IMPLEMENTING CHANGE IN CLINICAL PRACTICE

PART I

Barriers & Facilitators of Change in Clinical Practice

PART II

Evidence-based Strategies for Successful Implementation of Pressure Ulcer Prevention (PUP) Guidelines

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Part I:
Barriers & Facilitators of Change in Clinical Practice

Topics

- Targeting behavioral change
- Theories about implementing change
- General barriers & facilitators of change
- Evidence-based barriers & facilitators of PUP

Part II
Evidence –based strategies for successful implementation of PUP guidelines

Topics -

- Strategies for Effective Implementation of PUP Guidelines
- Criteria for measuring effective implementation
- Evidence based - strategies
- Personal observations

Part I: Targeting Change

- Whose Behavior Do You Want to Change?
  - Individual provider
  - Shift work-group
  - Single Unit staff
  - Divisions (i.e. geriatrics, acute care, critical care)
  - Hospital
  - Healthcare system

Theories about Implementing Change – Individual Provider

- Cognitive – thinking and choosing
- Educational – learning, styles, motivation
- Attitude – norms, control, self-efficacy
- Motivation or stages of change
- Planned behavior

Theories about Implementing Change - Groups

Social group/context theories

- Shift work-group
- Single Unit staff
- Divisions (i.e. geriatrics, acute care, critical care)
- Hospital

- Social learning (feedback, incentives, role models)
- Social influence (norms, opinion leaders, culture)
- Patient factors (patient expectations)
- Professional development (self-interest, discipline specific)
- Leadership (style, power, involvement)

Theories about Implementing Change – Organizational Entities, Economic Context

- Healthcare systems
  - Innovation (specialization, centralization)
  - Quality management (culture, team processes)
  - Process re-engineering (processes, collaboration)
  - Complexity science
  - Organizational learning
  - Organizational culture
  - Economic theories

Why Do Theories Matter When Implementing Change in Clinical Practice?

- Change = phenomenon experienced
- Theory = coherent explanation of phenomenon
- Theoretical explanation of behavioral change behavior (person, group, system) provides framework for -
  - Identification of barriers & facilitators
  - Selection of approaches to effective implementation
    - Rational approach
    - Participation approach

Now what?

- Change – complex phenomenon
- No one best theory
- VHA way may be great; not the only way
- What type of change is targeted?
  - Is it –
- Brand new routine
- Stop current routine
- Eliminate aspects of current routine
- Adapt a current routine
  - Whose behavior is targeted?
- Shift work-group
- Single Unit staff
- Divisions (i.e. geriatrics, acute care, critical care)
- Hospital

Generic Barriers

- What makes “implementation (i.e. planned process & systematic introduction of innovation &/or change of proven value”) more difficult?
  - Limited insight into social/organizational context
  - Inaccurate understanding/ measurement of current practice
  - Lack of knowledge (multiple levels)
  - Negative attitude/opinion re: change (multiple levels)

Generic Barriers

- What makes “implementation (i.e. planned process & systematic introduction of innovation &/or change of proven value”) more difficult?
  - Lack of motivation
  - Unique professional characteristics – (multiple levels; subgroups)
  - Unique patient characteristics- (acuity, age, LOS, etc.)
  - Inadequate financial resources

Barriers Related to PUP

- Lack of systematic approach to PUP practices (Price, 2004)
- Lack of time: forgetting &/or not bothering (Kennedy, 2005)
- Practice - routine thinking & traditional interventions (Buss et al., 2004; Funkesson et al., 2006)
- Lower RN staffing levels; lower NA,LVN staffing levels; lower RN direct care (Horn et al., 2005)

Barriers Related to PUP

- Limited understanding – evidence based PUP practice (Wilborn et al., 2006)
- Less direct care by nurses (Funkesson et al., 2006)
- No incentives (Rosen et al., 2006)
- Lack - supervisory belief in need for supervision/feedback - PUP care (Dellefield, 2007)
- Limited understanding of concept of clinical guideline (Colon-Emeric et al., 2007)

Barriers Related to PUP

- Limited inclusion of unlicensed assistive personnel in PUP; lack of empowerment (Howe, 2008)
- Lack of a scientific theory for PUP (Magnan et al., 2008)
- Limited evidence –efficacy of specific risk assessment process (Goodridge et al., 1998; Moore & Cowman, Cochrane Review, 2010; Magnan & Maklebust, 2009)

Barriers Related to PUP

- Difficulties & lack of feasibility in conducting randomized clinical trials for PUP practice (Baumgarten et al., 2009)
- Dilemmas in using PU prevalence & incidence as outcome measures (Baharestani, Et al, 2009)
- Not exchanging clinical information between RN & direct care staff (Horn et al., 2010)
- Documentation formats not consistent with capturing PUP guideline-relevant data (Horn et al., 2010)

Barriers – Values & Attitudes PUP

- Variation in value placed on PUP by nursing staff (Samuriwo, 2010)
- Assessment of personal competence
- Priority of PUP care
- Impact of PUs
- Personal responsibility
- Confidence in PUP practices overall
  - (Beeckman et al., 2010)

Barriers Related to PUP

- Lack of understanding of mechanisms to achieve PUP; conditions affecting success of specific interventions (Soban et al., 2011)
- Lack of education & training
- Limited involvement of MDs & unlicensed nursing staff
- Lack of plan for communicating risk status
- Limited evaluation of PUP practices (Jankowski & Morris Nadzam, 2011)

Barriers- ICU & Acute Care

- Inadequate/outdated knowledge
- Lack of time
- Low priority vs. critically ill patients
- Lack of equipment
- PUP mainly nursing issue (Kallman & Bjorn-Ove Suserud, 2009)
- Inadequate use of support surfaces & documentation (Rich et al., 2009)
- Lack of ability to reliably identify avoidable vs. unavoidable PUs (Levine et al., 2009)

Barriers - PUP Guideline Implementation Summary

- What makes “implementation (i.e. planned process & systematic introduction of innovation &/or change of proven value”) more difficult?
  - Types of barriers at multiple levels identified in PUP literature
    - Attitudes
    - Beliefs
    - Knowledge
    - Values
    - Work practices

Barriers - PUP Guideline Implementation Summary

- Attitudes – feeling that link between processes performed & outcome is weak
- Beliefs – PUP not top priority; traditional practices
- Knowledge – lack of understanding nature of clinical guidelines; lack of specific knowledge of PUP
  - Methodological issues – measurement
  - Limited empirical evidence linking specific practice to an outcome
- Values – Important but many work process barriers
- Work practices – documentation, skill mix communication, risk status communication, staffing, deficits in clinical supervisory skills, lack of systematic approach

PUP Implementation Barriers from Nursing Perspective– Anecdotal

- Lack of technical/product component to PUP
  - Not exciting; does not change much
- Minimizing skills involved; complexity of PUP
- PUs don’t occur . This success is not linked with risk-burden staff dealt with
- Lack of team work
- Unrealistic expectations of care frequency
- Lack of knowledge of actual practices & what can be sustained given resources
- Lack of targeting of most at-risk residents
- Thinking PUP consists mainly of turning & repositioning
- Not targeting practices most supported by evidence
- Routinized work practices

Generic Barriers from Medical Director Perspective– Anecdotal

- Rebecca’s list of barriers

Part II: Successful Strategies

- What makes “implementation (i.e. planned process & systematic introduction of innovation &/or change of proven value”) easier?
  - Need multi-dimensional strategies
  - Identify facilitators at multiple levels
    - Attitudes
    - Beliefs
    - Knowledge
    - Values
    - Work practices

Generic Facilitators

- Assess target group (multiple levels)
- Link implementation strategies with identified barriers
- Respect discipline-specific perceptions of barriers
- Have multi-dimensional approach
- Be realistic – consider available resources
- Have systematic plan & timeline
- Measure outcomes
  - Acknowledge/publicize individual/group success

Facilitators Related to PUP

- Supervisory practices focused on sustainability of change (Xakellis et al., 2001)
- Target high-risk residents (Schnelle et al., 2004)
- Nurse staffing related to research evidence
  - Levels- Skill mix- RN direct care (Horn et al., 2005)
- Use individual champion (Beck et al., 2005; Rosen et al., 2006)
- Provide performance feedback in real-time (Rosen et al., 2006)
- Use relationship-focused management style (Dellefield, 2007)

Facilitators Related to PUP

- Promote information exchange among staff, especially direct care staff (Horn et al., 2010)
- Include direct care staff (Horn et al., 2010)
- Have compensatory strategy to deal with turnover
- Complimentary approaches to documentation & information exchange (Horn et al., 2010)

Part II: Successful Strategies

- Attitudes – feeling that care practices related to outcome
- Beliefs – clinical practice is dynamic; prevention as interesting as treatment
- Knowledge –
  - Acknowledge methodological issues – measurement
  - Acknowledge limited empirical evidence linking specific practice to outcome
  - Emphasize practice changes linked with strongest evidence
- Values – PUP is important & requires skill
- Work practices – have complimentary forms/documentation process, skill mix communication, risk status communication, examine amount of direct care RNs, strengthen clinical supervisory skills, have systematic approach

Generic Facilitators - Medical Director Perspective

- See Rebecca's list

Summary

- Rome was not built in a day
- Multi-dimensional strategies
- When using QI processes to improve practice, consider factors related to sustainability when strategies developed
  - Attitudes
  - Beliefs
  - Knowledge
  - Values
  - Work practices

Resources

- Grol R., Wensing M., & Eccles M. (2005). *Improving Patient Care: the Implementation of Change in Clinical Practice*. London: Elsevier Butterworth Heinmann.
- *Implementation Science* – electronic journal