PROMOTION OF A COMMUNITY CULTURE IN NURSING RESEARCH

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This article focuses on local practice-based research and development. It uses examples from both nursing practice and education to explore some factors that prevent, promote and influence the establishment of a research culture in clinical nursing. The article presents potential approaches for successful practitioner-led and clinical/academic research initiatives, explored through practice development and communities of practice. It also highlights the challenges of these approaches.

INTRODUCTION

Local, practitioner-driven research often falls into the academic equivalent of a ‘black hole’ in nursing. The increasingly fluid boundaries between practitioners and academics encourage people to engage in practice development, as a result of gaps identified locally in service or education.

Looking at academic and practice challenges from a local perspective encourages the exploration of insider issues related to the needs of a local rather than a wider community. An example is enhanced understanding of local patient experience and health needs. These initiatives usually have occupational/internal restrictions and often findings are related to local practice rather than the wider national or international health arena. As a result, they may not be considered applicable or transferable and consequently may not be disseminated to the wider nursing community (Andrew et al, 2008a; Brennan et al, 2008; Booth et al, 2007).

Booth et al (2007) discovered the two approaches – local versus national investigation – are not mutually exclusive when their findings from local practice development initiatives are explored collaboratively, in a wider nursing community of practice (CoP). The result was the evolution of local research that was broadly transferable and worthy of both national and international recognition (Tolson et al, 2008).

This article uses examples from nursing and education to explore some of the challenges and benefits of engaging in practice-based research, highlighting the use of communities of practice. It also debates the complexity and challenges of the researcher role, focusing on ethical issues and dissemination.

PRACTICE-BASED RESEARCH

Practice development

Nurses in clinical practice are ideally placed to engage with and drive forward a practice-based research agenda. Local exploration of issues promotes the development of skills associated with inquiry, moving practitioners from the status of consumer to owner and promoting a clinical research culture (Tolson et al, 2006).

However, this process is not straightforward. Barriers to research engagement include a lack of managerial support and time as well as less tangible factors such as a lack of understanding and confidence (Purkis et al, 2008).

Gordon (2008) observed that ‘traditionally nurses may not feel that they fit into a research role’. She suggested that the term ‘research’ can cause unease among some clinically based nurses, who may associate it with academics rather than practitioners. Moreover, they may feel that academics’ findings lack applicability and relevance to practice.

Practice-based research in nursing often uses an insider or ethnographic approach that requires researchers to become immersed in the workings, customs and practices of a local community.

There are positive and negative aspects to the investigation of local work practices. Insiders, acting as researchers, may have already established rapport; however, they also need to provide evidence of research credibility. Conversely, outsiders may well be professionally credible but will have to establish rapport and integrate with the community under investigation (Roberts, 2007).

Where information and solutions to problems are sought outside and not within a local community, key insights can be lost. A solution proposed by an outsider may not be effective because it does not fit the lived experience of the insiders who have already developed negotiation and problem-solving skills to guide their own local work practices.

IMPLICATIONS FOR PRACTICE

- Despite their reservations about research, clinical nurses are ideally placed to contribute to improving patient care through practice development and research.
- Communities of practice may provide a way for clinical nurses to become involved in research, as practitioners and academics investigate at a local level and then disseminate findings nationally and internationally.
- There are several ethical issues that nurses need to consider, including issues around being an insider researcher and any possible negative aspects of local investigation.
(Yanow, 2004). Rolfe (2005) maintained that the current emphasis on a medical, academically focused model has downgraded the value of qualitative approaches in nursing. He felt the devaluing of these (usually small) studies that come from observing practice, which contain a depth of data not usually achieved in quantitative studies, ‘has contributed to practitioner apathy and antipathy’. The way in which most nurses want to assess, enhance and subsequently change practice has been downgraded and is seen by some as second rate.

**Different models**

Tolson et al (2006) suggested that practice development ‘reflects the balance and interplay among evidence, context and facilitation’ and is likely to occur when evidence means something to practitioners. They highlight two views of practice development – the emancipatory (practitioner enlightenment and empowerment) model and the technical (top-down, changing professional behaviours) model.

The emancipatory model is based on the understanding that practitioners are autonomous and empowered to effect change in practice. The technical model relies on the widespread dissemination of educational materials and audit policies to effect/compel behavioural change.

Tolson et al (2006) highlighted problems with both models. The emancipatory model assumes that practitioners are able to change practice and that they possess high-level skills of reflection and the critical analysis required to do so. The technical model, using top-down, widespread dissemination techniques, has been found to have only a limited effect on behaviour.

Tolson et al (2006) used a collaborative approach to practice development by creating a nursing community of practice (CoP). A community blends the dual approaches of practitioners and academics to create a vibrant, productive and internationally relevant research environment.

**COMMUNITIES OF PRACTICE**

There are different levels of engagement to consider when exploring the concept of practice-based research.

- Professional development occurs at individual practitioner level.
- Evidence-based practice is characterised by advancing patient care through the application of proven evidence.
- Research moves inquiry towards implementation and evaluation of cutting-edge interventions that are intended to challenge and extend the boundaries of discipline-related knowledge.
- Practice development using a community model encompasses elements of all three and exists at the intersection of research, practice and personal development. This represents the meaningful integration of practitioners and academics (Tolson et al, 2006). A community of practice is a model of situational learning based on collaboration among peers. People are joined by a common purpose and defined by knowledge rather than task.
- Communities develop around things that people value or that they consider important. Even when they are subject to organisational constraints and boundaries, it is the community and not the organisation that generates the knowledge (Wenger, 1998).
- Such a community is more than a team or a network and exists because it is perceived as being of value to its members. The life cycle of a community is dependent on the continuing value to its members. It differs from a network because it strives to become a knowledge hub that binds members together.
- Communities are formed around the gatekeeper of knowledge approach that enables organisations to ‘build, share and apply deep levels of competence’ (Wenger, 2005).

**REFERENCES**


Andrew, N. et al (2007a) The Enhance Project: supporting academic practice development in the first year of learning in higher education. Higher Education Academy, Bristol, Education Subject Centre (ESCalate), http://escalate.ac.uk/3852


To get ‘under the skin’ of an organisation, Solomon et al (2006) maintained there is much to be learnt from the study of covert or hidden practices that account for a large part of daily workplace activity. A community of practice can provide a vehicle for reflection on everyday practice at individual and group levels.

The community described by Booth et al (2007) (see Box 2) developed sophisticated ways of working and problem solving, through examining overt and covert practices within their workplace. They challenged their own perceptions of both individual and group capabilities by engaging with each other and the practice development agenda. They remained as a cohesive and supportive group throughout three years of community life.

**CHALLENGES OF PRACTICE-BASED RESEARCH**

**Insider issues**

Roberts (2007) argued that ‘as an educator I am with my students throughout their journey to becoming a nurse; we are inextricably linked’.

Andrew et al (2007a; 2007b) explored the academic/clinical skill acquisition patterns of first-year undergraduate nursing students as part of an action-research initiative that incorporated both qualitative and quantitative approaches. This study involved a team of university-based, insider researchers, working and collaborating with more than 500 students and a large first-year (20) teaching team.

As part of the study, a total of 555 students were asked to respond voluntarily to questionnaires. The response rate was 75%, considerably higher than in many published studies (Murphy-Black, 2006).

The project team were ‘insiders’, embedded in the community under study. One of the researchers also held the dual role of first-year teacher/researcher and all worked on a daily basis with staff and students.

It was acknowledged from the outset that the response rate could be influenced, either negatively or positively, by the strong element of familiarity. The team was aware of both the advantages and disadvantages of familiarity and took steps to avoid coercion, using third parties to distribute materials and ensuring the questionnaire collection point was on neutral territory and was not observed by researchers.

However, the challenges of the role of insider researcher in ethnographic approaches mean researchers must be diligent throughout, as there is often a fine line between cooperation and coercion (Andrew et al, 2007a; 2007b).

**Ethical issues**

Ferdinand et al (2007) discussed the nature of reporting (or not) of unethical actions and practices that arise during the data collection process.

There is, within this type of research approach, potential for close relationships to form or already exist between researcher and participant. This issue – coupled with the possibility that participants may impart information of a sensitive or ethically questionable nature – means researchers may have to face up to the consequences of whistleblowing or live with the potential harm caused by silence.

Ferdinand et al (2007) discussed the ‘universality of certain values’ that make it easy for society to agree on which actions are reported as unacceptable behaviours. As an example, they used the discovery of blatant physical/emotional harm or abuse, suggesting that ‘it stands to reason that one would not only be ethically justified but morally bound to reveal one’s findings’.

However, most researchers are more likely to be confronted with the dilemma of uncovering information that ‘nudges’ at ethical boundaries, rather than blatantly transgresses them (Grey, 2005).

Brannan and Worthington (2007) reported that insider researchers constantly struggle with the concept of ‘normal’ and ‘acceptable’, stating that ‘workplace ethnography is hard work, requiring constant attention to the phenomena to which one is exposed’. They believe that conventional ethical frameworks fail to take account of complex or harrowing situations where the subjective attitudes that researchers bring to the interview cannot be completely subjugated or ‘bracketed out’ and may therefore influence interpretation of data .

Practitioners undertaking research within their workplace should carry out risk assessment to gauge the potential for harm or distress both to researchers and participants. The need to assess
potential harm is important when the researcher is a member of staff, investigating patients or (sometimes senior) colleagues. Entering others’ lives is difficult and may be more challenging for staff members.

**DISSEMINATION**

Rolfe (2005) argued that the underpinning – and to an extent enduring – philosophy in nursing is one that embraces and values small practice-based studies. Yanow (2004) observed that, where knowledge has been developed within a community of practitioners, its very locality may be perceived as not having ‘any bearing on, legitimacy in, or value to the wider community’.

Yet it is the element of locality that gives meaning to practice for nurses. Even so, a lack of applicability of findings may subsequently limit opportunities for dissemination. Often small work-based studies allow local knowledge to emerge that is ‘specific to a context and a group of people acting together in that context and at that time’ (Yanow, 2004).

Generating local knowledge is key to developing practice-based professionals such as nurses. Local knowledge may be specific to a situation; however, that does not necessarily mean this knowledge lacks expertise or applicability.

Booth et al (2007) described the way in which a nursing community of practice collaborated to produce best-practice statements on aspects of gerontological nursing, including nutrition and depression (www.geronurse.com), and tested them at a local level before dissemination at a national (Scottish) level.

The expertise that underpins local knowledge is often overlooked and not disseminated in any meaningful way. A local community does not necessarily lack expertise – it is ‘the character of the expertise that is different’ (Greenwood and Levin, 1998).

**CONCLUSION**

Clinically based nurses do not always feel comfortable or confident in engaging with the research process. They may believe it is more the territory of academics rather than practitioners and that the findings do not readily transfer into everyday clinical practice.

Yet nurses are ideally placed to make a major contribution to enhancing the care of patients. Practice development within local areas has the potential to play a part in developing research skills and help to create and nurture a clinical research environment.

Practice development using a vehicle such as a community of practice, where practitioners and academics investigate at a local level and collaborate and disseminate at a national level, may provide a way forward.

Investigating the activity and work practices of colleagues and students remains a grey area and is fraught with potential challenges and pitfalls. Outsiders, who integrate themselves into a workplace community for a study, have the advantage of walking away from that particular community at the end of a project. However, insider researchers who work closely with their participants may have to live with the consequences of the investigation indefinitely.

The ethical implications of work-related research cannot be overstated, although they may be frequently overlooked.

Assessing the risk to researchers as well as to participants can help minimise the negative aspects of local investigation, and lessen the risk of compromising individuals and their relationships with patients, colleagues and students.

The effect of study on researchers is worthy of further investigation, especially insider work-based research, where there is potential for consequences that may damage working relationships and career development.

Research into nursing practice and education is likely to directly reflect local needs and provide solutions to local problems.

However, the results may not be generally applicable, making dissemination on a national or international scale difficult. Communicating the findings of local studies into the wider nursing/health community undoubtedly presents challenges.

Communities of practice may present a potential solution. They encourage practitioners to engage with academics in an environment where both skill sets are equally valued, resulting in a culture that allows both professions to innovate at local level, collaborate at national level and publish internationally.