Leading article/Uvodnik

Getting practice into evidence
S prakso podprti dokazi

Roger Watson

Make sure you read the title correctly as it is more common to see titles that examine 'getting evidence into practice'. I am not just playing with words here; I think we have had at least two decades of calls to close the gap between evidence and practice which assume that the evidence exists and, if it exists, it must be implemented (Watson, 2015). However, 'evidence' is rarely unequivocal and, where the benefits may be small, it is not easy—and probably not worth—convincing those who hold health service budgets to make changes which may or may not be more expensive.

The problem with evidence is that its generation is usually policy driven, either at national level or at whatever organisational level health services are administered across the globe (Watson, 2002). A problem becomes apparent, a public scandal over health care arises, such as at the Mid-Staffordshire Hospital in England (Francis, 2013) or, more commonly, something is costing too much and the search for solutions begins. The assumption is that something can be done about it, driven by the belief that something must be done about it. This is the classic 'top down' approach and it is expedited, usually, by evidence synthesis. If it is by research, such an agenda is set that the academics who take up these projects have little leeway to exercise their imaginations and, actually, make a discovery. In a sense, the answer is 'begged' and if it is not found then the project is deemed to have failed; the very antithesis of science which ensues through curiosity and inquiry.

The problem with the 'top down' approach to evidence implementation is that evidence-driven changes are usually being implemented by people who did not know they had the problem in the first place. If they do not see the sense in the change, then, unless coerced into doing so by micro-management, they will subvert the change anyway; such is the fate of so many good policy driven intentions. Unless frontline nursing staff and their allied health and medical colleagues see the problem, they will not know that it is being fixed. Unless these frontline staff are asked what problems they face, and they rarely are in my experience, then nobody will know what their problems are. But how does this relate to my title 'Getting practice into evidence'?

By getting practice into evidence I mean that the evidence presented to frontline healthcare workers should address the problems they face. To achieve that they must be given the opportunity to express the problems they face in their clinical work and the evidence - where it exists - should be sought to help them address those problems. In that way, the evidence will be based on practice issues and, thereby, on practice and is more likely to be owned, adopted and implemented. Where the evidence does not exist - and this is remarkably common - then this provides the opportunity for research projects. These are likely to be small scale and not definitive but they will be the first steps in the direction of solving recognised problems and contribute to the body of knowledge and, ultimately, to the evidence base.

Over the past few decades, small scale research seems to have been eschewed in favour of large scale, multi-million euro, multidisciplinary and large team collaborative research. This is clearly an effective strategy for problems which can be addressed this way and the RN4CAST project is an obvious and very successful example (Aiken, et al., 2014). However, while staff-to-patient ratios are an issue for frontline staff, I doubt many are vexed about the proportion of graduate nurses in the profession and, in terms of staff to patient ratios, frontline staff have no control over this. Small scale local research projects are ideal for solving local problems and they should not be dismissed, as so often they are. They can lead to greater things and it is impossible to predict where they will lead.

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However, getting practice into evidence and back again into practice does not happen by accident. Presently, we provide undergraduate nurses and allied health students with training in research and evidence-based practice. This, of course, is essential but it is only part of the solution. At the clinical level there needs to be a commitment and a strategy to ensuring that evidence and practice are linked. Strategy means budgets and personnel and a visible commitment to the cause. Therefore, how many hospitals have a research or evidence-based practice unit - actually concerned with doing research and not, as in so many cases, simply regulating it? How many hospitals have a group related to research and evidence-based practice that includes frontline clinical staff?

I will not end this editorial with a solution, rather I will point you to one excellent example where solutions are being sought which is the Evidence-based Council at Sheffield Teaching Hospitals National Health Service Trust in England (http://tinyurl.com/z39o2p2). Here an identifiable and funded group of committed individuals ask what the problems are, help staff to find solutions and then help them to publish those solutions. They also hold annual celebrations of achievement. I consider this an exemplary demonstration of how to bring practice and evidence closer together and if you want to know more, then information is easy to obtain on Google.

Slovenian translation/Prevod v slovenščino

Ste prav prebrali naslov? Pogosteje se namreč srečujemo s prispevki, ki preučujejo »z dokazi podprto prakso« V naslovu se ne poigravam z besedami – že vsaj dve desetletji se pojavljajo zahteve, da se izpolni vrzel med dokazi in klinično prakso, ki predpostavlja, da dokazi obstajajo, in če obstajajo, jih je potrebno v praksi uporabiti (Watson, 2015). Vendar pa so »dokazi« le redko nedvoumni, in kadar so koristi majhne, ni enostavno oziroma ni vredno prepričevati plačnikov zdravstveni storitev, da uvajajo spremembe, ki so (ali morda tudi ne) povezane z večjimi stroški.

Problem dokazov je predvsem to, da njihovo oblikovanje vodi zdravstvena politika na nacionalni ravni ali na ravni organizacij, ki opravljajo zdravstvene storitve v različnih delih sveta (Watson, 2002). Iskanje ustreznih rešitev se lahko prične šele, ko je problem na področju zdravstva v javnosti prepoznan in morda doseže sramotne razsežnosti, kot kaže primer bolnišnice Mid-Staffordshire (Mid-Staffordshire Hospital) v Angliji (Francis, 2013), ali pa največkrat zato, ker je trenutno reševanje problema povezano z velikimi stroški. Predpostavlja se, da je rešitev možno najti zato, ker jo je potrebno najti. To je klasičen pristop »z vrha navzdol«, ki se običajno pospeši s sintezo dokazov. Če to sintezo izvedejo znanstveniki – raziskovalci, imajo pri tem le malo manevrskega prostora za oblikovanje novih idej in dejanska znanstvena odkritja. Če rezultati ne ustrezajo željam in potrebam, projekt ne bo uspešen, kar predstavlja pravo nasprotje znanosti, ki se razvija na temelju vedoželjnosti in raziskovanja.

Problem pristopa z »vrha navzdol« pri z dokazi podprti praksi je predvsem to, da spremembe, ki jih narekujejo dokazi, izvajajo posamezniki, ki se niti ne zavedajo, da problem obstaja. Če se izvajalci ne zavedajo pomena sprememb, jih ne bodo podpirali in jih bodo izvajali le pod pritiskom neposrednih vodij. Tako pogosto propadejo številne dobre namere zdravstvene politike. Če se v vodstvih zdravstvene nege in povezanih zdravstvenih disciplin problema ne bodo zavedali, tudi ne bodo vedeli, ali je problem rešen. Če vodilnih delavcev ne bomo povprašali, s kakšnimi problemi se soočajo, in to se po mojih izkušnjah le redko zgodi, nihče ne bo vedel, kakšni so ti problemi. In kako se to povezuje z naslovom prispevka »S prakso podprti dokazi«?

Zagovarjam stališče, da bi morali dokazi iz prakse, predstavljeni vodilnim zdravstvenim delavcem, naslavljati probleme, s katerimi se le-ti soočajo. Zdravstveni delavci bodo učinkovito opravljali svoje delo le, če bodo imeli možnost izraziti probleme, ki jih v klinični praksi zaznavajo. Potrebno je poiskati dokaze (kjer le-ti obstajajo), ki bi omogočili reševanje problemov. Tako bi dokazi temeljili na problemih iz klinične prakse, torej na praksi, kar je lažje privzeti, sprejeti in izvajati. Kjer dokazi ne obstajajo, kar se dogaja izjemno pogosto, se ponujajo možnosti za raziskovanje. Taki raziskovalni projekti bi bili verjetno manjšega obsega in nedokončni, predstavljali pa bi prvi korak in usmeritev pri reševanju prepoznanih problemov ter prispevali nova spoznanja in končno tudi širitev baze dokazov.

V zadnjih desetletjih se manjše raziskave umikajo večjim multidisciplinarnim raziskovalnim projektom, ki so podprti z večmilijonskimi sredstvi in kjer sodelujejo številni znanstveniki različnih disciplin. To je seveda uspešna strategija za reševanje določenih problemov; kot odličen primer lahko izpostavimo projekt RN4CAST (Aiken, et al., 2014). Čeprav se vodilni zdravstveni delavci zavedajo problema številčnega razmerja med zdravstvenimi delavci in pacienti, pa je manj izražena skrb glede števila diplomiranih medicinskih sester med izvajalci zdravstvene nege oz. števila pacientov na posamezno diplomirano medicinsko sestro, na kar imajo vodilne medicinske sestre le neznaten vpliv. Z manjšimi raziskovalnimi projekti lahko uspešno rešujemo lokalne probleme, zato jih ni smiselno opuščati, čeprav se danes to žal pogosto dogaja. Rezultati takih raziskovanj so lahko osnova za pomembne spremembe in težko je v celoti predvideti njihovo vrednost.

Zavedati se moramo, da vključevanje prakse v iskanje dokazov in le-teh nazaj v klinično prakso ni samodejen proces. Danes se medicinske sestre in

drugi zdravstveni delavci že v času dodiplomskega izobraževanja usposabljajo za raziskovalno delo in z dokazi podprto prakso. To so seveda temelji, vendar le del rešitve. V klinični praksi so potrebni predanost zagotavljanju povezovanja dokazov s prakso in temu ustrezne strategije. Strategije vključujejo financiranje in zagotavljanje kompetentnih zdravstvenih strokovnjakov ter izraženo predanost doseganju teh ciljev. Torej, koliko bolnišnic ima svoje enote, ki se ukvarjajo z raziskovanjem in z dokazi podprto prakso? Koliko bolnišnic dejansko opravlja raziskovalno delo in ga ne le usmerja, kar se v večini primerov dogaja? Koliko bolnišnic v to delo vključuje vodilne medicinske sestre?

V zaključku svojega prispevka namesto rešitev navajam odličen zgled iskanja rešitev. V okviru »Evidence-based Council at Sheffield Teaching Hospitals National Health Service Trust« v Angliji (http://tinyurl.com/z39o2p2) deluje skupina neodvisnih, priznanih in predanih strokovnjakov, ki na osnovi ugotovljenih problemov zaposlenim rešitve pomagajo iskati in jih tudi objavljati, vsako leto svoje dosežke tudi obeležijo. Gre za odličen zgled zbliževanja prakse in dokazov, še več o njem si lahko preberete na spletu.

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