.3% felt 'very confident' and 8.2% did not feel confident (see Figure 4).

Figure 4: Confidence in capacity to read and interpret research papers



Evidence-based community nursing practice

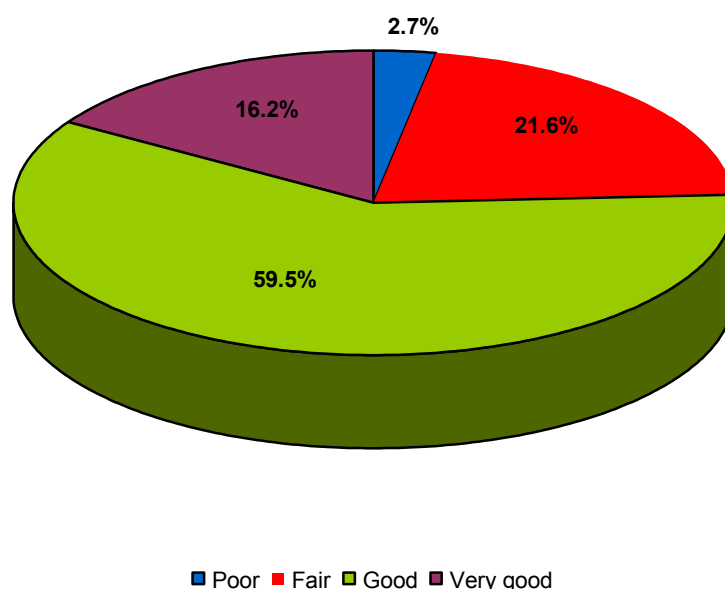
Respondents were asked to best describe their practice in relation to evidence-based community nursing, choosing from a list of statements. These statements are listed below (from the most commonly cited practices to the least common) with the percentage of respondents who agreed with the sentiments:

- 'I make sure my everyday practice is evidence-based by regularly comparing my practice against the best practice standards.' **54.2%**
- 'I assume that my everyday practice is evidence-based because I follow policy guidelines.' **40.3%**
- 'I assume my everyday practice is evidence-based because I follow the practices of other nurses I work with.' **4.2%**
- 'I have no idea whether my everyday practice is evidence-based.' **1.4%**

Capacity to use research evidence in decision-making

The questionnaire asked respondents how they would rate their capacity to use research evidence in decision-making. As can be seen in Figure 5, almost 6 out of 10 respondents (59.5%) rated their capacity in this area as 'good', 21.6% rated it as 'fair', 16.2% rated it as 'very good' and just 2.7% rated it as 'poor'.

Figure 5: Capacity to use research evidence in decision-making



Area 2: Continuous Professional Development (CPD)

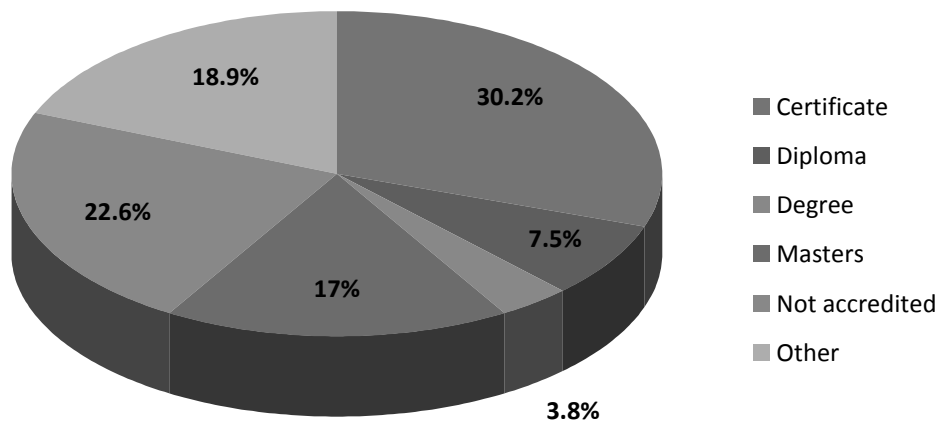
Experience of CPD in previous year

Almost two-thirds of respondents (65.4%) said that they had undertaken certified Continuous Professional Development (CPD) in the last year, while just over one-third (33.6%) had not. Types of CPD undertaken by respondents included training days, post-graduate degrees and doctorates (e.g. Diploma, MSc, PhD), programmes, courses, workshops, master classes and conferences. Many different subject areas were covered, ranging from clinical issues (e.g. basic life support, understanding blood results and IV training) to health promotion and protection (e.g. breastfeeding, ante-natal training, prevention of infections) to issues relating to management (e.g. clinical supervision, quality and risk in healthcare, health informatics).

CPD level

Respondents were asked to specify the level of CPD they had completed. As shown in Figure 6, out of the respondents who had undertaken CDP in the last year, 30.2% had completed CPD at Certificate level, 17% at Master's level, 7.5% at Diploma level and 3.8% at Degree level. Other levels of certification undertaken by 18.9% of respondents included post-graduate level diplomas, higher level diplomas, standalone modules, doctorates in nursing, special purpose awards, courses, CPD points, workshops and the Nursing and Midwifery Board of Ireland (NMBI) Category 1 Approval and Continuing Education Units. Just over one-fifth of respondents (22.6%) had undertaken CPD in the last year which was not accredited.

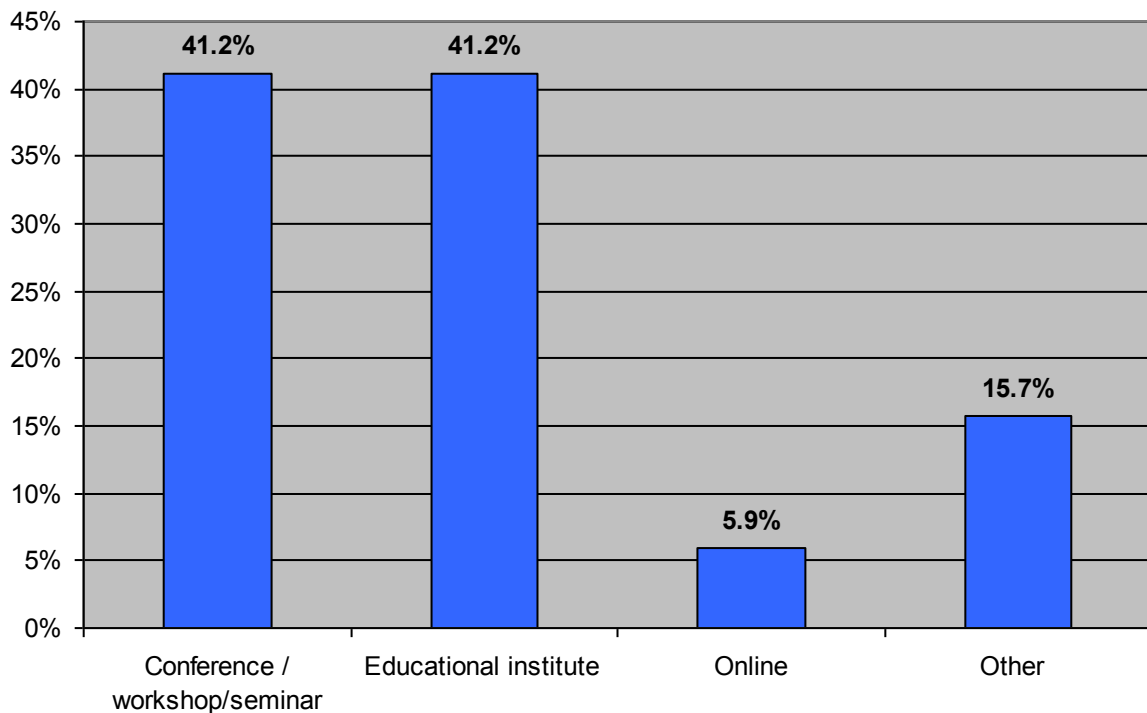
Figure 6: Levels of certified Continuous Professional Development undertaken in the last year



How CPD was accessed

Respondents were asked how they accessed CPD (see Figure 7). Of those who had undertaken CPD in the last year, 41.2% accessed it through an educational institute, while the same percentage accessed it through conferences, workshops and seminars. Just 5.9% accessed CPD online, while a further 15.7% accessed it through other means, such as through their workplace, by conducting research and in hospital-based education centres.

Figure 7: How CPD was accessed



Some discussion around online access to CPD took place in the focus groups. There was some agreement that online access is convenient, timely and a supportive way for busy personnel to keep up to date with key developments. One participant noted:

'I worked in the private sector before this job and we had exactly that system and it was just, like, you name it in relation to your job description, there was an online education. There was online education support and you just went through the programme and you did a little bit of an exam type thing at the end. It was just constantly documented and there and then, you had your documents.' [Focus Group 3]

Area 3: Access to resources to support evidence use

It was clear from the focus group discussions that considerable differences exist in terms of access to IT resources across the country and this has a significant effect on how community nurses are able to access and use information. Some issues raised related to having to queue to use the computer since these are often shared between a few nurses. In the course of one conversation, it was noted that one nurse was particularly privileged because:

'She has it [a computer] to herself, whereas most people – actually two or three people – are sharing one general computer, sometimes for an hour in the morning.' [Focus Group 1]

Others noted that many websites are blocked by administrators in the HSE, leading to frustrations in accessing information from legitimate websites:

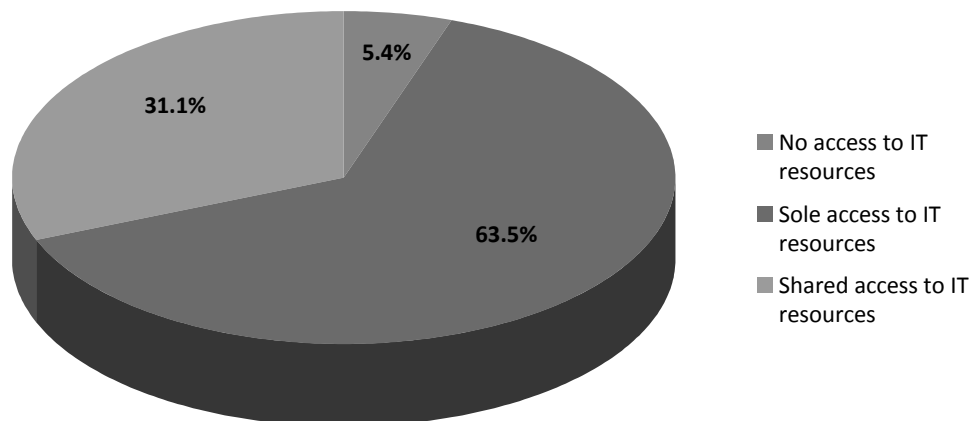
'When you go on to the HSE Internet and you want to go outside, to maybe the ESRI or something, it's blocked. I have to ring down to the number. It's so frustrating.' [Focus Group 2]

One person summed up difficulties around IT access and use with staff, as follows:

'Staff do not use their computers on a daily basis due to slow computers, poor skills, lack of interest, time, very slow web access.' [Focus Group 3]

Findings from the survey highlight these differences and challenges. Respondents were asked about their level of access to IT resources in their place of work. The majority of respondents (63.5%) reported having 'sole access' to a computer, laptop, tablet, etc; 31.1% reported having 'shared access' to IT resources in their place of work, while 5.4% reported having 'no access' (see Figure 8). Those with shared access to IT resources reported sharing computers, etc. with between 1-10 other colleagues.

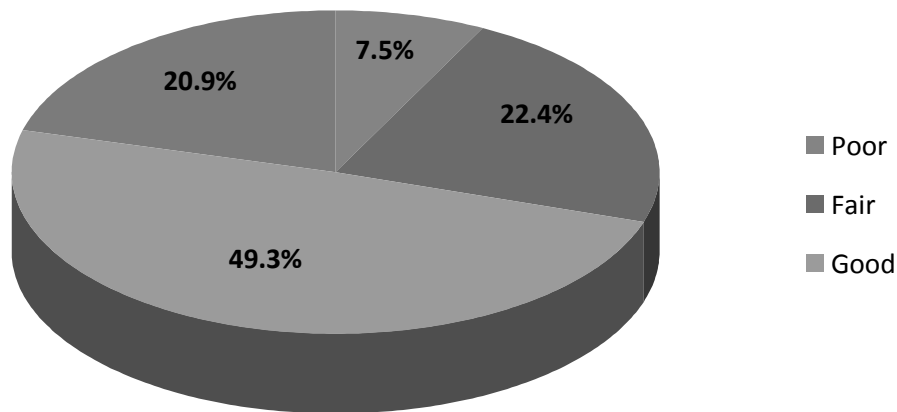
Figure 8: Level of access to IT resources among respondents



Internet access

Overall, 88.7% of respondents have access to the Internet at their place of work, while just over 1 in 10 (11.3%) have no Internet access. As regards the quality of Internet access in their place of work, almost half of respondents (49.3%) considered it to be 'good', 22.4% considered it to be 'fair', 20.9% considered it to be 'very good' and 7.5% of respondents considered it to be 'poor' (see Figure 9).

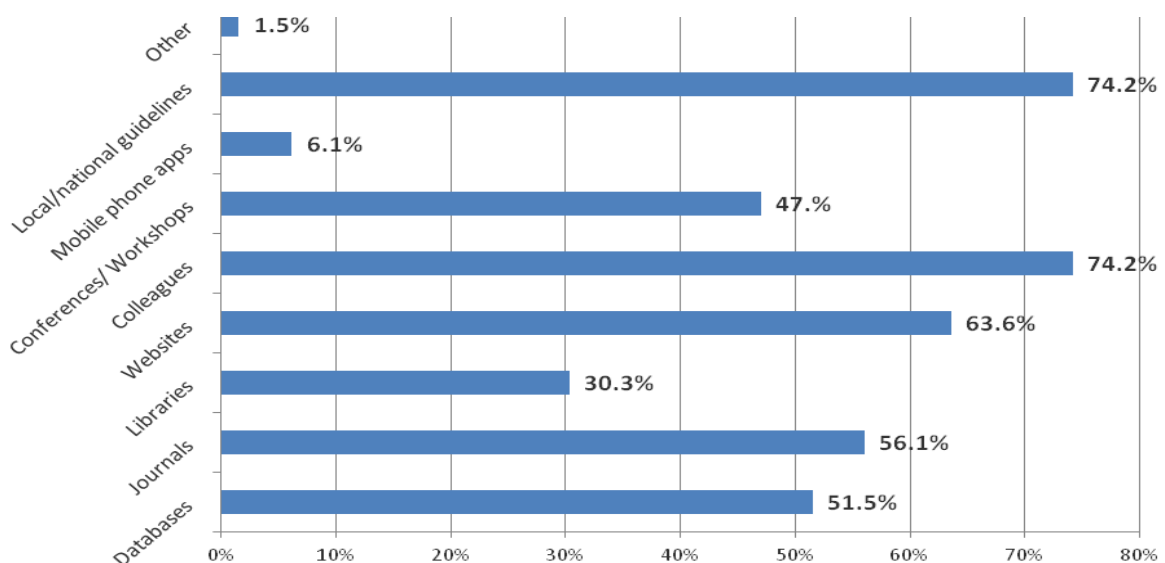
Figure 9: Quality of Internet access in place of work



Information sources

Respondents were asked to identify sources of information that they had used in the course of their work in the last 3 months. As seen in Figure 10, the most frequently identified sources of information were colleagues (74.2%) and local/national guidelines (74.2%), followed by websites (63.6%), journals (56.1%), databases (51.5%), conferences/workshops (47%), libraries (30.3%), mobile phone apps (6.1%) and 'other' sources (1.5%).

Figure 10: Information sources used in the last 3 months



Respondents were also asked to list the specific databases, journals, websites, mobile phone apps, guidelines, etc. they had accessed in the last 3 months.

Databases included:

- PubMed (www.ncbi.nlm.nih.gov/pubmed)
- Medline
- Science Direct (www.sciencedirect.com)
- EBSCO host (www.ebscohost.com)
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)

Journals included:

- IMNO Journal of Nursing
- Nursing in the Community
- Nursing Times
- Public Health Nursing Journal
- Community Health Nursing
- British Journal of Community Nursing
- Journal of Advanced Nursing
- Journal of Social Work
- Journal of Wound Care

Websites included:

- www.hse.ie
- www.hseland.ie
- www.ichn.ie
- www.immunisation.ie
- www.higa.ie
- <http://hisinm.ie>
- www.hpsc.ie/hpsc
- www.lenus.ie/hse
- www.unitardis.ie
- www.nursetonurse.ie
- www.nursingboard.ie
- www.imt.ie
- www.cso.ie
- www.esri.ie
- www.cochrane.org
- www.eric.org.uk
- www.prashisous.org.uk
- www.openathens.net
- www.ovid.com
- www.wocn.org
- <http://bestpractice.bmj.com/best-practice/welcome.html>
- www.aasmnet.org
- www.disabledliving.co.uk/PromoCon/About
- <http://onlinelibrary.wiley.com>
- www.hc-sc.gc.ca/index-eng.php

During the focus groups, some issues arose about guidelines being developed and implemented across the country and the time, energy and challenges involved in getting guidelines and policies that are relevant to those working in the community. Particular issues were raised about the duplication of work and the amount of time taken for these documents to be developed. One participant noted that:

'There seems to be a huge problem, though, in getting guidelines and policies published ... I've been involved in different national ones ... they take so long and they're so slow.'
[Focus Group 2]

Guidelines and policies being used by participants in this consultation included those from the HSE, HSE West, HSE North East, NICE and UK Trusts on issues such as:

- HSE Service Plan
- HSE Incident Reporting Policy
- Children First: National Guidance for the Protection and Welfare of Children
- Care of Hicks and PICCs in the Community Guideline (NWD)
- HSE Risk Management Guidance
- New-born bloodspot screening
- NMBI record-keeping and documentation guidance
- Clinical practice
- Post-natal care
- Safe use of bedrails in the community
- Wound care
- Infant nutrition
- Child developmental screening
- Tissue viability/leg ulcers
- Self-neglect
- Tracheostomy care
- Vac therapy
- Stoma care
- Non-attendance of children at appointments

Other cited sources included:

- Internet search engines (e.g. Google, Google Scholar, Safari);
- colleagues (e.g. public health nurses, clinical nurse tissue viability specialist, Wound Management Association of Ireland);
- conferences (e.g. hearing screening update);
- libraries/research centres (e.g. WRH library, INMO library, ABA library, Sligo Regional Hospital Library and Research Centre, TCD library);
- online libraries (e.g. HSE, RCSI, DCU);
- training/courses (e.g. HSE courses, private company training on medical products);
- forums (e.g. forum for diabetes injection technique);
- newspaper health supplements (e.g. *The Irish Times*, *Irish Independent*).

Area 4: Challenges, enablers and sources of evidence

Challenges in using evidence

Respondents were asked to identify the **Top 3 challenges** that apply to using evidence in their work. The most commonly mentioned challenges to the least common are listed below:

- lack of time to access/review information **93.1%**
- lack of training/education/guidelines on how to access information **37.5%**
- lack of access to information **30.6%**
- lack of emphasis on importance of evidence-based policy/practice from management **23.6%**
- lack of knowledge on how to access information **20.8%**
- no access to the Internet or computer in work **11.1%**

Other challenges cited by 26.4% of respondents included the following:

- lack of evidence-based policies/guidelines;
- lack of competency training for new/updated guidelines;
- lack of published research on Irish public health nursing (relevant because international research is not always comparable since based on varying models, etc);
- the expectation to access information in your own time;
- lack of staff cover to access training days;
- increase caseloads due to no staff replacements;
- lack of team research;
- lack of online learning resources;
- lack of concise, up-to-date information (e.g. free full articles);
- lack of decision support systems;
- lack of PHN Professional Development posts;
- slow Internet download speeds;
- inability to access some online information due to Internet security in the workplace;
- lack of funding.

The following quote from a participant at one of the focus group discussions sums up some of the challenges that apply to using evidence in community nursing work:

'The rate of evidence is difficult to keep up with and warrants decision support systems to aid practitioners to make up-to-date decisions in conjunction with clinical practice for the ultimate benefit of the patient.' [Focus Group 1]

Enablers to using evidence

In the same way, respondents were asked to identify the **Top 3 enablers** that would help them use evidence in their work. The most commonly mentioned enablers to the least common are outlined below:

- more time **68.1%**
- dissemination of regular, up-to-date policies/research findings in easy-to-read format **48.6%**
- clinical review meetings with colleagues to share evidence-based policy and practice **47.2%**
- access to a Practice Development Officer or Clinical Educators **30.6%** and **19.4%** respectively
- promotion of evidence-based policy and practice from management **26.4%**
- training/education/guidelines on how to access information **22.2%**
- more accessible databases **18.1%**
- access to a computer and the Internet at work **13.9%**

A further 11.1% of respondents highlighted other factors that would enable them to use evidence in their work, which included:

- journal clubs;
- team research;
- updated systems to access evidence;
- Practice Development Officers working 'on the ground' to promote evidence-based policy and practice on an ongoing basis;
- highlighting best practice areas, where evidence drives practice;
- faster Internet download speeds;
- collaboration with higher education institutes;
- specialist support for dealing with difficult cases;
- focus on community nursing needs in Centres of Nursing/Midwifery Education (CNME) and among Practice Development Officers.

Some innovative developments have taken place across different areas and one example of this was given by a participant at one of the focus group discussions:

'We used to do workshops in areas – a group would get together on one particular subject and everybody reads and looks up the research. We would bring cases and then discuss them at the workshop with the research and use it as of how we do it differently.' [Focus Group 2]

Area 5: Data and research

Data

Many participants in the focus groups drew attention to the amount of writing up they are expected to do – in the form of, for example, reports, case notes, assessments, monthly returns, to name a few – and the way in which this activity can detract from providing the actual service. One person noted:

'We just do so much writing and it takes us away from the clients ... They expect us to provide the same information again and again, and we never get to see anything back out of it.' [Focus Group 1]

Others drew attention to differences across individual counties, resulting in a lack of harmonisation across the country. This has implications for being able to report on a regional or national basis. One person noted that despite the amount of time being spent on writing:

'We're not able to describe accurately enough what we do. You prevent somebody going back to acute hospital service, but how do you document this positive outcome?' [Focus Group 2]

The importance of technology to support data collection was also highlighted, with one survey participant noting that what was needed was:

'... a good, comprehensive computer package where the data we collect could be inputted and could provide stats in relation to numbers of children, schools, areas, conditions/defects, number of referrals to where, reviews, length of clinic waiting lists, attendance, intervention (e.g. glasses) and [this would] provide easily accessible data for audit purposes and review purposes.'

In the course of discussions held, a number of stakeholders drew attention to the work carried out on the development of the Population Health Information Tool (PHIT) and its importance in supporting the collection of data in a systematic and harmonised way. This, it was suggested, would have many benefits for the client, the individual public health nurse and the overall delivery of the service.

In addition to such information gleaned from the focus groups, respondents in the survey were asked to identify the types of data they currently hold or collect in their role as nurses working within the community. An extensive list of data covering a wide range of areas was identified (see Box 1).

Box 1: Data collected through the community nursing service

- Monthly returns (e.g. child health, elderly care, crucial caseload)
- Patient/client records
- Patient/client care lists (e.g. home care package clients)
- Number of clinics (e.g. child health, leg ulcer, well baby clinics)
- Breastfeeding data/statistics
- Clinical returns (e.g. child health returns)
- Clinical data
- Patient/client database (e.g. physical and intellectual disability database)
- Active caseload lists
- Dressings list
- Area profiles
- Immunisation statistics
- At-risk registers (e.g. elderly, children and families)
- Risk assessments
- Screening records (e.g. audio/vision screening numbers who passed/failed, number of schools, absentees, etc)
- Call and communication data (e.g. number of calls, type of calls, number of communications)
- Caseload numbers (e.g. clinical and child caseloads)
- Education databases
- Area diary
- Absence data
- Clinical case meeting minutes
- Folders (e.g. policy folders, clinical record folders, wound care clinic folder, leg ulcer clinic, patient assessment folder, family folders, child repository folders)
- Digital images (consent given), anonymous and safely stored as per HSE policy
- Product information (e.g. about wound care)
- Yearly statistics
- Yearly point prevalence studies
- Annual caseload audits
- Annual and quarterly summary data from PHN caseloads
- Order forms (e.g. stock, equipment)
- Servicing data
- Performance indicators
- Register of births
- Charts (e.g. wound charts)
- School screening returns
- Expenditure reports
- Complaints and compliments files
- Vulnerable adult list for emergency planning purposes
- Staff data (e.g. staffing levels, personnel files, absenteeism data, mileage, travel expenses, training/courses completed)
- Budgetary information

Research

In terms of research, 18.5% of respondents stated that they had carried out studies or published papers in the last 5 years. The majority (81.5%) had not done so. Research themes cited by respondents included:

- breastfeeding;
- social workers' perceptions of the public health nurse's role in child protection;
- food neophobia in pre-school children;
- a referral system for Primary Care Teams;
- behaviour difficulties identified by parents at the 18-24 month development assessment;
- continence promotion in children;
- nurses' knowledge of leg ulcer management;
- changing practice to support service delivery;
- caseload management – an approach to making community needs visible;
- caseload dependency development of integrated teams;
- public health nurse services caseload profiling;
- electronic solutions.

One person in the survey commented that:

'Research can sometimes appear like it all happens in educational institutions and because there is minimal placements of students in the community, I believe we have lost out on that input from schools of nursing. Research and clinical practice in nursing are often poles apart and bringing it to the ground and demystifying it might encourage more participation in seeking evidence and in the research process itself.'

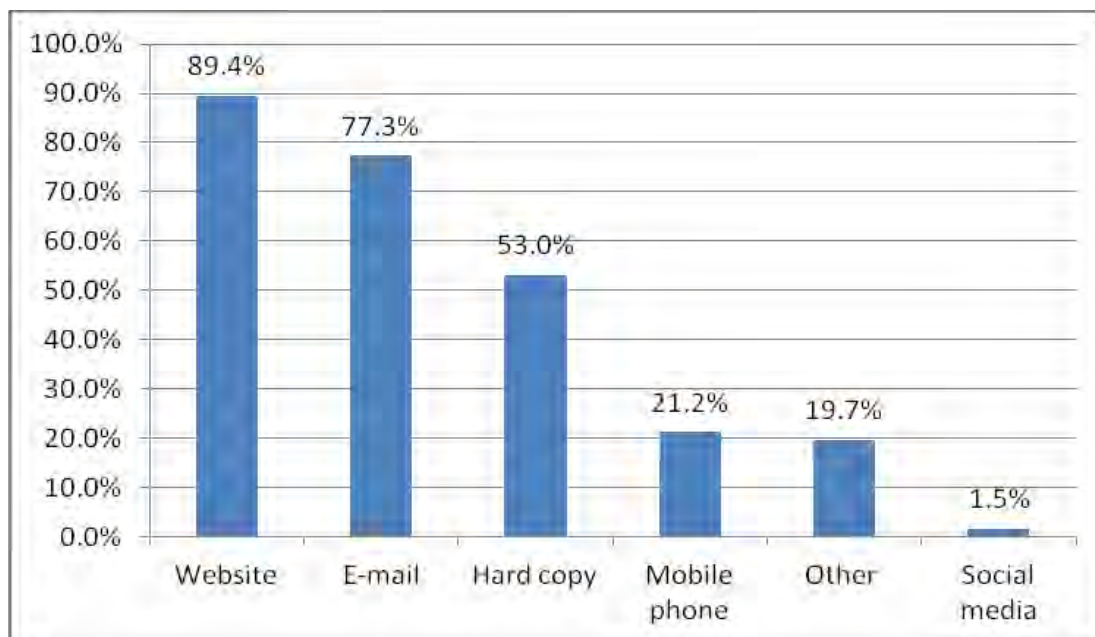
Studies and papers were published or submitted to educational institutes as part of academic studies (e.g. MSc, PhD), to the HSE and the HSE HUB, and to journals such as *Nursing in the Community*, *British Journal of Community Nursing*, *World of Irish Nursing* and *Journal of the Irish Nurses and Midwives Organisation*. A number of respondents were in the process of seeking publication and conference presentations.

Area 6: Mechanisms to support ICHN members

The survey asked respondents to identify the **Top 3 most useful ways to access information** to support evidence in their day-to-day work. As seen from Figure 11, the most useful way of accessing information was judged to be through websites (89.4%). This was followed by e-mail (77.3%), hard copy (53%) and mobile phone (21.2%), with only a small percentage identifying social media (1.5%). Almost one-fifth of respondents (19.7%) identified 'other' useful means of accessing information to support evidence in their daily work and these included:

- journals;
- libraries;
- databases;
- post/fax;
- work colleagues;
- professional meetings;
- local journal clubs/meetings;
- promotional literature from companies;
- expert lectures on site;
- HSE intranet;
- online HSE guidelines.

Figure 11: Most useful ways to access information to support evidence in day-to-day work



ICHN support in using evidence

Respondents were asked to identify the **Top 3 ways the ICHN could support them** in using evidence in their day-to-day work. The most commonly mentioned types of support were:

- Dissemination of information through the ICHN website, e-mails, blogs and newsletter, e.g. the latest research evidence findings, updates, reports, articles and new documents, links to journals and websites, information on conferences, networking, facility to reference evidence-based practices, recommended reading and case studies of evidence in practice submitted by PHNs, provide easy-to-read formats of information.
- Enable access to information, e.g. create an easily accessible database on the ICHN website, provide links to databases, research reports, allow PHNs to develop a library, provide links to other websites.
- Develop national policies and guidelines.
- Run educational courses/workshops/training, e.g. relating to clinical practice, best practice, reviewing local policies, accessing and using research followed up with link to ICHN research hub.
- Enable protected time/study days.
- Develop and provide information on online training and learning opportunities, e.g. online training, tutorials, courses, modules.
- Facilitate professional interest groups/research interest groups.
- Increase awareness of the importance of evidence-based practice, particularly at managerial level.
- Conferences and seminars.
- Recognise and support nurses with expertise and qualifications as 'knowledge brokers' by, for example, sharing knowledge with others or giving talks in a more systematic and accessible way.
- Provide research funding.
- Actively promote research among members.
- Write articles in national nursing magazines.
- Create a quarterly publication with a summary of recent studies on subjects of interest to public health nursing.

- Influence leadership in community nursing.
- Develop a mobile phone app.
- Lobby policy-makers.

The following quotes from survey participants highlight some of the ways the ICHN currently support them and how they would like the ICHN to support them in the future:

'I think the ICHN supports me by informing me of matters which are relevant to nursing in the community. It often gives links to websites that provide me with more information on particular topics. I find this very helpful.'

'How about a quarterly publication of recent studies on subjects pertaining/of interest to Public Health Nursing, with a brief synopsis? I receive this from the ICCS [International Children's Continence Society] on children's continence and it is really helpful.'

'... [would like] recognition for nurses working in the community and [for those who] have carried out academic studies in specific areas, as knowledge brokers for colleagues.'

Other comments

Lastly, all those who took part in the consultation (survey respondents and focus group participants) were encouraged to provide any other comments about using research in their work. The main issues highlighted related to the following areas:

- the importance of using evidence-based research;
- lack of time to access information and training;
- funding restrictions;
- increased awareness of the benefits of using research;
- lack of research in the area of community health nursing;
- more promotion/support for conducting research;
- develop links with educators to discuss current research findings;
- more Practice and Professional Development officers needed;
- review of the purpose of monthly returns;
- need for more efficient data collection methods;
- standardisation of nursing records and documentation nationally to support evidence-based practice;
- in-house clinical audits;
- develop easy-to-use handy checklists for specific clinical duties (e.g. dementia screening, tissue viability);
- increased integration of evidence-based policy and practice into documentation to highlight best practice;
- up-to-date databases;
- development of national policies, procedures and guidelines;
- development of a governance model and nursing data infrastructure for public health nursing;
- lack of access to IT resources/poor Internet download speeds.

Area 7: Priority topic areas

All those who took part in the consultation (survey respondents and focus group participants), as well as other stakeholders, were asked to identify **3 areas by topic which they considered a priority**. Amalgamating the themes that emerged from the quantitative and qualitative data, the most commonly identified areas are listed below.

Children and families

- Child health and development, e.g. autism, growth monitoring, immunisation, health assessments, behavioural issues, emotional and mental health
- Maternal and infant health, e.g. breastfeeding, post-natal depression, pre-term babies' development
- Parenting support, e.g. care planning, support for parents of children with behavioural problems
- Child protection, e.g. clinical supervision, effective interventions for children, families, schools
- Nutrition, e.g. childhood obesity, feeding issues in children, nutrition in the elderly
- Vision and hearing screening
- Health promotion, e.g. school health/hygiene, head lice

Adults and older people

- Tissue viability/wound care
- Care of the elderly, e.g. dementia, Alzheimer's, assessment/management of memory loss, depression, nutrition
- Palliative care in adults and children, including communication with families about end of life
- Super pubic catheterisation
- IV lines/central line care and management
- Continence/incontinence
- Infectious diseases
- Interpreting blood results
- Chronic illness management
- Oncology developments
- Stoma care
- Resuscitation policies

Population health

- Clinical governance
- Guideline development
- Risk management
- Legal issues, e.g. consent
- Patient-centred care
- Disability
- Nurse prescribing
- Rehabilitation
- IT skills, e.g. how to create databases
- Prioritisation/service rationalisation and risk management
- Measuring cost-effectiveness and value for money of nursing interventions in the community
- Population-based interventions in public health nursing
- Public health nursing outcome data for individual and population levels
- Health informatics/epidemiology
- Legal implications of documentation, record-keeping and report writing

Summary of consultation

In summary, while the Institute of Community Health Nursing (ICHN) can, and has, given a strong commitment to implementing this strategic approach to supporting nurses working in the community to use evidence in decision-making, it is clear that in order to fully achieve this aim, a number of key stakeholders also have important roles to play. Specifically, the part played by the Directors of Public Health Nursing, the HSE Office of the Nursing and Midwifery Services Director and the Division of Nursing within the Department of Health are all critical partners if implementation is to be successfully achieved. Other Divisions in the HSE, community and other organisations and structures are also crucially important. The ICHN commits to working collaboratively and in partnership with each stakeholder for the purpose of making evidence work for community nursing.