A qualitative examination of the perceived impact of bureaucratic managerialismon evidence-based practice implementation in Nigeria: a collective case study

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Abstract

Background: Evidence-based practice (EBP) is widely recognised as an essential aspectof contemporary healthcare delivery. However, the rise in cost containment and quest for profitability in healthcare management is found to be compromising implementation of evidence-based initiatives aimed at improving care quality.

Aims: The aim of this work was to examine perspectives of nurses regarding the impact of bureaucratic managerialism on EBP implementation in the Nigerian acute care setting.

Methods: A qualitative case study methodology was utilised to gather data from two large acutecare settings. Drawing on semi-structured interviews, 12 staff nurses, 21 ward managers and2 nurse managers were interviewed. Data were inductively analysed and themes generated.

Results: The managerial practice in this context is founded on bureaucratic managerialism, whichin turn generated hierarchical constraints that denied nurses the opportunity to self-govern. Implementation of evidence-based initiatives was consequently opposed by the managerialdesire to maximise throughput.
Conclusions: There is need for nurse managers to have greater managerial influence, which would allow opportunities for implementing EBPs to be created. Managerial autonomy for nursemanagers would allow them to create enabling environments capable of facilitating successful implementation.

Introduction

Internationally, evidence-based practice (EBP) has emerged as an important aspect ofhealthcare delivery as its principles are widely acknowledged to have instigated qualityimprovement initiatives. The National Academy of Medicine's roundtable on Evidence-based Medicine (EBM) set forth a goal requiring 90% of clinical decisions to be basedon evidence by 2020 (Bazyka, 2017). Indeed, several online databases, for example,the Cochrane Library and National Institute for Health and Care Excellence (NICE)website, have been established to serve as sources of evidence for clinical practitioners(Greenhalgh et al., 2014; Ominyi, 2019). In nursing practice, the delivery of evidence-based care to service users by adhering to standards is widely recommended (Ellis, 2016; Rycroft-Malone et al., 2013), as nurses are required to justify decisions they make inpractice. However, having the knowledge and skills required to utilise evidence does notnecessarily facilitate implementation since wider organisational change is required totranslate research into practice (Seers et al., 2012). There are concerns that what is knownto be best practice is not currently reflected in

practice, thereby exposing service users to risks and harm. This is due to complex and multifaceted barriers within practice settings limiting nurses' efforts to implement EBP (Melnyk et al., 2016; Seers et al., 2012; Shayan et al., 2019). In low- and middle-income countries, for example, Nigeria, the notion of EBP is relatively widely embraced; however, numerous obstacles forestall its implementation. Previous studies suggest that implementation of EBP is not a priority of healthcare managers in Nigeria (Ominyi and Ezeruigbo, 2019; Ominyi, 2019). Initiatives proposing EBPs often do not align with organisational goals, and bureaucracies inherent in the Nigerian healthcare system have been reported as a barrier to implementation (Ominyi and Ezeruigbo, 2019). In addition, healthcare governance in Nigeria is traditionally bureaucratised and has been previously reported as a barrier to implementation of quality initiatives such as EBP (Alubo and Hunduh, 2017). Ideally, bureaucracy is a useful management tool that aims to achieve effective management of large organisations (Traynor, 2013). However, the hierarchical relationships and top-down management approach characterising such bureaucracies have enormous demerits capable of impeding implementation of organisational change (Traynor, 2013; Wilkinson et al., 2011). As bureaucracy generates hierarchical constraints (Traynor, 2013), nurse managers (NMs) may not have the authority to influence decision-making processes within the organisation.

Implementation of quality improvement initiatives such as EBP was reported to be impeded by the managerialism that appears to be inherent in the Nigerian healthcare system (Alubo and Alubo, 2017). The discourse of managerialism shapes both the operation and experiences of healthcare services (Traynor, 2012), leading to contemplation about the provision of nursing or healthcare practice in the country. Alubo and Alubo (2017) suggest that the impact of managerialism be investigated, as it challenges the provision of nursing care in the country. Alubo and Alubo (2017) attribute the lack of autonomy among nurses in Nigeria to the rising effects of managerialism. There may be lack of shared governance in the management of healthcare in the country and NMs may have been side-lined. Like bureaucracy, managerialism creates a hierarchy of authority and fosters power relations between healthcare managers and clinicians (Connolly et al., 2009). The cumulative impact of bureaucracy and managerialism would imply that nurses and NMs may not have significant influence in overcoming the complex barriers that have been identified as impeding EBP in the Nigerian healthcare context. This study aimed to examine the perspectives of nurses regarding the impact of bureaucratic managerialism on EBP implementation in the Nigerian acute care setting

Methodology: qualitative case study

Case studies enable comprehensive examination of real-life events within their natural context (Stake, 1995; Yin, 2014). Case studies focus on exploring specific phenomena while aiming to provide in-depth interpretation of processes, actions, interactions relationships and experiences occurring in a setting (Stake, 2006). Qualitative case studies can be utilised to investigate single or collective cases with the intention of capturing complex issues, as they remain outward looking, and can collectively explore wider aspects of organisations (Stake, 1995). Case study is appropriate when the phenomenon of interest cannot be clearly separated from its

natural context (Yin, 2014). As Simons (2014) notes, a case study can provide the opportunity for exploring successes and challenges faced in implementation of healthcare interventions as it uncovers real life actions that corroborate told stories.

Design and sampling
A collective case study design was utilised in order to generate wider perspectives about the issue under inquiry. Two large acute care settings that were considered to have met the criteriafor a collective case study were purposively selected. The intent was to explore EBP in a large,complex and challenging clinical environment where rich information was likely to beavailable. Different participant groups were required to provide different sources of data,and participants were selected based on their job titles. The sample for this study consistedof 12 staff nurses (SNs), 21 ward managers (WMs) and 2 NMs who have worked in their rolesfor at least a year. These participants were purposively recruited to participate in the study.

Ethical considerations
Ethical approval was duly obtained through the Research Ethics Committee of the two hospitals in which the study was conducted. The Research Ethics Committee protocol ID are 1105/2015 and 1908/2015 respectively. Participants were provided with a participant information sheet outlining the study's purpose and their involvement, as well as strategies for maintaining confidentiality and anonymity. Participants were issued with written consent, which they signed prior to data collection.

Data collection
In-depth semi-structured, face-to-face interviews were utilised to gather data from participantsbetween 2016 and 2017. Interviews were conducted in English by the lead author, with each session lasting 50–90 mins, and were digitally recorded to ensure accuracy. All interview sessions took place at a time that was convenient to participants and were conducted using
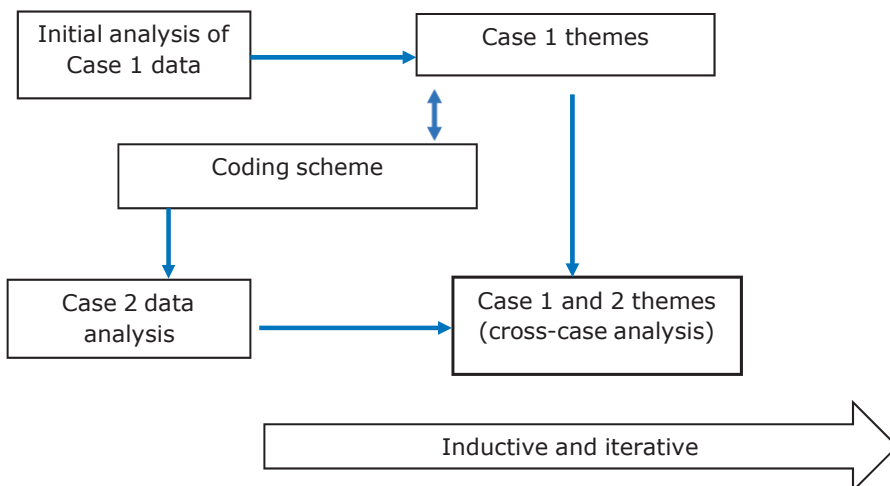
Figure 1. Data analysis framework.

an interview guide developed by all authors. Each interview session commenced with an introduction to the study's focus, then one broad open-ended question: *What are yourexperiences and feelings about EBP implementation in your hospital?* This aimed at allowingparticipants flexibility to talk through their areas of interest to capture the broadest perspectives of how they constructed their experiences of implementing EBP. Relevant prompts were used to explore further clarification about issues of relevance. Data collection ended at a point when no new information was forthcoming, indicating data saturation.

Data analysis
Data for this study were transcribed verbatim and were analysed through cross-case synthesis. As seen in Figure 1, individual case analyses were conducted, that is, case 1data was first analysed, and themes generated; these themes were then utilised as a frameof reference to analyse case 2 data. Then, through a cross-case analytic approach, case 1 and 2 data were compared to establish similarities and differences. Following transcription,transcripts were re-checked and corrected for mechanical accuracy by all authors, to enable deeper understanding of emerging ideas prior to data coding. Coding was carriedout using NVivo 11 by the lead author, while codes and categories were re-checked by other authors. This stage was iterative and enabled identification of new categories and thematic maps or pattern. Memos were used to capture analytic thoughts, feelings and insights about data during the processes of data analysis. To achieve rigour, this study examined perspectives of four participant groups who were engaged in the field for 9 months.

Results
Data analysis generated four key themes: managerialism-professionalism dichotomy, changemanagement (top-down driven), lack of nursing management support and managerial perquisite. These themes are in turn discussed below.

Managerialism-professionalism dichotomy
The dichotomy between discourses of managerialism and professionalism was identified as afactor in EBP implementation. Findings indicate that implementation of EBP stagnated due to managerial desire for profitability and lack of opportunity for innovation. Within the settings examined, nurses were required to focus on meeting targets rather than beingempowered to develop initiatives that would have promoted EBP. Nurses were keen to initiate strategies capable of promoting the delivery of EBP but could not do so due tothe lack of an enabling environment.

… it's been long I wanted to introduce some strategies that would help us change our practices, butI wasn't given the opportunity to do so … as a nurse manager I was highly interested in EBP andI initiated the process and some strategies but I was never allowed to implement them … (WM, case 1)
It's all about the management they dictate to us what to do and as far as I'm concerned, we [nurses] are not permitted to bring up any new idea not to talk of carrying out a research project that will cost money .. . all that matters is meeting

targets … (SN, case 2)

Participants' perceptions reflect settings where initiatives were rationally imposed on practitioners by top managers, leading to non-approval of evidence-based initiatives proposed by nurses. Imposition of initiatives was equally experienced from the wider healthcare context as bureaucrats in the Ministry of Health were developing and circulating clinical practice guidelines (CPGs) with mandates issued to health professionals, including nurses to implement them.

… the Ministry of Health initially brought the idea of EBP and it was during a meeting that the manager told us that Minister has sent him a memo which says that we have to implement the guideline … later on, they brought copies of guidelines for us to implement .. . so we didn't have the chance to decide whether we can do it … (WM, case 1)

It appears that there were initial negotiations between the Ministry of Health and top hospital managers on how to implement these CPGs. However, nurses seem to suggest that they were not invited to these initial negotiations, neither were they given opportunity to contribute to implementation processes.

Change management: top-down driven
As in the first subtheme above, there were indications that initiatives aimed at promoting EBPs were top-down driven. At the time of fieldwork for this study, new national CPGs were introduced into the system by the Ministry of Health. However, nurses in both settings perceived that necessary arrangements were not made prior to implementation, thereby forestalling the processes.

… as I said earlier when the ministry people brought guidelines and said we should implement them and the CMD too, I don't think they believe that we can contribute in the planning the guideline .. . they decide whatever they want and all we get are memos saying you have to do this and that .. . they don't care about how we do it (WM, case 2)

Nurses appeared frustrated that they were not involved in negotiating guideline implementation, which might indicate lack of professional recognition in this setting. Meanwhile, implementation of these CPGs was not successful due to perceived lack of fit and adaptability to the local context. There were notable flaws in the CPGs, with relevant infrastructures severely lacking, resulting in failed implementation. In case 1, for example, some aspects of the CPGs such as bladder washout were not implemented because there was no Urologist in the unit to lead procedures.

I really think they should do more work on this guideline because I've noticed some discrepancies … ok when you look at the procedure for treating unconscious patients from admission to time the patient regains consciousness, but it doesn't say what to do afterwards … the same thing applies to bladder wash because there is no Urologist to lead .. . (WM, case 1)

Unavailability of experts in some specialist areas, such as in the case of the Urologist, might suggest lack of relevant change champions within these settings. There is a strong interplay between evidence (CPGs) and the context (hospital) in which it is implemented. Seemingly, planning regarding implementation of these

CPGs did not consider relevant requirements before setting out as reflected in the failed efforts despite nurses not refusing to implement them. It appears that some aspects of the national CPGs that may have been implemented were forestalled due to the need to achieve targets.

... management will need to reduce admissions for us to implement these guidelines .. . (WM, case 1)
... we have two additional guidelines from the Ministry ... the one for diabetes and catheterisation but the management is not talking about it instead all we get is a memo telling us to ensure that patients don't overstay in the ward so the priority is that patients are going and coming and not about whether the real care is given .. . (SN, case 2)

'Real care' in this case might mean evidence-based care but it did not matter to the management. This may indicate that patient safety was being compromised as top managers were not interested in delivering evidence-based care. Therefore, nurses could not implement national CPGs as they were meant to achieve targets instead.

Lack of nursing management's support
Analysis of data shows that NMs have not particularly facilitated implementation of EBP. There were indications that NMs did not create favourable unit climate that could have empowered them to engage with change initiatives. Seemingly, nurses were devoted to delivering changes that would have facilitated EBP in their various wards; however, there was no supplementary support from NMs in relation to that.

... you are working on a research project that can affect change in practice, but it won't just happen without relevant support and you also need the manager's approval otherwise you won't be allowed time to complete it ... on many occasions I have applied for time off so I can complete the project I have at hand, but it wasn't approved because all the working hours has been allocated to admissions and discharges ... (SN, case 2)
You can never approach her for anything and she will listen to you ... even we don't have enough staff in the ward she doesn't care about it .. . the load is too much to provide evidence-based care in actual sense ... (SN, case 1)
In the light of the above, NMs might not be aware of what was happening in the ward areas. This might depict a dissonance between working towards achieving patients' needs and the manageability of nurses' work. Staff nurses seemed to suggest that NMs lacked awareness of their workloads. There were policies requiring nurses to implement new CPGs; however, nurses appear to suggest that there were no clear directives on how they were meant to be implemented.

... many of these guidelines can't work here but she kept sending them with warning that it has to be used .. . okay if she can make her own input on the guideline at least advise us on how to go about it then we can carry on even if it doesn't work ... but she is not ready to lead the way so how will the change occur ... (WM, case 1)
I have always suggested that we have a forum where we can discuss these guidelines

… she doesn't want to discuss the guidelines but wants us to implement them … (WM, case 2)

Nurses were mandated to implement CPGs but were never provided with clear directives on how best to carry out the implementation processes. It appears that there is lack of managerial awareness about the difficulties encountered by nurses whilst attempting to implement EBP.

Managerial perquisite
The right to manage was contingent on one's authority, which appeared to be derived from an individual's position within the hospital hierarchy. This entailed that administrative roles were allocated based on the position of individuals in the hospital hierarchy. As seen in Figure 2, there were three key individuals (Chief Medical Director [CMD], Deputy Chief Medical Director [DCMD], Chief Medical Advisory Committee [CMAC]) occupying higher administrative positions than NMs and were responsible for managing available resources within the settings.

The administrator is the one who controls the hospital budget if he thinks it's important to remember us when allocating resources funds .. . like I said before; the administrator is the

Minister for Health

Chief Medical Director (CMD)

Chief Medical Advisory Committee (CMAC)   Deputy Chief Medical Director (DCMD)

Nurse Manager (NMs)   Director of Administration

Ward Manager (WMs)

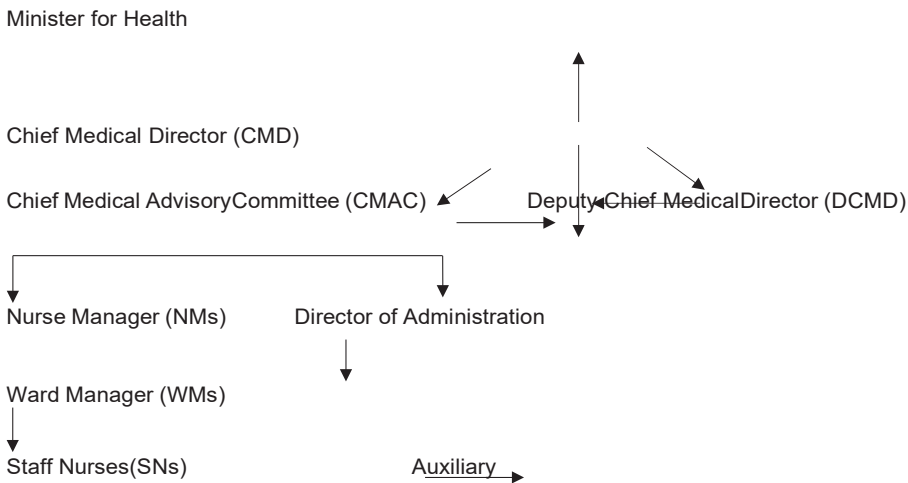Staff Nurses (SNs)   Auxiliary

Figure 2. Relationship between SNs, WMs, NMs and top managers.

Auxiliary person who has the power to allocate funds for EBP initiatives so if he decides to include in the plan then I'll be able to provide staff with relevant facilities otherwise .. . (NM, case 1)

.. . as a WM I personally feel that our practice should be based on sound evidence but bulk of the problem that we have a group is that we are placed in a position we don't directly manage the hospital budgets .. . it's unfortunate that I don't have the power to make that budgetary decision (WM, case 2)

NMs emphasised that authority or power to allocate resources lay with top managers. While NMs acknowledged that EBP was crucial to nursing practice, they were frustrated at their inability to control hospital resources, which could have enabled them to drive implementation processes.

As seen in Figure 2, the position of CMD as appointed by the Health Minister is the highest administrative position in hospitals, while NMs are located low down the hierarchy, below other top managers. Participants, including NMs, perceived that they would have been able to address the issue of time, as well as funding of EBP-related projects. They may have supported research activities if they had the authority to mobilise resources, or if the management had approved their proposals to initiate EBPs.

Invisibility and lack of voice
The issue of NMs' lack of influence as raised by nurses was echoed by NMs themselves, perhaps unconsciously. Analysis of interview data showed that NMs repeatedly expressed the difficulties they experienced in getting their voices heard at upper management level. This upper management level was judged to be both local, within the hospital, and national, at the Ministry of Health. NMs described the hospital management structure as highly bureaucratised, just as governance was mainly centralised. In both cases, NMs suggested that there was only a little they could do without the support of top managers.

No, the solution to these problems doesn't lie with me because my hands are tied … the structure is designed in a way that as a Director of Nursing [NM], I still don't have much to do regarding the way the hospital is managed … I feel embarrassed that I must negotiate my way before initiating any new even the evidence-based practice project you are talking about … (NM, case 1)

They [nurses] would agree with me that this issue didn't start today, I mean we would be very glad to do anything that will guarantee safety of our patients and as far as I'm concerned, we must do our best to utilise the best evidence in our caring for them … to suggest that I'm not bothered about the situation is ridiculous and they [nurses] should understand that the hospital is managed from above and even the management receive orders from the Minister (NM, case 2)

NMs expressed the view that the hospital's structure makes it difficult for them to circumnavigate the system, thus, conceding their inability to influence managerial decisions. NMs noted that they must negotiate with top managers, including perhaps the Management Board, to gain approval for possible funding before initiating new projects, including those related to EBP. However, NMs perceived that the existing management structure was constraining, and further expressed that NMs have a limited role in managing the hospital's affairs.

… we [NMs] used to manage and even lead management responsibilities but this is no longer possible … everything has now been altered and we are no longer involved in management services so it makes it difficult to negotiate funding for projects like this [EBP] … (NM, case 2)

This may suggest that NMs were previously involved in managing the hospital prior to role refinement, in which NMs are now responsible mainly for nursing and nurses. While the reasons for this role refinement were not stated, the overarching responsibility of running the entire hospital has now been eroded from

NMs. There is a sense of powerlessness in the quote above, which might relate to a lack of keen interest by the Ministry of Health in improving healthcare delivery within hospitals.

Discussion

As one of the first few studies investigating nurses' experiences of implementing EBP in a bureaucratic clinical environment, the findings of this study highlight difficulties surrounding implementation of EBP in the Nigerian acute care setting. These complexities are contingent on a range of contextual factors, most of which reinforce the position of previous studies recognising the relevance of nursing management in EBP implementation processes (Cheng et al., 2017; Kueny et al., 2015; Ominyi and Ezeruigbo, 2019). Specifically, the findings of this study highlight the importance of the context within which nurses and NMs operate, including the components characterising these elements. The findings of this study present a complex picture of the main factors, which are intrinsic in a clinical environment where EBP in nursing may be implemented.

The crucial need to better understand how organisational contextual factors impact EBP implementation in nursing has been previously reported (Rycroft-Malone et al., 2013; Ominyi and Ezeruigbo, 2019). While evidence emerging from this study support the assumption that EBP implementation is shaped by contextual factors, it further implicates known demerits of organisational bureaucracy in EBP implementation in nursing. Bureaucracy created environments undermined nurses' innovativeness because they were located at the bottom of the hospital hierarchy. Not only did top managers not prioritise EBPs, they generated hierarchical constraints that consequently placed limits on the nurse's ability to initiate and or implement new ideas. Organisational support for the adoption of EBP may likely be a precondition for its implementation through such settings. Leadership behaviours of NMs and those in management positions are reported to play a key role in successfully implementing evidence in practice (Cheryl and Sheeron, 2014). Similarly, hierarchical organisational structure has been reported as limiting the ability of NMs to drive EBP (Kueny et al., 2015 Shayan et al., 2019). The findings of this study indicate that the structural positioning if NMs did not accord them the visibility required to influence organisational policies. They did not have many options as they had to adhere to bureaucratic rules that were enforced by top managers.

Top-down managerial approaches resulted in situations where NMs were excluded from participating in strategic planning, budgeting and organisational decision-making. This, of course, may have contributed to the non-implementation of CPGs that were developed by the Ministry of Health as discussed in the findings. There were indications that the CGPs were not properly adapted prior to implementation, which might have led nurses to consider them as an imposed change. Top-down management is interlinked with failed implementation processes and can impede innovativeness within a healthcare setting (Anderson et al., 2015), just as drawbacks exist when practice guidelines are incompatible with the local context in which implementation normally occurs (Rycroft-Malone et al., 2013). Adequate understanding of the context of implementation is crucial in determining the success of what is to be implemented (Sin and Bliquez, 2017). Seemingly, planning regarding implementation of national CPGs did not consider

relevant requirements before setting out, as reflected in failed efforts despite nurses attempting to implement them.

Conclusions
The findings of this study reflect difficulties surrounding nursing practices. Currently, nurses in this context are conflicted in how they desire to practise nursing and how they practise. Traditionally, nursing practice is based on rituals, and does not seem to be meeting the contemporary healthcare needs of patients. Relevant stakeholders and healthcare managers must set aside the economic priorities which currently drive them, and restructure the workforce to minimise the hierarchical constraints facing nurses. By so doing, constraints generated by the discourses of bureaucracy and managerialism may be minimised. Empowering nurses would enable them to implement new ideas such as EBP and deliver care that is professionally acceptable.

Study limitations
The findings of this study can be considered to have cast light on the influence of bureaucratic managerialism on EBP. However, circumstances may have limited the quality of evidence generated in this study. Data for this study were derived from the perspectives of SNs, WMs and NMs, and do not include either the perspectives of patients or those of top managers and policy makers. Inclusion of patients' and/or top managers' perspectives might have provided a more triangulated analysis. This is a report of a qualitative study that was not intended to achieve generalisability in a quantitative sense. Therefore, the findings of this study may be judged only in relation to the Nigerian clinical environment or settings.

Key points for policy, practice and/or research

- Administratively, there is need for nurses to have greater involvement in managing practice organisations.
- There is need for NMs to have adequate leadership visibility and managerial influence that would enable them to develop impetus to engage with EBP implementation.
- NMs' lack of visibility in clinical areas may have contributed to lack of interdisciplinary knowledge sharing between nurses and other professionals.
- NMs may need empowerment to be able to create opportunities for EBP implementation in nursing.
- Relevant stakeholders in the country must fully involve nurses whilst developing policies underpinning healthcare delivery.

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