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Barriers Contributing to Policy Deviation: A Mixed Methods Study of Policymakers and Frontline Nurses

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Abstract Deviation from the policy at the point of care is frequently studied as a balancing act of health professionals, resulting in a lesser focus on barriers leading to such deviation. This study investigated practices of policy application or deviation with two aims. One, to assess if the frontline nursing staff is applying or deviating from the policy. Two, to understand the barriers that lead to policy deviation from the perspectives of policymakers and frontline staff. An explanatory sequential mixed methods design was applied, with a quantitative survey first (n=50) and then two qualitative focus group discussions. Data was collected in 2018 within a Local Health District (LHD) in New South Wales, Australia. Most respondents (96%) rated policy application to be the usual practice at work. Despite that, survey respondents (54%) agreed to have discretionally acted against policy requirements. Frontline nurses deviated from policy when they perceived a lack of functional merit. Examples of barriers that contributed to deviation from policy are unstructured policy review, inadequate support for policy writing and communication challenges during policy implementation. These barriers were jeopardizing appropriate policy development and implementation and often negatively influenced the functional merit of policy. A few known strategies, such as appointing policy champions and promoting policy messages through a combination of channels, should be considered to mitigate the identified barriers. Future studies can explore effective ways to manage policy deviation rather than relying on street-level bureaucracy.

Keywords: *policy deviation, policymakers, frontline nursing staff, practice policy at point of care, barriers*

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1. Introduction

Health professionals deviating from policy guidance is an ongoing strategic dilemma that health systems are experiencing across the globe in countries as diverse as Australia [1], Malawi [2], Netherlands [3], Norway [4], USA [5,6] and UK [7,8,9]. The term "policy" for this study refers to general guidelines that a health organisation instructs the staff to follow during service delivery [10]. The literature has posited that policy deviation by health professionals can aid or impede positive patient outcomes, with the latter more common than the former [3,11]. There is a realization that the effectiveness of healthcare policy is decided at the point of care [12]. A frontline staff's deviation not only jeopardises the effectiveness of health policy and quality patient care; it also raises hesitation with the empowerment of frontline staff [13] and implies distorted goal congruence with staff being unaware of broader organisational healthcare strategies [13,14]. Management approaches towards frontline staff's policy deviation are dependent on the associated barriers in question. Hence, an investigation into frontline staff's policy deviation and different barriers that lead to such deviation is a worthy research agenda.

Street-level bureaucracy provides a historical and theoretical context to frontline staff's practices of deviation from policy. The concept of street-level bureaucracy was introduced by Lipsky in 1969 [7,8], identifying public servants as influencers of policy, as they directly interact with citizens during implementation and exercise discretion in the process [13]. Nurses qualify as street-level bureaucrats, as they often need to accommodate the varying requirements of policy and frontline practices [8]. Literature relating to street-level bureaucracy suggests health professionals' deviation from the policy is necessary to negotiate patient care amidst administrative functions [5,8].

A related literature of workarounds explains behaviors that allow nurses to counter perceived or actual impediments to workflow, including difficult rules, inadequate technology or organisational or system problems [11]. Nurses employ workarounds when they do not feel policies reflect the frontline service environment and when they feel policy deviation is culturally

acceptable in the workplace [5,11,12]. Limited input or engagement from frontline staff, through incidents of workarounds, has been identified as a barrier impeding innovation in the public sector [15].

The rationales of policy deviation, as discussed above, suggest there can be many work-related barriers at the point of care. It is logical that the barriers leading to policy deviation will be influenced by different players in health. The perspective of health policymakers who operate at the same organisations as the frontline staff, is particularly relevant here, since they are obligated to empower frontline staff with feasible practices [16]. This is a complex process that would require effective discourse and negotiation of interdependent roles between frontline staff and policymakers in the same organisation [17]. Understanding the various barriers that policymakers face in processes of policy management at an organisational level, is critical to a positive resolution of frontline staff's practices of deviation.

It is critical to assess if the frontline staff's deviation is influenced by different streams of policy processes, such as problem definition and program development with policies [18]. These are relevant considerations in frontline nurses' deviation, as lapses in development and implementation stages hinder nurses' engagement with policies [14]. Current literature does not explain mechanisms of policy management stages that could associate with application or deviation at the point of care. This study addresses these issues by examining current practices of policy application at the point of care in the nursing team in an organisational health setting.

2. Research Aim

The aim of this research is twofold: the first used to assess if and when nursing staff is applying or deviating from policy at the point of care. The second aim utilized to recognize the barriers that lead to nursing staff's deviation from policy at the point of care from the perspectives of policymakers and frontline staff.

3. Research Setting

The research setting includes nursing groups of two hospitals within a Local Health District (LHD), that is, a State-level public health organisation in New South Wales (NSW), Australia. Staff at the research sites are required to comply with directions within policy documents issued by the NSW Ministry of Health (the Authoritative Government Organisation for the State's health system), the LHD and their hospital of employment. Policy documents published by the Ministry at state-level are of broad scope and often principle-based, as they apply across all public health organisations. This necessitates additional policies at LHD or hospital level to operationalise the policies to the local requirements. As of December 2020, there were 823 policy documents published by the NSW Ministry of Health on their website, each requiring local implementation [19]. Publication of such high-volume policy documents highlights the frequent policy development and implementation roles of the policymakers and the frontline staff, respectively, at the research site.

The selected hospitals involves a referral hospital and a major hospital by peer group classification [20]. These two research sites serve patients who are from diversified and multicultural backgrounds. The hospital in the major group has about 300 beds capacity and is going through major expansion of services to accommodate significant population growth. The referral hospital has about 1000 beds and offers a much broader breadth of specialty services than the other research site. The combined approximate population size is about 3000 nurses in the two research sites. The nurses represent the majority of the workforce, accounting for approximately 66% of healthcare workers involved in direct patient care in the LHD. The chosen two hospitals were appropriate research sites to understand practical and varied complexities of policy application, offering transferable insights for contemporary health settings in developed countries.

4. Methods

An explanatory sequential mixed methods research design was applied that comprised a quantitative survey and two qualitative focus group discussions (FGDs). The questions of the survey and FGDs were structured around the two research aims. Quantitative data was collected and analysed for a snapshot of respondents' views of current practices and barriers impacting policy application. Qualitative data was collected and thematically analysed to explain the quantitative survey data and explore nurses' lived experiences regarding policy application at the point of care.

4.1. Data Collection and Research Sampling

The survey questionnaire comprised 32 multiple-choice questions, a combination of Likert-type (ordinal) scale and specific response options. The break-down of topics of the questions are: 6 questions about respondent's demographics and work profile, 10 questions about access to policy, 7 questions about relevance or merit of the policy and 9 questions about responsibilities related to policy and patient care. The FGDs covered overarching questions that presented relevant survey data to probe response regarding the research aims.

All nurses working at the two hospitals were circulated the research participant information pack that included the survey questionnaire and expression of interest to participate in the FGD. The sampling technique was purposive, screening only those nurses who matched the employment details of the two hospitals from the LHD employment registry. Fifty-four survey responses were returned, indicating a response rate close to 2%. The sample size for quantitative data analysis was 50, as 4 survey responses were excluded due to missing data. All fourteen nurses who returned the expression of interest had participated in the FGD.

Two separate FGDs, FGD-A for policymakers and FGD-B for frontline staffs, took place in stage 2,

following the survey in stage 1 in July 2018. Each semi-structured FGD was chaired by the same independent facilitator and was scheduled for one hour. The separate FGDs were necessary to ensure a carefree discussion environment for both the policymakers and frontline staff. The independent facilitator was an experienced interviewer who encouraged engagement from all participants in the FGD sessions. The lead researcher also completed a transcript confirmation process with the FGD participants, prior to thematic analysis of the transcripts.

The 50 survey participants covered the nursing positions of registered nurse (16), clinical educator (9), clinical consultant (9), Unit manager (8) and Enrolled nurse and others (8). Majority of survey participants belonged to the age group of 30 to 39 (22%), 40 to 49 (24%) and 50 to 59 (32%). The FGD-A for policymakers covered the nursing positions of clinical consultant (3), clinical educator (2) and unit manager (2). Lastly, the FGD-B covered nursing positions of registered nurse (5), enrolled nurse (1) and clinical consultant (1). It is noted that only 6% of the total participants were enrolled nurses as opposed to registered nurses, consultants or educators. This indicates the majority of the research participants came from experienced and higher skilled nursing roles.

4.2. Data Analysis

Data analysis for the survey data included descriptive statistics of percentage analysis. Two sets of percentage analyses were conducted. The first set was applied to identify the survey participants by age and nursing positions. The second set was applied to address the two research aims.

The FGD data was subjected to thematic analysis, guided by the steps outlined by Braun and Clarke [20]. This analysis identified themes that reflected patterns of shared meaning in response to the research aims. The lead researcher conducted the coding, maintaining a matrix of FGD participant quotations that led to the themes. The co-researcher reviewed the coding process.

5. Ethical Considerations

Ethical approval was obtained from the healthcare organisation's Human Research and Ethics Committees (protocol number LNR/18/LPOOL/190). As per the approved ethics protocol, the nursing and midwifery executive unit of the hospitals facilitated electronic circulation of the survey to all employed nurses in the two hospitals in July 2018. The circulation was managed with the web application tool REDCap [21] and included an invitation for voluntary participation in the FGDs.

6. Results

The results from the survey and FGD are organised into the three sections reported in Table 1. The seven qualitative themes that address the research aims are also outlined in this table.

Table 1. Qualitative themes from the FGDs

Result Sections	Research Aims and Themes
6.1. Practices of application or deviation from policy	**Aim One:** To assess if and when nursing staff are applying or deviating from policy at the point of care. Theme/s: Functional merit of policy is the key
6.2 Barriers in policy development leading to deviation	Aim Two: To understand the barriers that lead to deviation from policy at the point of care from the perspectives of policymakers and frontline staff. Theme/s: • Lack of consultation with frontline nursing staff • Unstructured policy review process • Inadequate support for policy writing
6.3 Barriers in policy implementation leading to deviation	**Aim Two:** Same as above. Themes/s: • Communication challenges • Confusing presentation of policies • Electronic search hindering access to policy

6.1. Practices of Application or Deviation from Policy

In the survey, most respondents (n=48, 96%) rated policy application to be the usual practice at work. Most survey respondents (n=36, 72%) believed policy documents should always be followed at work. They clarified that application of policy at point of care can ensure functional benefits of legal compliance (n=40, 80%), delivery of quality patient care (n=36, 72%), standardisation of practices (n=34, 68%) and fulfillment of organisational agenda (n=30, 60%). Similarly, in the FGD, a recurring theme was "functional merit of policy is the key", drawn from how respondents value policies when they serve functional benefits in their practices. The policymakers in the FGD discussed how nurses quote certain policies at the point of care when the policies make a difference in clinical practices and patient care. A respondent's statement supporting this notion is provided below:

> "They love it, they embrace it, and they quote it…Because that policy makes… a lot of difference to all the clinicians... And every single person out there in my land knows that policy intimately." (FGD-A – Policymaker 7).

The following quotation from a frontline nursing staff confirmed a similar positive notion of policy application at point of care:

> "I think with the policies…you're looking for guidance…they are quite standardised, so you know you're coming in, you're looking at your aims, looking at the objectives, the stuff you need to know, it's the process you need to know." (FGD-B – Nursing staff 1)

Interestingly, FGD respondents also expressed that policies are not remembered well when they are not useful to day to day work. Nurses often intimately work with a small selection of policies and neglect the rest, as stated below:

> "When for the most part nobody even knew the policy existed, never seen it, never heard of it… Because I could count only three policies and I write bloody tons of them… there's only a couple that people know intimately." (FGD-A – Policymaker 1)

Some survey respondents (n=29, 58%) also noted that policy documents hinder their clinical autonomy; that is, their discretion around how best to deliver care. Moreover, survey respondents (n=27, 54%) reported knowingly acting against policy requirements during patient care. There was discussion in the FGD around how clinical judgement and practicality determine when a policy is important to follow and when it can be ignored. A nurse (FGD-B- Nursing staff 2) provided an example of how context and experience may contribute to deviation:

> "There's a big difference between, say, the adrenaline policy says I should administer this much via this line, and then me making a choice to go 'I'll do five times that via a different route', as opposed to perhaps, say, if a clinical deterioration policy says I should call a MET (Medical Emergency Team) call at this time, and I work in ED, where I'm never calling MET calls, well I'm not really adhering to that policy. Or when I'm thinking the blood pressure's 79, maybe I'll check it again, as opposed to calling a MET call which it says in the policy I should call a MET call."

This suggests staff may recognize or perceive that they are not the intended audience for a particular policy. Therefore, while deviation from the policy at the point of care was not the norm, it did happen when policies lack functional merit for patient care or are more relevant to staff with less experience in an area of care.

6.2. Barriers in Policy Development Leading to Deviation

Survey respondents (n=45, 90%) believed that frontline nursing staff should be consulted in policy development; however, respondents (n=29, 58%) also reported that frontline nursing staff are rarely or never consulted. A corresponding theme in the FGD was "Lack of consultation with frontline nursing staff", which acted as a barrier to apply policy at the point of care. A respondent reflected on this barrier, stating:

> "So if you're writing, you know, an ED policy, then it's filtered out to senior staff, and then it'll go through the executive…you're going 'I'm the person who has to implement it, but I haven't had anything into it.'" (FGD-B Nursing staff 2)

There was also a discussion of the dilemma that nursing staff often lacked the time to appropriately engage in policy development. Regardless, consultation with nursing staff for policy development came across as critical for effective application. The following statements clearly evidenced this notion:

> "If they're (nursing staff) involved we're more likely to influence the change." (FGD-A – Policymaker 1)
>
> "If you consult with staff involved in direct patient care, they're going to tell you whether it's relevant or not." (FGD-A – Policymaker 3)

In the last statement, the policymaker indicates overlap of this theme with the previously discussed theme, clarifying consultation with nursing staff is necessary to ensure functional merit of the policy towards patient care.

Respondents in the FGD highlighted another theme "unstructured policy review process" that led to frontline staff's deviation, with 46% of the respondents reporting never being personally consulted during a review. Lack of regular auditing of frontline staff's practices came across as another key feature of the unstructured policy review process. In the FGD, as evident in the following statement, frontline nurses discussed the need for a representative for constructive policy reviews:

> "I'm thinking, for example, like in every ward if there's a representative, for example, somebody from the floor, to check the obs [observations], to check they're following the policy… if there's a particular incident done, and if it is not done, then consult with the person: 'what was the idea? What happened?', why they didn't follow that policy – it could be something like that." (FGD-B – Nursing staff 6)

Similarly, the policymakers expressed the need for proactively matching auditing compliance requirements to actual procedures. They discussed the need for policy champions who could represent senior (e.g., Clinical nurse consultant/educator) and frontline staff. Moreover, the policy champions could facilitate review as well as promote relevant practices at the unit level.

In contrast to the above expressed notion, the current policy review came across as a reactive act. As the following quote from a respondent explains, it often takes an adverse outcome to initiate a review of frontline practices against policy directives:

> "That's the only time that it's relevant… the adverse event." (FGD-A – Policymaker 7)

During the FGD, the policymakers also agreed that current reviews are not helping to keep the policy relevant to the current practices. As a policymaker stated:

> "We're actually not looking at… current research (during policy development and review), and we're just using all the old references…" (FGD-A– Policymaker 4)

The issue of outdated referencing can influence policy deviation. As suggested in the following statement that frontline staff may ignore the policy if their faith in the currency of the document was compromised.

> "That's why we get non-compliance, because we go 'oh yeah, I've referenced something from 1947.'" (FGD-A – Policymaker 1)

The last statement from the policymaker highlights how the theme of "unstructured policy review process" can be connected to frontline nurses' perception of functional merit regarding patient care.

A theme of "inadequate support for policy writing" was also noted during the FGD. Policymakers described the process of policy writing to be a time-consuming process, for which often they are not given adequate protected time. They also discussed how they had to take on policy writing without any experience of the task. Overall, as the following statement indicates, the policymakers strongly felt the need for better education for policy writing:

> "I walked into the (Clinical Nurse Educator) role and I was given a policy to write and I had no idea. I'd never done one before…When supporting, like, CNEs, CNCs when they, like, you've got your CNCs who do policies, and actually educating them 'look, you need to go to your floor staff to get information from them as well'". (FGD-A – Policymaker 6)

Furthermore, the policymakers felt their inexperience with policy writing contributes to weak practices of development and review. It was discussed how there should have been a pathway for them to learn the skills for

policy development when they were a frontline staff member. That way, the organisation could have ensured a positive culture for the staff's continuing engagement in policy writing, review, and application。

6.3. Barriers in Policy Implementation Leading to Deviation

Respondents in the survey and FGD raised issues around policy implementation that acted as barriers in frontline staff's application. Most of the survey respondents (n=44; 88%) acknowledged policy implementation happens frequently at their health organisations. Despite that, some survey respondents (n=16; 32%) informed that policy documents were not well discussed during the orientation in their current role. Similarly, the FGD participants discussed a theme of "communication challenges" that referred to their experience of barriers during policy implementation. One such challenging situation was the simultaneous implementation of multiple policies from different levels (for example, the LHD and the hospital). This situation made the communication process of implementation more difficult and negatively influenced frontline staff's capability to receive each policy with due attention.

Additionally, the policymakers and the frontline staff discussed how adherence to policy requirements suffered from poor communication during the implementation of policy changes. They mentioned different methods of communicating the policy changes at the point of care, such as, a communication book, staff email, the nurse unit manager's discussion during ward meetings and the nurse educator's teaching during handover. However, the challenge was that any one of these could not be an effective method for communicating the changes on its own. As evidenced in the following statement, current communication of policy changes needs improvement on the following accounts:

> "It's a bit of everything. They could discuss it, it could be the NUM telling them, it could be at handover, it could be at a ward meeting… So it's like everything, every change in practice, or every implementation of something new, you know, you've got to have multiple steps to be making sure that you're getting that across, up to your staff." (FGD-B – Nursing staff 5)

Some survey respondents described the LHD-level (n=14, 28%) and the State-level (n=13, 26%) policy documents as confusing. During the FGD, the frontline staff identified a theme of "confusing presentation of policies" that referred to inconsistencies in naming of the policies. For example, policy naming conventions exclude the obvious terms or trade names that frontline staff understand and use in everyday practice. They also cited issues of convoluted language, vague statements and superfluous information hindering the practical understanding of the policy that is required at the point of care. The following statements are indicative of this notion:

> "You have to go through quite a lot (of policy content) before you find one thing that you actually need." (FGD-B – Nursing staff 2)
>
> "You know, we can put together hypokalaemia and low potassium – we can do those things – but there's no capability for us to even use our skills. Because it's not up to you what the policy document is called in the first place. So I think that's a barrier." (FGD-B – Nursing staff 1)

In the last statement, the frontline staff indicates an overlap of this theme with the previously discussed theme of functional merit of policy. Here, it is clarified how policies presented with unfamiliar names do not facilitate appropriate use of nursing skills for patient care.

Access to policy documents came across as another barrier to frontline compliance. This barrier was situated at the point of frontline staff's attempt to access an implemented policy. Survey respondents (n= 48; 96%) confirmed the use of the organisation's intranet to access policy documents. However, 40% of respondents faced difficulty in accessing hospital and/or LHD policies through the intranet. Such difficulty happened despite all survey respondents confirming access to a computer to use the intranet.

The perception of the above difficulty was more evident in the frontline nursing staff, generating a theme of "electronic search hindering access to implemented policy". They used terms such as "disaster" (FGD-B – Nursing staff 1) and "major hindrance" (FGD-B – Nursing staff 2) to clarify that the intranet lacked a policy search function that can offer appropriate search terms or filter the intended policy documents. Existence of a huge volume of policies spanning across the different contexts of hospital, LHD and State further aggravated the situation. The following are sample statements to depict the barrier of electronic search of policy:

> "We've always had too many policy documents." (FGD-B – Nursing staff 1)
>
> "Either you can't find anything, or you find everything. And both pose an issue to people who are time poor." (FGD-B – Nursing staff 4)

7. Discussions

This study investigated application of or deviation from policy at the point of care by the nursing staff in an empirical health setting in NSW, Australia. Furthermore, the study analysed the frontline nursing staff's and policymakers' perception of barriers leading to deviation at point of care. It is found that frontline nursing staff usually adhere to policy driven practices; however, the deviation happens when they perceive the policies to lack practicality and functional merit for patient care. The study identified that the barriers leading to deviation from practice of policy were situated in policy development as well as implementations stages. The barriers, as presented in this study, include lack of consultation with frontline staff during policy development, unstructured review processes, inadequate support for policy writing, communication challenges during implementation, confusing presentation and electronic search issues. Hence, the study extends the current literature of global contexts [5,9,11], identifying it is not just the bureaucracy of frontline staff but also barriers in policy development and implementation that lead to discretionary practices at point of care. This study makes a case for a fresh look at the deviation of policy at the point of care, exploring whether the barriers leading to such deviation can be mitigated through better management actions [2].

The study findings emphasise a policy's functional merit is the key to frontline staff's application or deviation. Nursing staff were found to apply workarounds when the policy documents are neither practical to frontline care nor perceived to enhance optimal patient care [9,22]. Additionally, an aspect of deviation from policy is frontline staff's subjective judgment to enhance practicality. As the case of the FGD-B nursing staff 2 clarified, the relevant policy requiring escalation to the emergency team was deemed unnecessary as she was an experienced nurse in a critical care environment. An implication of these findings is to consider whether health professional's subjective judgement in deviation from policy could become an adaptive component of health policies. That is, whether health policies could be designed with the right balance of flexibility and standardization to accommodate the subjective judgments of frontline practitioners of varying contexts [9]. As health systems are becoming adaptive to the varying and valid contextual needs [23], the consideration for proposed adaptive health policy seems beneficial; particularly if such consideration is guided by functional merit of policies in consultation with the target audience [23,24]. Future studies can explore whether a health policy that is adaptive of health professional's subjective judgement can mitigate practices of street level bureaucracy in the health system.

The study found evidence of barriers in processes such as lack of consultation with nursing staff during policy development [13], reactive review [25] and communication challenges around implementation [14] that jeopardised the functional merit of the policy and led to deviation at the point of care. The identified barriers are of great concern, indicating a disconnect to patient-centricity in the absence of adequate discourse with frontline nursing staff [14,22,24,26,27,28,29]. Similarly, presenting or naming policies without the obvious terms that frontline staff understand highlights the divide between frontline vernacular and upstream formality that exists in top-down policy implementation [18]. Additionally, maintaining electronic access to a policy with a faulty search function signals the danger of patient care suffering due to fixable technology issues.

Interestingly, strategies to mitigate some of the identified barriers in policy application are already known. The introduction of policy champions, essentially functioning as intermediaries between organisational demands and frontline needs has reduced obstacles in policy processes in the past [30]. Combining different communication channels for effective message delivery is a proven practice [24] and should be a practical solution to manage frequent policy implementations in health. It should be within the healthcare organisation's priority and capability to fix the faults in electronic access of policy. The complexity of frontline nursing staff being time-poor to engage with policy processes [26,29,31], could also be better managed with instant, user-friendly and technology-enhanced communication platforms. This reinforces the pragmatic value in a health organisation's management of barriers leading to policy deviation, rather than accepting the deviations as an inescapable characteristic of street-level bureaucracy [7,11].

Another critical finding of the study is the inexperience of staff with policy writing and lack of relevant organisational support. Respondents' suggestion to have a pathway for staff to engage in policy processes draws attention to a long-term commitment of capacity building for policymakers and frontline staff towards policy discourse, review, writing, and application [13]. This will require nursing leadership to prioritise resourcing and educational strategies [14] for frontline staff and policymakers to make appropriate contributions to policy processes.

8. Limitations

A limitation of this research was a focus on only two hospital sites in Sydney, Australia, with a relatively small participation rate. This limitation was mitigated by the addition of detailed qualitative insights through FGDs. Strength of this research is that the findings are relevant to other national and international contexts, since the chosen hospitals have comparable characteristics, experience, and environment to public health systems in developed countries. The authors encourage the readers to draw transferable insights in a context-sensitive manner.

9. Conclusion

Deviation from policy by health professionals has severe implications for staff and patients, deserving greater attention towards its management. This study has clarified deviation from policy at the point of care happens due to lack of functional merit as well as organisational barriers. Mismanagement of policy processes (e.g. inadequate discourse with frontline nursing staff, faulty technology and lack of long-term commitment to capacity building for policy application) is a barrier leading to deviation of care practices. Health organisations should attempt management of barriers leading to policy deviation in favour of staff and patients. Future studies can explore flexible health policies that can make the health system adaptive to the subjective but positive judgment of health professionals of varying contexts.

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