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Knowing and acting — A strategic practitioner-focused approach to nursing research and practice development

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Clinical outcomes, effective decision-making and the use of evidence in practice have been part of the nursing agenda for many years and a key focus of knowledge generation and utilisation activities in nursing research. However, while this focus prevails, the ability of our organisational systems to support nursing research in practice is still limited. There continues to be a divide between the 'knowledge generators' and the 'knowledge users', and while considerable progress has been made in the use of research in practice, less progress has been made in formally connecting academic and practice communities.

This paper argues for such a connection through a focus on practitioner research — a focus that can enable the sharing of academic and practice agendas at a variety of levels. It will be argued that if we are serious about creating 'research cultures' in practice settings, the most feasible way of doing so is through practitioner research, as this approach integrates knowledge-generation with knowledge-utilisation. A strategic approach to practitioner research in one organisation will be described and implications for research career structures discussed.

INTRODUCTION

'No man [sic] is allowed to put his mother into the stove because he desires to know how long an adult woman will survive at a temperature of 500° Fahrenheit, no matter how important or interesting that particular addition to the store of human knowledge may be ...'

'... the right to knowledge is not the only right; and its exercise must be limited by respect for other rights, and for its own exercise by others.'

George Bernard Shaw, 1856-1950 – *The Doctor's Dilemma*

Shaw contends that knowledge-generation for its own sake is an unsustainable position to adopt. He highlights the fact that while the generation of knowledge is a laudable activity, it cannot be set outside of other values. In nursing, this is indeed a relevant issue. The dominant position of nursing as a practice-based profession, means that the challenge to nursing research is to find ways of generating, disseminating and using knowledge that informs and is informed by practice itself. This paper addresses this challenge and argues that there needs to be a more explicit commitment to the connection between academic and service communities. This is not a new argument, of course, but one that is still relevant today in a healthcare environment that is dominated by discussions of evidence, outcomes and outputs.

The paper suggests that a practitioner research approach to knowledge-generation and dissemination is one strategic method of connecting academic and practice communities while preserving the agendas of both. An example of a strategic action plan for nursing research and practice development at the Royal Hospitals Trust in Belfast is outlined, and career progression issues are raised.

KEY WORDS

Practitioner research,
Research strategy,
Research culture, Critical
inquiry

BACKGROUND

Plato makes a distinction between 'those who know and do not act and those who act and do not know' (Harrison-Barbet, 1990). What is being suggested here is that there are those groups who strive to know but do not engage in acting on the basis of that knowing and those who act but do not always have the knowledge to underpin their reasoning for acting in a particular way. This argument could be seen as underpinning the traditional divide between researchers (those who strive to 'know') and practitioners (those who 'act'). The divide has led to practitioners viewing researchers as being in an ivory tower because of a perceived hierarchy between the bearers of the knowledge and those who need the knowledge to support their practice. This subordination of practice to research has always been so and is highlighted by the way academic research is often supported in healthcare organisations at the expense of practical concerns; for example, a hospital team's decision to participate in another clinical trial without direct consultation with the ward team members; career decisions made by nurses — moving into a research career is seen as career progression whereas staying in clinical practice is not; and the difficulty researchers have in disseminating research findings other than through academic publications. This hierarchical relationship between the knowledge-bearers and the knowledge-users is one that has greatly influenced the development of knowledge in nursing.

Healthcare practice is currently dominated by discussions about the need for evidence-based practice. Consequently there is a drive towards developing approaches that will enable practitioners to read literature critically, make sense of published literature in their own practice context, and change the culture of practice within their sphere of influence. Despite growing acknowledgement within the research community that the implementation of research into practice is a complex and 'messy' task, conceptual models describing the process still tend to be uni-dimensional, suggesting some linearity and logic. For example, Lomas (1994) cites the model developed by *Milbank Quarterly* (1993) as an acceptable approach for mapping issues, contexts and processes, suggesting that the complexities in implementation occur when evidence meets everyday practice, while Haines and Jones (1994) suggest a more straightforward connection between continuing education, audit and research findings. Indeed guidance from the Department of Health in England on clinical effectiveness, suggests a framework based on informing, monitoring and changing practice.

In Northern Ireland, documents such as *A Strategy for Research and Development* (DHSSPS, 1999) and *Best Practice – Best Care* (DHSSPS, 2001) exalt the value of practice based on 'best evidence' and the need for health and social care practitioners to work within an evidence-based framework. However, there continues to be a reliance on 'normative-re-educative' strategies, that is, strategies that are based on traditional notions of education, dissemination and utilisation through protocol and guidelines development. For example, in the Northern Ireland R&D strategy document, the concept of development is narrowly defined within an experimental approach and does not explicitly consider the broad range of methodologies for getting research into practice. While such frameworks have superficial appeal, if applied literally they often fail to help those involved in change processes to capture their complexity, thereby reducing the potential for successful implementation (Oxman, 1994; Kitson et al., 1996; Walshe and Ham, 1997; Dunning et al., 1998; Rycroft-Malone et al., 2002). However, despite these examples of policy and strategic development, there is continuing concern about the quality of practice 'on the ground' and the reality of the use of evidence in practice (DoH, 2001a).

Many studies have been published about ways of creating a 'research culture' in health and social care organisations (Parahoo, 1999; Perälä, 2000; Rodgers, 2000; Thomas, 2000; Parahoo, 2000). While many offer some useful perspectives in terms of effective approaches to the generation of 'research awareness' among practitioners, most make the assumption that there is a common understanding of the meaning of a research culture and that such a culture (if we know what it is) can be created. While the intention in many of these studies is to empower staff to use research to the advantage of both them and their patients, the assumption that the import of knowledge into practice is inherently a good thing is rarely challenged. Ironically, despite a plethora of research and development publications into organisational development (Jackson and Hinchliffe, 1999); learning cultures (Wallace, 1998); barriers to research utilisation (Parahoo, 2000; 1999); practice development (McCormack et al., 1999; Garbett and McCormack, 2002); effective practice cultures (Manley, 2000) and staff empowerment (Aiken et al., 1998), there remains a 'top down' academically driven inductive approach to the utilisation of research in practice. Cullum and Sheldon (1996), Kitson et al. (1998) and Estabrooks (1999) argue that there is a need for the gap between research and practice to be addressed strategically, and that focusing only on the practice of individual practitioners cannot fill this gap. Instead, there is a need to change the culture and context of practice by addressing practice developments at individual, organisational and strategic levels (McCormack et al., 1999).

McNiff (1998) asserts that 'we have grown so accustomed to the idea of the solitary and wilful creator that we find it difficult to see the deeper ecology of creation'. McNiff argues that we need to look at how things are created and not rely solely on external experiences and forces to shape our experiences. In other words, to see what is around us, we need to be able to find systematic and rigorous ways of exploring and making sense of the resulting experiences. One way of doing this, according to McNiff, is to adopt principles of 'practitioner research' in healthcare research strategies.

A PRACTITIONER-FOCUSED RESEARCH APPROACH

Schön (1991) comments that the reality of practice is messy, complex and enmeshed in ethical conflict. Practice is contextually located and embedded in multiple cultures that are created and re-created by the 'actors' in that context. Individuals can influence the context of practice, but this influence can be translated into sustainable change only when the culture is receptive to it (Argyris, 1999). Cultural change happens from 'within' and Manley (2000) refers to this as 'workplace culture', that is, the multiple cultures that make up the setting of practice (the workplace or context). Accessing these cultures enables the release of the practice knowledge that is embedded in experience, contextually bound and rarely reproduced in propositional form (Titchen and Higgs, 2001). Embracing such reality of practice treats nurses as adult learners, set within the underpinning belief that adults learn what 'they need to learn' and what makes sense to their experience (Jarvis, 1983; Schön, 1991; Griffin, 1983). Such an approach values knowledge that is both inductively and deductively derived (Kitson et al., 1998).

Practitioner research is a movement that has been in existence for some time (Brooker and McPherson, 1999) but, in general, it is poorly understood. It emphasises building on knowledge generated through practice experiences. 'Experience' is seen as a valuable source of knowledge (Benner, 1984). Recognising and learning from the development of nurses' experience in a particular practice context is considered to be an essential route towards the development of 'expertise' in practice (Manley and McCormack, 1998).

The definition of practitioner research in this paper is one that has been adapted from a definition by Brooker and MacPherson (1999):

'Practitioner research is a formal and systematic attempt made by practitioners alone, or in collaboration with others, to understand practitioners' work, with the intended purpose of transforming self, colleagues and work contexts and the development of new understandings of practitioners' work.'

This definition is deliberately inclusive in terms of paradigm, methodology and method; that is, it does not attempt to dictate acceptable forms of knowledge, methodological approaches or data collection methods. In part this is deliberate, as the tendency in the literature is to view practitioner research as synonymous with action research. Within Brooker and MacPherson's definition, various interpretations of what constitutes 'research' are possible.

The definition also makes reference to the practitioner adopting a role as a researcher. For example, the research may be conducted alone focusing on the practitioner's own practice; the work may be the focus of research conducted by others; or the practitioner's work may be the focus for research conducted in some form of collaborative arrangement between the practitioner and others (Brooker and MacPherson, 1999). In all cases, the practitioner is somebody engaged in the planning, management or delivery of health and social care. However, despite these differences, some common principles do exist. Thus practitioner research:

- Uses research processes that are negotiated and that are an integral component of practice development
- Adopts processes that are based in practice and supported by a variety of potential supervisory frameworks (for example, academic supervision; clinical supervision; mentorship; external facilitation; appraisal; action learning)
- Focuses on personal and professional effectiveness
- Enables the systematic development of practice and an integrated approach to the evaluation of the effectiveness of structures, processes and outcomes
- Considers knowledge to be contextually bound; therefore new knowledge is derived from an engagement with the context of practice.

CRITICAL INQUIRY THROUGH A PRACTITIONER-FOCUSED RESEARCH APPROACH

Much effort is expended on the creation of a research culture through such activities as journal clubs, lunchtime seminars, critical appraisal training, newsletters, individual and team journal subscriptions. However, as the Department of Health (England) (DoH, 2001b) asserts, few trusts in the UK have managed to embrace fully the development of a research culture at strategic and organisational levels. While many Health and Personal Social Services trusts in Northern Ireland have developed, or are in the process of developing, research governance infrastructures, for the majority of nurses in practice there is little evidence of a systematic and coordinated approach to nursing research. It is a situation that can best be described as a 'traditional culture of practice versus research'.

The traditional culture of practice versus research

In this culture, hierarchical management approaches prevail. Decision-making, power and authority in the organisation are vested in 'the few', and the majority of staff look to these few to make all the important decisions.

Research in this culture is carried out by academics or others in specific roles. These researchers are not seen as being engaged with practice in terms of its daily reality and challenges, thus research is unimportant to practice — research has no influence on how decisions are made about practice. Research becomes important only if it needs to be; because, for example, of some critical event, such as a patient's complaint, negative feedback, or because of an external imposition (such as an imposed policy agenda). Staff in such a culture may be familiar with the evidence but its lack of use in practice is defended from the perspective of the realities of practice; for example, too busy, poor staffing levels, poor skill-mix, no time, patients too demanding, no support. In such a culture there is usually a poor research infrastructure and what does exist does so to support those in formal research roles. Furthermore, it is not a culture that supports reflective inquiry, and there are no facilities available to make it happen. While there may be a rhetoric of support for supervision and reflection, in practice this does not happen. Interestingly, in this culture, as demonstrated by Aiken et al. (1998) there are usually significant recruitment and retention problems.

Attempts to generate a research culture in this kind of organisation are best seen as an organisational endeavour that includes:

- Supporting individual research activities/projects
- Developing methods for practitioners to access knowledge/evidence
- Co-ordinating research activities from proposal through to dissemination
- Ensuring ethical research practice
- Supporting the development of a research community among researchers.

It could be argued, however, that despite the best of efforts, this culture will only ever have an impact on 'the few'; for the majority of practising nurses engaging in research in such a formalised way it is not a realistic or desired ambition. We have to ask, therefore, what the purpose of a research culture for everyday practising nurses is. One answer to the question is that such a culture exists to create 'inquiring practitioners'; that is, to generate a culture of critical inquiry.

A culture of critical inquiry

This kind of culture is focused on a shared governance approach to management, where everybody is seen as a leader of something, and accountability and autonomy are actively promoted at every level to lead. Quality is everybody's business, and all staff working in a culture of critical inquiry are committed to continuous quality improvement and feel responsible for quality patient care.

In line with this commitment to quality improvement, a patient-centred approach to practice is adopted. This philosophy is reflected in the way practice is organised, how staff are employed and the support mechanisms in place for staff and patients. Feedback from patients is welcomed and valued at a clinical practice level and patients are encouraged and enabled to reflect on their health and social care experience. The feedback from patients is used to develop practice. Such working practices ensure that practitioners are active participants in evidence-generation and its utilisation.

Responsible for creating this culture is the clinical leader, whose central remit is that of practice developer. He/she does this by role-modelling expertise in practice, creating a culture where patient-centredness can flourish, enabling critical inquiry to happen through a variety of approaches (including supervision, supported reflection, staff meetings), actively seeking feedback from service-users, working in partnership with staff members and using internal and external policy developments as opportunities for further devel-

opment and improvement. In such a climate there is a systematic approach to the evaluation of practice achievements through clinical audit, patient stories, and organisational review. In addition, activity reports are made accessible to the public, and achievements, no matter how small, are celebrated.

In such a culture of critical inquiry, learning is an explicit component of practice. Every aspect of nursing — clinical, managerial or educational — is practice-focused. Experience on its own does not result in learning or the development of expertise. Rather, expertise is predicated on learning from experience so that future practice is enhanced. Benner (1984:36) describes expertise that is derived from experience as being 'the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of difference to theory'. In other words, experience needs to be processed if it is to have an impact on an individual's behaviour.

To facilitate the process of learning from experience, there needs to be organisational support for the principles and values underpinning practitioner research. This needs to be combined with an infrastructure that systematically assists nurses to reflect on practice experience, critically review the elements of that practice, actively engage in developing/experimenting with practice, and synthesising the learning gained from the process.

For such a culture to be created, criticism should not be suppressed but, rather, welcomed as a part of a continuous learning process. Evaluation of practice in this culture will not rely solely on managerial-driven agendas of efficiency and effectiveness in order to demonstrate corporate accountability. Instead, evaluation means 'self-evaluation', and will use a variety of approaches, including feedback from colleagues, from service-users and from service-leaders in a continuous cycle of improvement. For such evaluations to be of genuine value they must lead to action — action that is instigated and owned by practitioners and supported by service-leaders at every level. Because any action must be within the boundaries of the broad corporate goals of the organisation, responsibility for any actions lies with practice leaders. The organisation is thus showing that it trusts practitioners to exercise their autonomy.

Leadership is central to this culture, and everybody is seen as a leader of something (transformational leadership). Clinical leadership is of greatest importance in this culture: it is the clinical leaders who give the staff the confidence to take the risks that working in this way requires. Knowledge generated externally, for example, from academic communities, professional bodies and statutory organisations, is welcomed, because it helps to place local developments in a strategic context.

Creating such a culture does not (in the first instance) require the establishment of 'new' structures. However, it does require:

- A commitment to clarifying and making explicit values underpinning practice
- Embracing transformational leadership and being systematic and rigorous in its operationalisation
- Commitment to making critical inquiry happen
- Role clarity among leaders and 'enablers' of this culture.

Developing such a culture of critical inquiry does not, however, necessarily lead to the creation of an inquiring culture; it also requires what Winter and Munn-Giddings (2001) refer to as an 'emotional climate', by which they mean that the nature of relationships and interactions among and between staff groups is important. Goleman (1996) refers to this relationship as 'emotional intelligence' and suggests that it comprises the arts of

supportive criticism, emotional self-awareness, respecting diversity of opinion as a resource rather than as a personal threat, listening to and learning from each other and maintaining group productivity. Putting this concept into practice requires group/team members to listen to each other as equal partners, to value diversity of opinion and acknowledge individual and group feelings as an important part of critical inquiry. It can be argued that clinical supervision, supported reflective practice and action learning are formalised processes for embracing a culture of inquiry and enabling practitioners to develop emotional intelligence.

CRITICAL INQUIRY IN ACTION: THE ROYAL HOSPITALS TRUST NURSING AND MIDWIFERY RESEARCH STRATEGY

The Royal Hospitals Trust, Belfast, is the largest healthcare trust in Northern Ireland, with a staff of approximately 2,400 nurses. The trust consists of four integrated hospitals on one site — The Royal Victoria Hospital (RVH), which provides all major 'adult' specialties; the Royal Jubilee Maternity Hospital (RJMh); the Royal Belfast Hospital for Sick Children (RBHSC), and the Dental Hospital. In September 2000, the Royal Hospitals appointed a professor/director of nursing research and practice development with the intention of developing the nursing and midwifery research and practice development infrastructure in the trust. Over the past two years, work has been in progress to develop a strategic direction for research and practice development that is focused on the needs of practising nurses in the continuous development of the quality of patient care.

The vision statement for nursing and midwifery research and practice development in the trust is:

'To have a systematic approach to the development of practice and practitioners, using and generating knowledge from a variety of sources.'

This vision is consistent with the previous description of an inquiring culture as being one that embraces research and practice development in the everyday world of practice. A three-stage approach was adopted in developing this strategy.

Stage 1: Consensus workshops

During January and March 2001, four consensus workshops were held with staff from the clinical directorates in the RVH to which 130 nurses from all grades attended. In addition, formal consensus-seeking processes were undertaken with midwives from the RJMH and with nurses in the RBHSC, thus recognising the related but differing agendas of different nursing specialties. The aims of these workshops were to:

- Agree the values underpinning the research and development strategy
- Understand staff commitment to the strategy
- Seek views regarding staff willingness to participate in delivering the strategy
- Determine nurses' and midwives' priorities for research and development.

Stage 2: Questionnaire survey

The data from the consensus workshops were analysed, from which themes were derived which were used to develop a questionnaire for a sample of 20% of the nursing staff across the trust. Four hundred and forty one questionnaires were distributed and 308 were returned, representing a 64% response rate.

Stage 3: Analysis of survey data and strategy development

The data from the survey were analysed using NUDIST N5. Broad themes were derived from the data, and were analysed by members of the nursing and midwifery research committee and validated using NUDIST N5. The strategy was then developed to reflect the data from these themes and priority issues raised by staff. The priority issues raised are listed below.

The principles that staff want to underpin the strategy

- Research processes used should be negotiated and be an integral component of practice development
- Research and development processes adopted should be based in practice and supported by a variety of potential supervisory frameworks (eg academic supervision; clinical supervision; mentorship; external facilitation; appraisal; action learning)
- The focus should be on increasing personal and professional effectiveness
- Practice should be developed and evaluated systematically
- Because knowledge is embedded in practice, new knowledge should be generated from an increased understanding of our practice.

The purposes of the strategy as recommended by staff

- Provide a structured framework for critically evaluating practice
- Develop reflective, questioning practitioners
- Offer direction for changing practice
- Motivate nurses to develop practice
- Demystify research processes
- Develop consistency of practice among nurses
- Increase standards of professional practice
- Generate new knowledge from practice
- Raise awareness of evidence for practice
- Systematically disseminate research findings
- Promote beneficial changes in practice
- Create an environment that values research and development
- Support rigorous approaches to research and development
- Increase the profile of nursing research and development
- Promote research and development work in clinical practice.

Action required by nurses to achieve the strategy purposes

- Actively promote the implementation of systems in each directorate to develop questioning, reflective practitioners
- Identify ways of using involvement of research as a part of career progression
- Make research integral to daily practice in wards and departments
- Implementing the strategy is every nurse's responsibility
- Ensure that the continuous improvement of 'essential aspects of care' is a priority.

The role that staff see for themselves if they are to implement the nursing and midwifery research and development strategy (listed in order of priority)

- Be open to change
- Reflect on practice
- Participate in research and development activities
- Identify aspects of practice that need to be developed
- Question practice and raise concerns

- Lead by example
- Support reflection on practice
- Communicate research with others
- Act on research findings
- Disseminate research and development results
- Motivate others to participate in research and development activities
- Promote the value of research and development
- Provide patients with information based on research
- Contribute to the collection of data
- Engage in practice that is supported by evidence
- Facilitate other staff in questioning practices
- Lead the involvement of staff in research and development.

Factors identified by staff that will enable the strategy to be successful (in order of priority)

- Resources must be available to support the strategy
- It must be relevant to clinical practice
- There must be good communication with all clinical areas
- Everybody should 'own' it
- It must have clear and measurable objectives.

THE STRATEGIC FRAMEWORK

Figure 1 is a representation of the integrated research and practice development strategy, embracing all the themes identified by staff. At the core of the strategy is the development of person-centred nursing practices. This is a key priority of the nursing directorate's strategic focus and one that was reinforced by participants in the strategy development. The development of person-centred practices requires nurses and midwives to draw upon a variety of sources of evidence. In some cases this evidence will already exist and systems will need to be developed to translate the evidence into an understandable format (knowledge transfer).

In other cases, assistance will be needed to help practitioners use knowledge in practice through a variety of developmental processes (knowledge utilisation). Engaging in the transfer and use of knowledge in practice is a research process in itself, and through these processes new knowledge is generated (knowledge generation). An integrated approach to research, practice development, learning and professional development is the most appropriate approach to achieving person-centred practices.

To achieve this integration, four 'targets' are identified. A summary of the target areas and the key areas of work is set out below:

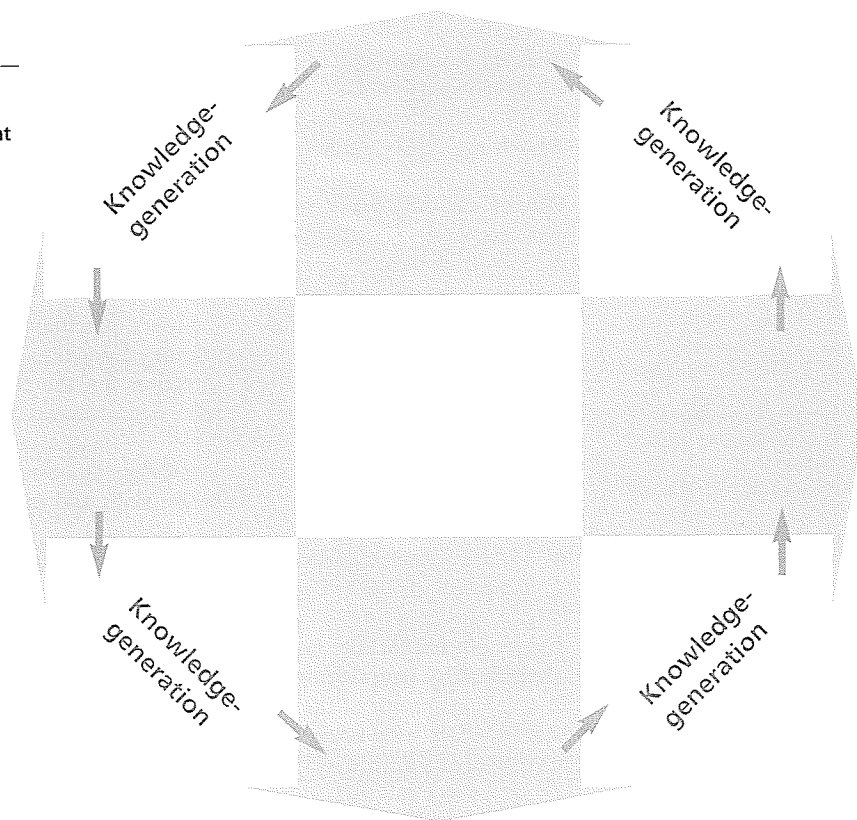
Target 1: Develop research and practice development knowledge and expertise

Improve the knowledge base among staff at all levels in terms of:

- Identifying appropriate questions for 'new' research and distinguishing between the need for new research versus the implementation of existing knowledge
- Research methodologies
- Practice development frameworks and processes
- Data collection, analysis and dissemination processes
- The use of systematic approaches to audit and evaluation in order to transfer knowledge into practice
- Reading research critically and understanding how to make judicious use of research in practice.

FIGURE 1

The Royal Hospitals Trust nursing and midwifery research and development strategic framework



Develop staff knowledge in approaches to developing a culture of 'critical inquiry' in practice settings:

- Increase awareness of approaches to reflective practice.
- Develop an understanding of the way knowledge can be generated from practice as a legitimate research activity in itself.
- Expose staff to models of critical inquiry.
- Help clinical leaders identify the readiness of their practice context for critical inquiry.

Target 2: Develop the research and practice development infrastructure

Build the capacity for nurses and midwives to sustain a proactive programme of research and practice development, through:

- Developing a centre for nursing and midwifery research and practice development
- Creating a 'lead research nurse' post in each clinical directorate
- Creating an infrastructure to support staff-led small research and practice
- Developing ward-based IT infrastructure
- Increasing the numbers of nurses/midwives undertaking higher degrees.

Target 3: Develop the practice context to support an expert person-centred inquiring culture that integrates research, practice development and clinical leadership.

Pilot a framework of development based on the principles of shared governance as explicated through the 'magnet hospitals' initiative in one directorate in order to:

- Apply and evaluate the principles of shared governance in one setting

- Identify enabling and inhibiting factors that have an impact on the effectiveness of the model in place
- Provide a detailed account of the model in use and replicate this in other settings.

Develop an integrated research and practice development project across directorates to:

- Determine the systems and processes that enable the development of person-centred practices
- Evaluate the outcomes for service-users, practitioners and key stakeholders from the development of person-centred practices.
- Inform the trust's strategic direction for the further development of person-centred practices.

Create a professorial nursing unit in gerontology in order to:

- Develop expert nursing knowledge, skills and expertise in nursing work with older people
- Create a centre of excellence in person-centred gerontological nursing practice.

Target 4: Undertake and utilise research in key clinical priorities identified by practitioners

In the development of the research and practice development strategy, nurses and midwives were asked to identify their priorities for research and practice development under five key themes. The themes and a list of topics were developed from a consensus-seeking exercise with nurses and midwives in the Royal Hospitals Trust. They were then asked to 'rank order' the topics in each theme, identifying their priority topic. The priority topics for research and practice development in adult, child and maternity service are shown in Figure 2.

RESEARCH CAREERS IN AN INTEGRATED RESEARCH AND DEVELOPMENT APPROACH

Integrated, practitioner-focused research approaches require a sustained commitment to participants in order to ensure the value of the person is held central. For many researchers working with pre-determined deadlines, this is often an impossible goal. However, there is clearly a moral issue of means and ends here. For example, if we are committed to changing the healthcare experiences of service-users, is it ethical to undertake an isolated survey of users' views of a service or practice without a long-term commitment to acting on the results of the survey? Evidence from audit, quality and research activities suggests that this commitment is not always present (Rycroft-Malone et al., 2002). The key issue is that researchers should consider a long-term vision for their research before undertaking the first step in the research journey and in doing so have a clear understanding of how best to commit to a sustained involvement in each stage of the research — from design through to implementation and beyond.

The drive to complete research studies in the shortest time possible is increasing all the time, as institutions are often judged on their 'research study completion rates' as an indicator of quality. The research assessment exercise (RAE) has been a key influence on this agenda, with the allocation of research funding to universities being made, in part, on the basis of completion rates. This drive is influencing greatly the attitude of funders to part-time PhD study, which is increasingly being frowned upon. While the

Figure 2. Priority topics for research and practice development in adult, child and maternity services

Research and practice development theme	Adult nursing	Children's nursing	Midwifery
Clinical topics	Infection control practices	The value of breast milk in the care of sick infants	Why are breastfeeding rates so low in Northern Ireland?
Nurse relationships with service-users	Impact of staff attitudes on quality of care	Impact of staff attitudes on quality of care	Are women aware of all the choices available to them?
Nursing practice	Communication with patients	Documenting care of IV infusions	Do midwives practise normal midwifery?
Leadership and management	Staff recruitment and retention	Staff recruitment and retention	Approaches to identify staff needs, provide support and increase staff morale
Client group management	Managing violent and aggressive patients	The support provided to families of children with chronic illness, physical or learning disability. Meeting the needs of adolescents in hospital.	None identified

difficulties associated with part-time study of any kind are in no way being denied, the approach also has clear benefits. In a proposal-writing learning set that I facilitate in the Royal Hospitals Trust (set up for people who wish to apply for research fellowships), I find myself in increasing levels of conflict with participants as I try to encourage them to study full-time, while they argue for part-time status. Their rationale is usually to do with their need and desire to stay in practice while conducting their research because they feel that not being in practice would compromise their connection with the practice they wish to study and thence their research work. This argument is convincing if we believe the challenges of bridging the so called 'theory-practice gap'. The traditional view of researcher socialisation still prevails (Rolfe, 1996) despite the espoused values of the primacy of practice. Thus to have a research career means leaving practice, studying full-time for a PhD, undertaking post-doctoral work and joining an established research team and working one's way up through the academic ranks, for example, assistant officer, senior officer, reader, professor.

It could be argued that there is an alternative research-career route that as yet has been given little serious consideration, that of the 'researcher practitioner'. A research career using this model might involve undertaking part-time PhD study with a clear practice focus; undertaking post-doctoral work in a practice setting; coordinating small-scale practitioner-research projects; developing practice-based research teams; leading practice-based research programmes, and working through a clinical-academic career structure. This would involve posts as a research practitioner, senior research practitioner, clinical reader and clinical professor. However, such routes and associated positions are few and there continues to be much scepticism about their appropriateness among the majority of the academic community.

The professor/director's position in the Royal Hospitals as a formal trust

management position recognises the importance of service-based academic appointments in changing the dominant practice cultures. Further attempts to create 'alternative' career structures are an explicit component of the Royal Hospitals research and practice development strategy. For example, in the critical care service, a practitioner-driven programme of nursing research and development is being created, and the model has all the potential to embrace the practitioner-researcher model of career progression that has been suggested. In fact, two lead research nurse posts have been created to lead on the development of person-centred practices in gerontology and operating room nursing. All research, practice development and clinical education staff members in these specialties have been integrated into a single team with the intention that all team members use the same methods of 'inquiry' in their work. These developments, while smallscale, represent the first steps towards developing a fully integrated approach to nursing research, practice and personal development.

ANTICIPATED BENEFITS OF ADOPTING AN INTEGRATED APPROACH

Few evaluated models of integrated practitioner-focused research and development are available to draw upon: it is an area of work that continues to be relatively under-developed and poorly supported in practice. The benefits listed below are thus 'tentative' in nature and are a key focus of the evaluation of the Royal Hospitals approach:

- Offers more effective research practice as the approach matches principles underpinning professional practice
- Gives explicit recognition to participants' personhood
- Allows engagement with staff in the development of research practices thus creating a culture of 'reciprocity' between researchers and practitioners
- Offers practitioners an opportunity to assist researchers with their learning and professional development
- Provides a framework for continuous professional development in advancing a research career
- Engages staff with the continuous development of practice as an integral component of their roles
- Enables the development of creative approaches to the development of effective person-centred services
- Provides a model of learning and development through research
- Provides a framework for academic supervision
- Acts as a means of developing research expertise
- Acts as a means of continuous performance review
- Generates new knowledge from practice to inform the development of research methodologies
- Provides a basis for the development of a 'person-centred' research agenda
- Enables the evaluation of care inputs and their impact on person-centred outcomes
- Assists with the utilisation of evidence in practice
- Generates inductively derived knowledge
- Tests deductively derived knowledge
- Contributes to the evaluation of the effectiveness of organisational systems in supporting person-centred practice.

CONCLUSIONS

This paper has highlighted the need for evidence-based healthcare to embrace all forms of evidence. To a large extent, many of the proposed ways of work-

ing are tentative as we have little evidence thus far upon which to base an integrated practitioner-focused research framework. The paper has further argued that evidence needs to be created from and through practice as well as from external sources. The challenge for academic communities is to explore ways of linking the agendas of researchers with the agendas of practitioners in a more proactive way. The relationship between academic and practice communities, that is, knowledge-provider and knowledge-user, is untenable if nursing is only to embrace an evidence-based approach when this is inconsistent with a person-centred practice agenda. Principles of practitioner research can go some way towards embracing the agendas of healthcare and academic communities through an integrated framework, but as McNiff (1998) asserts: 'The creative spirit demands persistence.'

KEY POINTS

- Practitioner research must be contextual
- Methodological paradigms should not be dictated in practitioner research
- Practitioner research seeks to transform self, colleagues and work, and develop new understandings of practice

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