FROM THE EDITOR - Jackie Jones

POLITICAL SCHOLARSHIP: NURSING, KNOWLEDGE, EVIDENCE AND PATIENT CARE

Nurses are now considered 'knowledge workers'. How our knowledge is developed and perpetuated to new generations of nurses and the discipline is the cause of ongoing concern (DEST 2002). From within an international context (Australia and Canada), Borbasi and Caelli, in our guest editorial, debate the nexus between a research agenda and academia (knowledge production) and the risks that having such a road map can have on practice. These matters are of importance to the image nursing portrays to the public and policy makers, and the capacity nurses have for participating in the larger health agenda of a nation. The recent challenges faced by nurses in Queensland in speaking out against poor medical practice (BRNM 2005), for example, highlight the complexities of participation and the potential consequences of inaction.

However, journalist Suzanne Gordon, in conversation with Armstrong (2005) argues that nurses need to move beyond their current 'protest narrative' of difficulties with staffing and workloads and move toward telling 'practice narratives'. These practice narratives suggest that nurses are really 'rescue workers' who 'rescue patients from the risks and consequences of illness, and the risks and consequences of treatment of illness' (p.15). Communication, negotiation, advocacy and collective action are promoted as solutions to dysfunctional power driven health care teams and systems deterioration. Failure to hear what nurses are saying may be a language issue, or as Gordon points out, it may be that others 'must be helped to understand that they are missing the point', that 'its not a power issue it's a patient care issue' (Armstrong 2005, p.17).

Scholarship in the articulation of practice knowledge, its context and its data are vital to the development and documentation of potent practice and health narratives that show nurses make a difference in the lives of people who need their care; and how nurses also facilitate the enhancement of individuals' capacity for self management in chronic illness and disability trajectories. In this issue, examples of how nurses can challenge existing knowledge for the patients' advantage and how knowledge and education impact on patient outcomes are explored.

Ryan reports on a pilot trial of a 23-hour care centre at a principal referral hospital in Sydney. Its primary aim was to provide efficient and high quality care to patients requiring a brief stay in hospital for surgical or medical procedures within one coordinated unit.

Blay and Donoghue describe a randomised controlled study that sought to determine if pre-admission patient education affects post-operative pain levels, domiciliary self-care capacity and patient recall following a laparoscopic cholecystectomy. They found that pre-admission education intervention helps reduce postoperative pain levels and significantly increases patients' knowledge of self-care and complication management.

McMurray et al investigate recovery from total hip replacement over a three-year period on the basis of patient perceptions of: health-related quality of life, demographic and clinical characteristics; use of and satisfaction with health services; unmet health needs; and, social re-engagement. Recovery after hip replacement surgery is dramatic, especially in alleviation of pain, but for older patients, there is a subsequent decline in general health concomitant with others in this demographic group.

Campbell and Torrance explore self-reported changes in coronary risk factors by patients three to nine months following coronary artery angioplasty. Although the majority of patients had altered their lifestyle and reduced at least one risk factor, 40% of patients in this study had a recurrence of chest pain and 42% believed their condition had been cured. Diet modification, increased exercise and stress reduction were the top three changes in lifestyle reported. The findings suggest there is a major need for better health education and follow-up for patients after coronary artery angioplasty.

In order to influence how we measure and determine practice knowledge Fisher and colleagues challenge the construct validity of critical care competency standards as a tool for assessing the clinical practice of specialist level critical care nurses in Australia.

Pelletier et al sought to determine the frequency and time of day that documentation and transfer of clinical information activities occurred for nurses of all skill levels in two aged care facilities in Australia. Over 16,000 observations of nursing activities were recorded. While documentation may take up less time than perceived by nurses these authors emphasise the need to re-structure the workday in terms of documentation to achieve greater efficiencies or effective use of nursing time.

Finally, Wang and Moyle provide a critical review of contemporary literature published between 1992 and 2003 on the use of physical restraints with residents in long-term care. They argue that despite nurses' desire to use physical restraint for protection, there is no scientific evidence that physical restraint actually protects residents against injuries.

REFERENCES

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