Author's response to reviews

Title: A need for a multifaceted approach to guideline implementation: perceptions of oncology nurses

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Author's response to reviews: see over
Author's response to reviews

Title: Preconditions for Successful Guideline Implementation: Perceptions of Oncology Nurses
(Previous title: A need for a multifaceted approach to guideline implementation: perceptions of oncology nurses)

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Author’s response to reviews: see over
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Dear Editors,

Thank you very much for this opportunity to revise and re-submit our manuscript entitled “Preconditions for Successful Guideline Implementation” to BMC Nursing.

We have outlined in detail our responses to the reviewers’ comments. We do hope that this will be acceptable.

We are looking forward to hearing from you soon.

Sincerely yours,

Kaori Yagasaki, MSN, RN
Thank you very much for your valuable comments and suggestions. Despite your prompt review, we regret to say that we received your comments on July 7, 2011 so that our reply was delayed. We hope you understand our situation which was beyond our control. According to your advice, we revised our manuscript as outlined below.

Response to Reviewers’ Comments

Reviewer: Anna Gagliardi

Reviewer's report:
A need for a multifaceted approach to guideline implementation: perceptions of oncology nurses

This manuscript addresses an important health services research issue. While guidelines recommend appropriate care based on best available evidence they are often not used according to population based studies. This is a result of multiple factors, and it is essential to identify those factors for a given guideline to design relevant implementation strategies. This manuscript describes an analysis of issues influencing use of a particular guideline across several sites, which is an essential first step. Use of exploratory methods is also appropriate to gain an in-depth understanding of the issues. The study would have been strengthened through use of a theoretical framework to guide data collection and analysis, otherwise the findings are not unique, and of interest locally rather than broadly. The manuscript could be strengthened by clarifying relevant concepts in the Background and how this study addresses a particular gap in our knowledge of guideline implementation, including essential qualitative methodological details, and elaborating on implications in the Discussion.

1. Introduction
A number of concepts introduced in the background could be better defined and linked to create a clear justification of the need for this study. For example, teamwork and multidisciplinary care are different, and both of those concepts differ from the fact that multiple factors influence whether and how guidelines are used. Moreover, the study is relevant to cancer guidelines, but background literature on teamwork and factors influencing guideline use in the context of cancer is not cited.
We clarified the concepts of “multidisciplinary care” and “teamwork,” and also described the guideline implementation in the context of multidisciplinary cancer care in the “Background” section.

Background:
“Another important aspect of meeting the diverse needs of cancer patients and their families is the team approach to multidisciplinary care [9, 10]. The term “multidisciplinary” refers to a group of different disciplines, but the team concept is integral to the functioning of multidisciplinary care [11]. Xyrichis performed a concept analysis of teamwork, and suggested that the attributes of teamwork included concerted effort, interdependent collaboration and shared decision-making [12]. Multidisciplinary care is defined as “an integrated team approach to health care in which medical and allied health care professionals consider all relevant treatment options and develop collaboratively an individual treatment plan for each patient” [13]. Since practice guidelines promote consistency of knowledge and practice among team members [14] and improve the processes and outcomes of care [15], the guideline is helpful for oncology multidisciplinary care providers who are expected to practice evidence-based medicine [9]. However, as the previous study shows that differences among practitioners relate to the endorsement of and intention to use cancer guidelines [16], multidisciplinary care further complicates implementation.”

Some key citations related to guideline implementation and views about guidelines, ie. Grimshaw, Brouwers are also not cited.

Thank you for reminding us of very important literature. We added the following literature in the “Background” and “Discussion” sections:

Oncology:
· Brouwers MC: Implementation Science 2009, 4:34.
· Cancer Australia: CanNET. 2011

General:
The Intro concludes by saying that exploring clinician perceptions is the focus for this study but does not explain why individual views are more relevant than other intrinsic and extrinsic factors that influence guideline use.

We clarified why a qualitative study was carried out and listed the objectives of this study in the “Background” and “Methods” sections.

**Background:**
“To understand the complex phenomena involved in the process of guideline implementation, we need a qualitative study. Our focus in the present study was on the perceptions of oncology nurses regarding guideline implementation, as oncology nurses are well positioned to disseminate best practice information, and thus their views are critical for successful guideline implementation [22, 23]. We conducted an exploratory study to understand oncology nurses’ perceptions of guideline implementation and to learn their views on how their experiences affected the implementation.” See Methods below.

**2. Methods**
**Methods**
There are no citations for the methods used. Under Design the authors might indicate the methods used.

We described the detailed methods we used, and revised the Methods section as follows.

**Design:**
“Our focus was on oncology nurses’ perceptions of guideline implementation within
the realities of everyday clinical practice. Symbolic interactionism theory assumes that people create meaning through social interaction [24]. Grounded theory is the inductive discovery of a theory by analysing data in terms of a particular phenomenon [25]. We used the grounded theory approach based on symbolic interactionism to collect data about the behaviors of oncology nurses through focus interviews, and to identify their interactions with the guidelines, with others, and with the environment, with the goal of discovering how these interactions influence the implementation of guidelines.”

In our previous manuscript, we used the Japanese version of the book by Strauss & Cobin (Misao H, et al.), but we used the original book in English this time so we changed the reference.

Sampling sounds more like convenience than theoretical sampling...if theoretical sampling was used what attributes/units was it based on?

Because theoretical sampling needs a series of samplings, we used open sampling, as described in the “Methods” section. We purposefully selected a group of oncology expert nurses who had taken a basic course in using guidelines and who had attended a chemotherapy workshop. However, we failed to conduct relational and variational sampling and discriminate sampling, which we stated in the “Limitations” section.

Participants:
“We conducted an open sampling in this study, and at a chemotherapy workshop we purposefully selected 30 oncology expert nurses who had basic knowledge of oncology care guidelines to participate in our study. Each nurse had more than 5 years of oncology nursing experience and had attended a training session on the use of guidelines in Japan. The nurses studied chemotherapy for 6 months and held oncology nursing certifications (certified nurse), issued by the Japanese Nursing Association, and differed from master-level clinical nurse specialists. Of the 30 selected oncology nurses, 11 agreed to participate in the study, while 19 elected not to participate, possibly because the focus group interview day was not convenient for them or they lived outside of Tokyo.”

Limitations:
“We conducted only open sampling. We failed to conduct relational and variational sampling, and discriminate sampling. The limitations of the sampling and questions based on the semi-structured interview guide might influence the deeper exploration and generation of an emerging theory.”

How was data saturation determined?

We added the following sentence regarding saturation in the “Methods” section.
“The data reached saturation when no further unique theme emerged.”

How did the experienced researcher verify the analysis?

We added the following explanation in the data analysis.
Data analysis:
“To ensure the validity of this study, a single investigator performed all analyses, and this investigator discussed the interpretation and saturation of the data with a second investigator, who was an experienced qualitative researcher in nursing. In addition, a nurse sociologist verified the data and categorization.”

Even for a grounded theory study the focus group questions would be informed by a theoretical framework, perhaps related to perceptions or other factors influencing guideline use but this is absent. A theoretical framework would clarify whether perceptions are the key issue being explored. The Results would suggest otherwise.

We described the theoretical framework we used in “Methods” (See the above). We added the possible influence of the questions of the interview guide in the “Limitations” section.
Limitations:
“The limitations of the sampling and questions based on the semi-structured interview guide might influence the deeper exploration and generation of an emerging theory.”

3. Results
It would be helpful to see a table that lists and defines the coding scheme.
We added a new table (Table 3) that shows the coding scheme. 

*Terminology remains confusing, ie. multidisciplinary, multilevel, multifaceted.*

We clarified the concept of “multidisciplinary.” Due to potential confusion, we decided not to use the terms “multilevel” and “multifaceted.”

*The purpose was to identify problems and solutions, but only problems seem to be listed. The authors state that the participants were asked to suggest solutions but none of those quotes are included.*

Although some participants had suggestions for possible solutions, the data were too weak to categorize as solutions and list in the table. Following your advice, we further explored our data to probe the key issues beyond the general level and found emerging categories (goal congruence at the organizational level, equal partnership at the multidisciplinary level, professional self-development at the individual level, and user-friendliness guideline at the guideline level) and a new core category (Preconditions for successful guideline implementation). As new categories (preconditions) emerged, the previous 11 categories were shifted to subcategories. The rest of the data including raw data, remains unchanged. Figure 1 was revised accordingly, and we added Table 3 to show a core category, categories and subcategories. The positive quotes were included in “Results.” For example:

“Since financial matters are important for management, administrators will implement the guidelines if costs are reimbursed (Participant I).”

“We also need companions to work with. We hope that the researcher determines whether or not appropriate evidence exists. We want to present the necessary information together with the researchers (Participant F).”

*All quotes should be identified by an anonymous code so that the reader knows that data came from multiple participants with a range of attributes according to theoretical sampling, and not just one or two individuals.*

We identified all cited phrases by anonymous coding.

4. Discussion
While the study identified numerous factors influence guideline use in this particular setting, these issues are not novel. If a theoretical framework had been used, then the investigators may have been able to probe more deeply to explore particular problems and identify potential feasible solutions. For example, format and content of guidelines is noted as a problem, but there is no mention of AGREE, a tool which supports development of high quality guidelines. The authors note that the findings are consistent with previous studies but cite few such studies and do not elaborate how. Much of the Discussion is a summary of the Results without examining the implications for policy, practice and ongoing research. The overall recommendation is a multifacted approach...what would this consist of?

As we explored the data more deeply to discover more focused categories, we found new categories and altered the core category to: “preconditions for successful guideline implementation.” We therefore revised the Discussion section accordingly (only newly added parts are shown in red, but the order of some of other parts was also changed).

We cited “AGREE,” elaborated other studies, and added a description of the implications of policy and clinical practice, and noted the need for future studies. “It is feasible for guideline developers to modify the content and format of guidelines in consideration of implementability [35]. AGREE II is a useful tool for health care providers to appraise the guideline [36]. Indeed, when we developed the chemotherapy guideline, an external evaluation was performed using the Japanese version of AGREE [37], the volume of the guideline and applicability to the local context persuaded us to revise the guideline draft [38].”

“This study has implications for policy and clinical practice. Japan has established the initiatives to improve the quality of cancer care, begun when the Cancer Control Act was approved in 2006. The use of guideline has been encouraged for standardization of treatment. Preconditions derived from practical issues at different levels identified in this study will provide policy makers with a better understanding of practitioners’ perceptions, and help practitioners to facilitate guideline implementation.”
5. MINOR ESSENTIAL
The manuscript is fairly well written and organized, but some grammatical editing is required.

Our revised manuscript was edited by a professional native proof-reader.

Thank you very much for your valuable comments and suggestions. According to your advice, we revised our manuscript as outlined below.

Response to Reviewers’ Comments

Reviewer: Maritta Välimäki

1. Reviewer's report:
A need for a multifaceted approach to guideline implementation: perceptions of oncology nurses

The paper focuses on guideline implementation. The topic is very important and it covers a global concern in nursing: a lack of effective guideline implementation and their use in clinical practice. We definitely need more research in this area. In generally, the paper is well written and interesting. Its outcomes support existing literature. We may also ask what is the added value of this paper and what new information this paper will offer to the readers. Although Biomed Central may want to offer papers for international audience, the rationale behind the paper could be focused more on situation in Japan. For example, the knowledge gap mentioned in this paper; it would be important to be aware how familiar nurses in Japan are with existing guidelines (based on the previous literature), how well are guidelines implemented in clinical practice in Japan etc. More detailed information about situation in Japan could explain why this study needs to be done in Japan and with qualitative methods.

We added detailed information about the guideline implementation situation in Japan in the “Background” section and implications for policy and clinical practice in the “Discussion” section as follows:

Introduction:
“An increasing number of Japanese professional societies have developed their own
practice guidelines in addition to the Japanese versions of the American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN) guidelines. In nursing, international guidelines such as the Best Practice Guideline of the Registered Nurses' Association of Ontario (RNAO) and Putting Evidence Into Practice: Improving Oncology Patient Outcomes (PEP) of Oncology Nursing Society (ONS) have been or being translated into Japanese. Although it is easy to access these guidelines on the Internet or in publications except the PEP which will be published soon, they are not systematically used by the health care organizations. Not only in Japan but also globally, the utilization of such guidelines in practice is below expectations [5, 7]."

Discussion:
“This study has implications for policy and clinical practice. Japan has established the initiatives to improve the quality of cancer care, begun when the Cancer Control Act was approved in 2006. The use of guideline has been encouraged for standardization of treatment. Preconditions derived from practical issues at different levels identified in this study will provide policy makers with a better understanding of practitioners’ perceptions, and help practitioners to facilitate guideline implementation.”

The rationale for qualitative study was described in the objectives and design of this study.
1. The question posed
The purpose of this paper is to investigate the oncology nurses for adoption and implementing practice guidelines. The overall goal is clear although at quite general level. Therefore, more focused research questions could be offered. For example, the authors have described hindering factors or barriers for the guideline implementation.

We clarified why a qualitative study was needed and explored the data more deeply to discover more focused category. Based on our deeper exploration, we modified our objectives of the study as follows:

“We conducted an exploratory study to understand oncology nurses’ perceptions of guideline implementation and to learn their views on how their experiences affected the implementation.”
2. Methods

See point 4.

3. Soundness of the data

The data have been collected with focus group interviews (11 nurses and 2 groups). The topic of the questions used in interviews have been very structured (e.g. adaptation and implementation; areas to be developed; strategies). Some questions will require yes/no answer. More detailed description is needed for the rationale for the data collection method and data used to answer the research questions (with references).

The author developed the interview guide based on the concepts of following literature (e.g., guideline implementation, barriers, influence factors, nurses’ perception) described in the “Methods” section.

References:


4. Standards of reporting

In generally, the methods used are quite well described. I would still recommend that the authors could use some checklists to ensure that all details of the methods used have been described. This would improve the quality of the paper. See an example:

Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups ALLISON TONG, PETER SAINSBURY, AND JONATHAN CRAIG

Thank you for introducing the COREQ. According to the COREQ, we added the followings:

Participants: Of the 30 selected oncology nurses, 11 agreed to participate in the study, while 19 elected not to participate, possibly because the focus group interview day was not convenient for them or they lived outside of
Tokyo.

Data collection: We conducted two focus group interviews at a nursing school in Tokyo in March 2009.

5-6. Discussion and conclusions & limitations of the study

The discussion and conclusions are quite “strong” keeping in mind that the data have been collected with qualitative methods; 11 nurses has participated out of 30; and the goal of the paper has been described at very general level.

We further explored our data to probe the key issues beyond the general level and found emerging categories (goal congruence at the organizational level, equal partnership at the multidisciplinary level, professional self-development at the individual level, and user-friendliness guideline at the guideline level) and a new core category (Preconditions for successful guideline implementation). As new categories (preconditions) emerged, the previous 11 categories were shifted to subcategories. The rest of the data including raw data, remains unchanged. Figure 1 was revised accordingly, and we added Table 3 to show a core category, categories and subcategories.

In our previous manuscript, we used the Japanese version of the book by Strauss & Cobin (Misao H, et al.), but we used the original book in English this time so we changed the reference.

As a limitation of the study, it should be discussed more, how questions used in the interview may have affected on nurses’ answers or their general attitudes to the guidelines. (e.g. the questions have focused strongly on challenges, difficulties, non-using, difficulties to understand etc.)

We added the possible influence of the questions of the interview guide in the “Limitations” section.

Limitations:
“The limitations of the sampling and questions based on the semi-structured interview guide might influence the deeper exploration and generation of an emerging theory.”
7. Acknowledgements have been identified.

8. Title and abstract
The paper have used concepts, such as multifaceted approach, multidisciplinary care, and multilevel challenges and solutions. Where the title “multifaceted approach” has came? Further, in Abstract the goal of the paper differ from Page 5 (ADOPTION and implementation).

   We altered the title to “Preconditions for successful guideline implementation: perceptions of oncology nurses”.

Further, in Abstract the goal of the paper differ from Page 5 (ADOPTION and implementation).

   We revised the goals of the study in the Abstract to be consistent with the objectives.
   We clarified the concept of “multidisciplinary.” Due to potential confusion, we decided not to use the terms “multilevel” and “multifaceted.”

9. The paper is generally clear and well written.
I hope that these comments help the authors to modify the paper.

Declaration of competing interests:
I declare that I have no competing interests