Nursing Policies and Protocols

Do Nurses Really Use Them?

Ursula Kelly, PhD, APRN, ANP-BC, PMHNP-BC, FAANP, FAAN;
Geneva Edwards, MHA, MSN, RN-BC; Susan E. Shapiro, PhD, RN, FAAN

NCPD 2.0 Contact Hours

ABSTRACT

Background: Nursing policies and protocols exist to promote high-quality, safe, and effective nursing practice; however, there is little evidence demonstrating how nurses actually use them to inform their everyday, routine practice.

Purpose: The purposes were to explore the extent to which nurses use nursing policies and protocols to guide their routine practice, and identify barriers and facilitators affecting the frequency with which nurses use nursing policies and protocols.

Methods: Licensed nurses (N = 235) providing direct care to inpatients and outpatients in a large medical center participated in an 18-question online survey.

Results: Most nurses access policies and protocols once a month or more; the greatest barrier to more frequent access was length of the policy or protocol.

Conclusions: Organizations should make policies and protocols succinct, current, and easily accessible. Studies are needed to determine how policies and procedures can best meet the needs of stakeholders, including health care organizations, staff, and patients.

Keywords: nursing policies, nursing procedures, nursing protocols, nursing quality

Nursing policies and protocols promote safe and effective nursing practice by ensuring it is evidence-based, standardized, and likely to result optimal clinical outcomes; however, there is little evidence demonstrating how nurses actually use them to guide their everyday, routine practice. Toward that end, the aims of this study were to: (*a*) explore the extent to which nurses use policies and protocols to guide their usual, day-to-day practice, and (*b*) identify barriers and facilitators affecting the frequency with which nurses use nursing policies and protocols. This information may help health care settings better support nursing quality and safety by effectively deploying new and updated policies and protocols in a manner that supports their utilization.

Author Affiliations: *Nursing and Patient Care Services, Atlanta VA Health Care System, Decatur, Georgia (Dr Kelly and Ms Edwards); and Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, Georgia (Drs Kelly and Shapiro).*

This material is the result of work supported with resources and the use of facilities at the Atlanta VA Health Care System.

The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

The authors declare no conflicts of interest.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.jncqjournal.com).

Correspondence: *Ursula Kelly, PhD, APRN, ANP-BC, PMHNP-BC, FAANP, FAAN, Atlanta VA Health Care System, 1670 Clairmont Rd, Mail Code 118, Decatur, GA 30033 (ukelly@emory.edu; ursula.kelly@va.gov).*

Accepted for publication: October 5, 2020

Published ahead of print: November 23, 2020

DOI: 10.1097/NCQ.0000000000000532

BACKGROUND AND SIGNIFICANCE

In nursing, the terms *policies, protocols,* and *procedures* often are used interchangeably and in different combinations to describe health care organizations' official written positions detailing specific actions to take in clinical and nonclinical situations. Unlike state regulations, these documents serve as authorized descriptions of institutional-specific nursing practice, serving 2 primary purposes: to standardize nursing practice based on current best evidence and reduce organizational risk.[1] As such, they are thoroughly developed statements designed to help nurses decide appropriate action to be taken for specific clinical circumstances.[2,3] In this article, the phrase *nursing policies and protocols* is used to refer to all such organizational guidance and directives.

Nursing policies and protocols have a long history, dating back to Florence Nightingale's time, when they were intended as instructions for nurse trainees.[1] In their current forms, nursing policies and protocols are intended to optimize patient safety and quality care and to improve clinical outcomes,[4-6] assist nurses to integrate new knowledge into practice, promote nurses' decision-making capacity in challenging

situations, and increase nurses' autonomy and accountability.[4,5] By standardizing practice, nursing policies and protocols may help health care providers, patients, and organizations by reducing the risk of harm to patients, reducing work load, and facilitating maximum benefit to the organization.[1,5-8] Other sources cite conflicting evidence, noting wide variations in in the use of and adherence to nursing policies and protocols across settings.[1,9-13]

Regardless of these disparate findings, the collective evidence is limited in its ability to describe nurses' use of policies and protocols to guide their day-to-day routine practice. These studies took place in specialty clinical settings such as intensive care units, pediatric palliative care, and transplant programs; were focused on use of specific policies or protocols; or covered issues indirectly related to accessing and using policies and protocols to guide daily practice.[1] To our knowledge, there are no published studies on the actual routine use of nursing policies and protocols to guide day-to-day care for patients.

Both organizational and individual factors have been identified as barriers and/or facilitators to nurses' use of policies and protocols. Alley[3] found that the culture of a health care system has a significant influence on what a nursing policy addresses and how it is perceived and/or managed by a nurse; it can produce both order and conflict.[3] For example, one study found that nurses did not follow a nursing protocol to document medication errors due to fear of punitive action, such as termination of employment, professional discipline, or a charge of malpractice.[5] Additionally, policies and protocols may be poorly written and difficult to understand,[3,14] and nurses may lack knowledge of the health care organizations' nursing policies and protocols.[12,15] Another organizational factor that has been identified as a barrier to nurses' use of policies and protocols is workload, which is seen most commonly in inpatient settings.[2] One shortcoming of these studies is that they either were completed in specialized settings or were related to singular policies or protocols.

Several individual factors act as facilitators or barriers to nurses' use of policies and protocols. Porter et al[16] reported that nurses' perceptions of the value of the nursing policy influenced their adherence to the policy (ie, if the policy was viewed as benefitting the patient, reducing the nurse's workload, or standardizing practice, the nurse was more likely to adhere to it than if perceived otherwise). Nurses' perceptions that following nursing policies and protocols is time consuming is another individual factor that results in nurses' failure to use them.[2] Perhaps more troubling is the finding that nurses' decisions to use policies and protocols were dependent on their assessment of patients' acuity, with nurses stating they were more likely to consult policies or protocols when their patients were more acutely ill,[2] raising concern for guidance related to day-to-day care. Again, these studies focused on adherence to selected policies or protocols and did not examine how frequently nurses used policies or protocols to guide their daily routine practice. To overcome limitations in the previous studies, this study recruited nurses from a large health care system, including all licensed nurses in both inpatient and outpatient settings, and inquired about utilization of nursing policies and protocols generally and not pertaining to a specific policy or protocol.

METHODS

This exploratory, descriptive study was conducted in a large Veterans Affairs Health Care System (VAHCS) in the southeast United States. The study was approved by the appropriate university Institutional Review Board and VA research oversight committees and entities.

Target study population and recruitment

The target population was all licensed nurses providing direct care to patients in both outpatient and inpatient settings. Excluded were nurses in supportive roles such as care coordinators, nurse managers, quality managers, performance improvement analysts, and telephone advice nurses. Advanced practice nurses also were excluded since their work is guided more by clinical practice guidelines than nursing policies and protocols. Of the approximately 1000 nurses employed at this facility, it was estimated that between 70% and 80% were in direct patient care roles, with 60% of those working in inpatient areas and the remainder working in outpatient clinics. Based on these estimated numbers of total nurses and direct care staff, the approximate response rate for the survey was 31.3%.

Recruitment was conducted via emails to the nursing listserv, which included all licensed nurses in the health care system. The email contained a brief description of the study, including the inclusion criterion of providing direct care to

patients and exclusion criteria of (1) performing supportive roles (eg, care coordinators) and (2) advanced practice nurses. The emails included a hyperlink to the electronic survey that was used to collect data. The online survey began with a detailed description of the study, requisite information for consent, and the option to consent to participate or exit the survey. A total of 235 nurses consented electronically and completed the survey. A few items, had missing values, yielding a slightly smaller sample size. There was no discernible pattern to missing data.

Data collection

Data were gathered using a survey developed by the investigators; it was pilot tested among a small sample of potential participants to ensure questions were clear, responses yielded usable data, and to estimate participant burden (<15 minutes to complete). The final survey consisted of 18 multiple-choice and short-answer questions covering (1) demographics (eg, nurses' education, experience, and unit and shift assignments); (2) the nurses' use of policies and protocols (eg, How often do you refer to nursing policies and protocols? When was the last time you referred to a nursing policy or protocol?); (3) factors that affect how frequently and how easily nurses use policies and protocols (eg, If you have not referred to nursing policy or protocol in the past month, what has prevented you from doing so?); and (4) possible barriers to access (eg, If you have not accessed a policy or protocol in the past month, what has prevented you from doing so?). Surveys were accessible through a VA-approved electronic survey vendor during a 2-week period in early 2018. The identity and IP address of survey respondents were not identifiable or traceable.

Data analysis

Data obtained from the survey vendor were uploaded into SPSS v23 (IBM Corporation, Armonk, New York). First, the sample was divided into 2 groups: infrequent users (those who never or rarely accessed policies and protocols) and frequent users (those who did so occasionally or frequently). These 2 groups then were compared across demographic characteristics, identifying any significant differences. A similar process was used to differentiate those who had recently referred to a policy or protocol (ie, within the past month) and those who had not done so. Results of univariate analyses then were used to construct logistic regression models with the dichotomous outcome of recent referral to a policy or protocol (within the past month) or no recent referral. Using backward elimination, nonsignificant predictors were removed one at a time until only significant predictors remained.

RESULTS

The characteristics of the analytic sample (N = 235) are summarized in Supplemental Digital Content Table 1 (available at: http://links.lww.com/JNCQ/A804). Most respondents (n = 197; 84%) were registered nurses (RNs); the remainder were licensed practical nurses (LPNs). Most of the RNs (n = 185; 79%) indicated they had a BSN or higher degree in nursing. Over 80% of respondents (n = 190) indicated they had 6 or more years as a licensed nurse. Over half the respondents (n = 125) had more than 6 years' experience at the study site, and over half (n = 120) worked in the outpatient setting.

Analyses were conducted to determine predictors of how frequently respondents accessed policies and protocols (frequency), and how recently they had done so (recent). Univariate analyses failed to identify any statistically significant differences between infrequent and frequent users based on demographic variables. However, several factors did emerge that were related to nurses accessing policies and protocols within the past month. As can be seen in the Table, the odds of having referred to a policy or protocol within the past month was 3.6 times greater for those who listed *no* barriers to access than for those who identified any barriers at all ($P < .0001$). The odds of younger nurses (generation Y/millennials, born 1981-2000) accessing a policy or protocol was 2.7 times the odds of older nurses (baby boomers, born 1946-1964; $P = .032$). The odds of RNs accessing a policy or protocol were 2.16 times the odds of LPNs ($P = .036$). Based on these results, further analyses focused on predictors of *recent* referral to a policy or protocol, not *frequency* of referral.

The results of the first multivariate model, including all variables, identified age group, education, and years of experience as significantly associated with recent referral to a policy or protocol (see Supplemental Digital Content Table 2, available at: http://links.lww.com/JNCQ/A805); younger nurses, those with a master or doctorate in nursing, and those with 6 or more years

Table. Predictors of Recent Access

Predictor	Policies and Procedures: Recently Used (n = 134)	Policies and Procedures: Not Recently Used (n = 100)	Odds Ratio (95% CI)	Wald χ^2	*P* Value
Barriers					
Some listed	29	52	Reference		
None listed	95	47	3.62 (2.04-6.43)	19.39	<.0001
Age (categorical)					
Baby boomers (Born 1946-1964)	47	51	Reference		
Gen X (1965-1980)	67	40	1.82 (1.04-3.17)		
Gen Y/millennials (1981-2000)	20	8	2.71 (1.09-6.74)	6.89	.0318
Role					
LPN	15	21	Reference		
RN	119	77	2.16 (1.05-4.45)	4.39	.0361
Education					
LPN/ADN/RN diploma	22	26	Reference		
BSN	56	38	1.74 (0.86-3.51)		
Masters/doctorate	56	35	1.89 (0.93-3.84)	3.40	.1830
Years of experience					
<6	25	19	Reference		
≥6	109	80	1.03 (0.53-2.01)	0.01	.9177
Years at health care system					
<6	23	13	Reference		
≥6	110	87	0.72 (0.34-1.49)	0.80	.3709
National certification					
No	83	72	Reference		
Yes	46	33	1.62 (0.94-2.81)	3.02	.0822
Setting					
Inpatient	60	49	Reference		
Outpatient	72	48	1.23 (0.73-2.07)	0.57	.4488

Abbreviations: ADN, associate degree-prepared nurse; BSN, baccalaureate-prepared nurse; Gen, generation; LPN, licensed practical nurse; RN, registered nurse.

of experience had greater odds of recently referring to a policy or protocol than comparators. After adjusting for all potential predictors (age group, role, education, years of experience, years at the facility, national certification status, and setting), the odds of having recently used policies and procedures were 5.84 times higher in those who listed no barriers compared to those who listed some. Finally, stepwise elimination of the nonsignificant variables and adjusting for age group, education, role, and years of experience, multivariate modeling revealed the odds of

having recently used policies and protocols were 5.57 times higher among those who listed no barriers when compared with those who listed some barriers ($P < .0001$; see Supplemental Digital Content Table 3, available at: http://links.lww.com/JNCQ/A806).

Two sets of questions asked about barriers to access. When asked what prevented referral to policies and protocols in the past month, most respondents (n = 168; 75%) indicated the question was not applicable (ie, that they had no need to, or no problem with referring to policies and protocols when needed). Of the remainder, 14% indicated they had difficulty locating the required information. Significantly fewer respondents (n = 14; 7%) identified lack of time or outdated policies. When asked more directly if they had been able to use nursing policies and protocols, here again, most (76%) stated they were able to do so in a timely manner. When asked what prevented them from timely access, only the length of time it took to read the policy or protocol to get to the important information stood out (12% of respondents); lack of time, unclear language, and lack of knowledge that the policy or protocol existed each were endorsed by no more than 4% of respondents.

Suggestions for making access more user-friendly included more effective communication regarding the existence and location of the relevant information (73%); providing more in-service education, especially to off-shift and clinic staff (56%); and removing outdated screens from the electronic health record (37%). Interestingly, although 76% of respondents indicated they were able to access policies and protocols in a timely manner, only 14% of respondents (n = 33) indicated they found the policies and protocols "user-friendly."

DISCUSSION

This study was undertaken to explore both the extent to which nurses use policies and protocols to inform their day-to-day practice and to identify the factors that facilitate or prevent nurses from consulting policies and protocols. Our results indicate that almost half the nurses who responded to the survey referred to policies or protocols within the previous 6 months, and 44% did so every 1 to 3 weeks. Reported barriers to access, respondents' age group (younger vs older), and professional role (RN vs LPN) were all significantly associated with recent use of a policy or protocol. Age group and years of experience also were significantly associated with recent access, but those relationships were somewhat contradictory. This apparent contradiction (ie, that both younger nurses and those with more experience reported more recent access to policies and protocols than their comparison groups) indicates the need for further research to determine whether it represents a statistical artifact or some underlying pattern that this sample could not delineate.

It is notable that 75% or more of the respondents indicated they had no difficulty accessing policies and protocols when needed and were able to do so in a timely manner. The few who reported difficulties cited the time it took to read through the relevant policy as the greatest barrier to ease of use; other barriers (eg, lack of time to access policies and protocols) were cited less than 4% of the time. Barriers to use of policies and protocols cited in earlier studies (eg, limited time due to workload[2] or lack of knowledge regarding the existence of policies and protocols)[12,15] were not operative in this sample. For the minority who reported barriers to use, document length seemed to be the biggest barrier. This is consistent with findings by Alley[3] and Drolet et al.[14]

Results of this survey suggest health care organizations should keep policies and protocols as succinct as possible and update them frequently based on emerging evidence and changes in best practices. In addition, it is important to communicate policy and protocol updates effectively to intended end users; nurses cannot use policies and protocols they do not know about. Clinical leaders such as clinical nurse specialists and clinical educators play critical roles in augmenting electronic communications and ensuring nurses are using new and updated policies and protocols appropriately.

The respondents worked in all areas of a large VA health care system and included both tenured staff and those new to nursing and the system. As such, they are likely representative of nurses at this facility, and may not be generalizable to other VA health systems or beyond. Other limitations include selection bias and response bias, both of which are present in all surveys such as the one used in this study.

CONCLUSIONS

The role of policies and protocols in contemporary nursing is complicated, as Bail et al[1] have

pointed out. Regulatory agencies at the state and federal level expect health care organizations to have comprehensive policies and protocols to standardize administrative and clinical practices and set behavioral expectations. Despite the expectation that such policies and protocols be updated regularly, rapid advances in medical and nursing technologies and therapeutics, along with the ever-changing health care system, may leave institutions struggling to integrate evolving evidence into their institutional documents in a timely manner. Consequently, nurses sometimes find themselves in the unenviable position of having to choose between following an outdated institutional policy or protocol or using updated current best evidence to guide their practice.[1] Electronic medical record vendors have incorporated some evidence-based protocols into their products, but they must be kept relevant and in line with rapidly changing best practice guidelines and that remains an ongoing challenge. The practice changes mandated by the COVID-19 pandemic, for example, are great examples of the challenge health care organizations and practicing nurses face in maintaining congruency between rapidly evolving evidence-based care and institutional policies and protocols.

Finally, there is no accepted standard for how frequently nurses should access policies and protocols during their routine, day-to-day practice. Should newer nurses consult policies and protocols more frequently than mid-career nurses, and if so, what should their focus be? Or should nurses with more years of experience consult policies and protocols more frequently to ensure their practice is still current? Health care organizations and nursing services generate numerous administrative and clinical policies and protocols, yet despite the time and attention to keep these documents relevant, current, and accessible, little is known about how their use affects system function and clinical outcomes. More studies are needed to determine just how well these documents are meeting the needs of the organizations that generate them, the staff they are meant to serve, the health system overall, and most importantly, the patients they are meant to benefit.

REFERENCES

1. Bail K, Cook R, Gardner A, Grealish L. Writing ourselves into a web of obedience: a nursing policy analysis. *Int J Nurs Stud*. 2009;46(11):1457-1466. doi:10.1016/j.ijnurstu.2009.04.005
2. Coats A, Marshall D. Inpatient hypoglycaemia: a study of nursing management. *Nurs Prax N Z*. 2013;29(2):15-24.
3. Alley LG. The influence of an organizational pain management policy on nurses' pain management practices. *Oncol Nurs Forum*. 2001;28(5):867-874.
4. Manias E, Aitken R, Dunning T. How graduate nurses use protocols to manage patients' medications. *J Clin Nurs*. 2005;14(8):935-944. doi:10.1111/j.1365-2702.2005.01234.xoi
5. Manias E, Aitken R, Dunning T. How graduate nurses use protocols to manage patients' medications. *J Clin Nurs*. 2005;14:935-944. doi:10.1111/j.1365-2702.2006.01533.x
6. Parry MF, Grant B, Sestovic M. Successful reduction in catheter-associated urinary tract infections: focus on nurse-directed catheter removal. *Am J Infect Control*. 2013;41(12):1178-1181. doi:10.1016/j.ajic.2013.03.296
7. Wongrostrai Y, Fongkaew W, Pinyokham N, Hanneman SK. A qualitative study of factors affecting sustainable implementation of a mechanical ventilation weaning protocol. *Pac Rim Int J Nurs Res Thail*. 2016;20(2):132-147.
8. Roh JH, Synn A, Lim C-M, et al. A weaning protocol administered by critical care nurses for the weaning of patients from mechanical ventilation. *J Crit Care*. 2012;27(6):549-555. doi:10.1016/j.jcrc.2011.11.008
9. Keeler M. Central line practice in Canadian blood and marrow transplant. *Can Oncol Nurs J*. 2014;24(2):67-71. doi:10.5737/1181912x2426771
10. Marino J, Bucher D, Beach M, Yegneswaran B, Cooper B. Implementation of an intensive care unit delirium protocol: an interdisciplinary quality improvement project. *Dimens Crit Care Nurs*. 2015;34(5):273-284. doi:10.1097/DCC.0000000000000130
11. Mohamed KAE. Compliance with VAP bundle implementation and its effectiveness on surgical and medical sub-population in adult ICU. *Egypt J Chest Dis Tuberc*. 2014;63(1):9-14. doi:10.1016/j.ejcdt.2013.10.019
12. Powers KA, Candela L. Nursing practices and policies related to family presence during resuscitation. *Dimens Crit Care Nurs*. 2017;36(1):53-59. doi:10.1097/DCC.0000000000000218
13. Van De Steeg L, Langelaan M, Ijkema R, Nugus P, Wagner C. Improving delirium care for hospitalized older patients. A qualitative study identifying barriers to guideline adherence. *J Eval Clin Pract*. 2014;20(6):813-819. doi:10.1111/jep.12229
14. Drolet C, Roy H, Laflamme J, Marcotte M-E. Feasibility of a comfort care protocol using oral transmucosal medication delivery in a palliative neonatal population. *J Palliat Med*. 2016;19(4):442-450. doi:10.1089/jpm.2015.0045
15. Dale S, Levi C, Ward J, et al. Barriers and enablers to implementing clinical treatment protocols for fever, hyperglycaemia, and swallowing dysfunction in the Quality in Acute Stroke Care (QASC) project—a mixed methods study. *Worldviews Evid Based Nurs*. 2015;12(1):41-50. doi:10.1111/wvn.12078
16. Porter J, Raja R, Cant R, Aroni R. Exploring issues influencing the use of the Malnutrition Universal Screening Tool by nurses in two Australian hospitals. *J Hum Nutr Diet*. 2009;22(3):203-209. doi:10.1111/j.1365-277X.2008.00932.x

The test for this nursing continuing professional development article is available online only at http://NursingCenter.com/CE/JNCQ.