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Myths and Realities of EBP

Marita G. Titler, PhD, RN, FAAN
Rhetaugh Dumas Endowed Chair
Department Chair, Systems, Populations and Leadership
University of Michigan School of Nursing

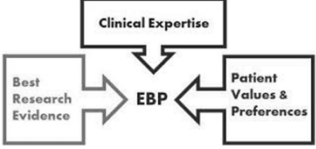


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Evidence-Based Practice

- Integration of best research evidence with clinical expertise, patient values, preferences, and culture/ethnicity (Sackett et al, 2000)




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Why Listen to Bowel Sounds?

Project Director:
 Diane Madsen, RN



Team:
 Laura Cullen, MA, RN
 Tamara Sebolt, RN, BSN
 Beverly Folkedahl, RN, BSN, CWOCN
 Toni Mueller, MSN, RN, CCRN
 Corrine Richardson, RN, BSN

(see December 2005 AJN)

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Why Listen to Bowel Sounds?

TRADITION



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Literature Summary

- Auscultation of bowel sounds first proposed in 1905 (Cannon - reported in Nachlas, Younis, Roda, et al, 1972)
- Motility involves electrical activity coordinated with motor/muscle contraction leading to propulsion (Livingston & Passaro, 1990)
- Return of motility: small intestine, stomach, colon (Hotokezaka, et al, 1996; Livingston & Passaro, 1990; Schippers, et al, 1991)

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Literature Summary

- Return of bowel sounds likely represents early uncoordinated motor activity in small intestine and not coordinated propulsion in colon (Boghaert, et al, 1987; Nachlas, et al 1972 ; Rothnie, et al, 1963; Benson, et al, 1994; Morris, et al, 1983)
- Ability to tolerate feeding is limited by stomach and colonic motility (Cali, et al, 2000; Hotokezaka, et al, 1996; Nachlas, et al, 1972)
- Monitoring bowel sounds does not serve to indicate recovery of motility s/p abdominal surgery patients (Huge, et al, 2000)

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EBP Standard

- Primary markers of return of GI motility (Bauer et al, 1985):
 - First flatus
 - First BM
- Additional markers of return of GI motility:
 - Return of appetite
 - Benign abdomen or absence of other symptoms
- Monitoring for complications

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The Facts


- EBP is no longer a luxury but a necessity.
- Leadership accountability for EBP is upon us.
- There is an evidence-base applicable to administrative and leadership decisions as well as clinical phenomena/topics

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Myth or Reality

- Saying “this is an evidence-based practice” makes it so.




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Reality

- Show me the evidence
- Know the evidence – author and year
- Document the evidence sources



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Myth or Reality

- “All evidence is created equal”
- It is published, therefore the evidence must be good.



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Reality



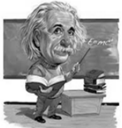
Must critically appraise all evidence sources

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Myth or Reality

- I know how to conduct research, therefore I know how to do evidence-based practice.



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Reality




- Conduct and evidence-based practice are different processes.
- Research is undertaken in controlled conditions with a defined research protocol and homogeneous sample.
- EBP is a messy, iterative process in real world settings.

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Researchers

- Very helpful in critical appraisal process and synthesis of the evidence
- Caution: Tendency to view EBP questions and evaluation through a research lens.




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Myth or Reality

- EBP guidelines are trustworthy – no need to critique or critically appraise them




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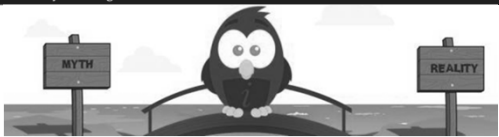
Reality: Critique Guidelines

- Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument
 - It can be accessed at www.agreetrust.org
 - Site has many great tools and learning modules



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- The evidence base is strong, thus there is not need to implement the EBPs on a small scale first.

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Reality

- Recommend implementing on a small scale initially
 - attend to unexpected consequences
 - refine EBPs and implementation process



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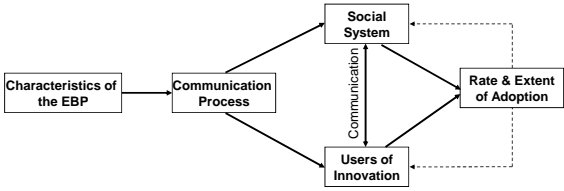


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Model to Guide Implementation

(Rogers, 1995, 2003; Titler and Everett, 2001; Titler, 2008)



Multifaceted strategies are necessary to translate research into Practice (Greenhalgh et al, 2005)

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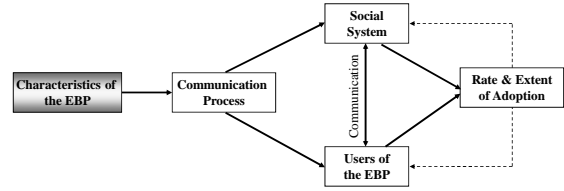
General Illusions about Implementation

- We just need to tell them what to do
 - "I told them what to do and they don't change"
- Clinicians will remember the change once they are told
 - Once should be enough
 - Clinicians can be more watchful so they will remember to use the new way
- I just need to find the one right way to implement a practice change.
- Implementation is an event.

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Implementation Model



(Rogers, 2003; Titler and Everett, 2001)

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Myths

- Dissemination of trustworthy practice guidelines promotes use of EBPs.
- The evidence is strong, thus clinicians will change their practice – we just have to show them the evidence.
- Clinicians care about the EBP topic (e.g. fall prevention; CAUTI)
- An EBP standard will change practice

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Realities about the EBP Topic or Innovation



The Topic Matters

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Reality: Characteristic of the EBP Topic that Influences Adoption

- Complexity of EBP (simple versus complex)
- Relative advantage of EBP – effectiveness, relevance to the task, **social prestige**
- Compatibility with **values, norms**, work flow and perceived needs of end-users: clinicians, patients and families
- Strength of the evidence – needs to have an evidence-base.
- Leader/facilitator needs to have an understanding about the evidence-base; articulate of the evidence source (authors, year), and document them.

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Reality: Important Principle

- Attributes of the EBP topic as perceived by users and stakeholders (e.g. ease of use, valued part of practice) are neither stable features nor sure determinants of their use.
- Rather it is the interaction among the characteristics of the EBP topic, the intended users, and a particular context of practice that determines the rate and extent of adoption.

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Reality: Strategies for adoption related to characteristics of the EBP topic

- Creating interest and excitement about the EBP topic.
- Practitioner review and use of the EBPs to fit the local context - localization.
- Use of quick reference guides and decision aides
- Use of clinical reminders – CDS; electronic reminders.

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Fall Prevention Bundle

- Focus on interventions that reduce or modify individual risk factors.
- Studies with sustained reductions in falls have
 - focused on identifying individual fall risk factors (rather than ticking boxes to get a score),
 - put in place interventions to address each risk factor,
 - used a fall as a learning opportunity to improve care,

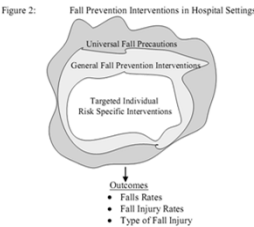


Figure 2: Fall Prevention Interventions in Hospital Settings

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RFI-2

Risk Factor: Compromised Mobility, Gait Instability, or Lower Limb Weakness

Indicators	Interventions	Hints and Tips
<ul style="list-style-type: none"> • Insteady/veering during transfers or walking • Reaching for walls or other supports while walking • Overbalancing, especially when reaching, bending, straightening or turning • Unable to rise from chair without assistance 	<ul style="list-style-type: none"> • Ambulate 3-4 times per day with assistance unless contraindicated • Refer patient to PT for assessment, gait and strength training • Active or passive range of motion three times daily • Minimize use of immobilizing equipment (e.g. indwelling urinary catheters) • Assure proper assist equipment is readily available 	<ul style="list-style-type: none"> • Seek advice from PT about safe exercises and activities the patient can perform on their own or with supervision • Ask patient's family and friends to assist with mobility interventions as appropriate

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RFI-3

Risk Factor:
Incontinence, Urgency, Requires Toileting Assistance, or on Diuretics

Indicators	Interventions	Hints and Tips
<ul style="list-style-type: none"> • Goes to toilet frequently • Experiences urgency • Urinary or bowel accidents • History of nocturia 	<ul style="list-style-type: none"> • Schedule toileting and assistance to bathroom (e.g. 12 hours) • Bedside commode available for easy use • Leave bathroom light on at night • Stay within arms reach during toileting • Review medications that may contribute to toileting issues • Look for signs of UTI and notify physician • Assistive devices available to go to toilet • Administer diuretics before 5 p.m. to minimize night-time toileting 	<ul style="list-style-type: none"> • >50% of falls are associated with toileting activities • Patients who fall while toileting note that they perceived their nurses were "too busy" and did not want to bother them • Post signage at bedside about activity level and toileting

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Pediatrics

MRN: _____
NAME: _____
BIRTHDATE: _____
CSN: _____

Care Plan – Poke and Procedure

Today's date: ____/____/____ (mm/dd/yyyy)

Comfort measures for (child's name): _____

How would you describe your/your child's experience (s) with previous needles/sticks/procedures?
 no problems cries worries very fearful no previous experience

Comments: _____

Information:

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ANMC

Kay Branch
Elder/Rural Health Services
4000 Ambassador Drive
Anchorage, Alaska 99508
Ph: (907) 729-4486
Fax: (907) 729-3652
kbranch@anmc.org

Injury Prevention Program
4000 Ambassador Drive OCHS
Anchorage, Alaska 99508
Ph: (907) 729-3799
Fax: (907) 729-3513
http://anmc.org/ohp/ehp/prev/

ANMC FALL SAFE-T
(Stop All Falls Everyday Team)
Char. Nicole Tanguchi, PT
ANMC Physical Therapy
Ph: (907) 729-1263
ntanguchi@anmc.org

Be Strong, Be Healthy

Alaska Native Tribal Health Consortium
Injury Prevention Program

Tips to Prevent Falls to Elders

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Preventing Falls Inside Your Home

Stairs and Steps:

- Are papers, shoes, books, or other things on the stairs?
Move these things off the stairs. Nothing should be left on the stairs.
- Are steps broken or uneven?
Have someone fix your steps as soon as possible.
- Are stairways dark?
Have someone put lights at the top and bottom of the stairs.
- Is there a handrail on the stairs?
Make sure handrails are on both sides of the stairs and as long as the stairs.
- Is the carpet on the stair steps loose or torn?
Make sure the carpet is firmly attached to every step or remove the carpet and put non-slip rubber bath tub decals on the stairs.

Kitchen:

- Are the things you use the most on high shelves?
Keep things that you use the most on the low shelves where it is easy to get.
- Is your step stool unsteady?
Replace step stool with a new one or use a strong wooden box. **Never** use a chair as a step stool.

Ice grippers like these can help keep you safe when walking on snow and ice. Ask your Health Aide or Doctor how to get a pair.

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Implementation Model

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    graph LR
      A[Characteristics of the Innovation] --> B[Communication Process]
      B --> C[Social System]
      B --> D[Users of Innovation]
      C --> E[Rate & Extent of Adoption]
      D --> E
      C -.-> E
      D -.-> E
  
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Myths

- We stay abreast of the latest evidence in our practice.
- It is feasible to know all of the latest evidence for healthcare practice.
- Clinicians learn about new evidence from?
- We just need to educate them about the EBP – didactic presentation preferred.
- Focus on nursing practice

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Realities

- Most clinicians learn about the evidence from a trusted colleague
- Explosion of evidence today: know evidence sources (e.g. AHRQ.gov); use EBP guidelines (critique them 1st)
- Electronic world – use search engines (not just google scholar)
- Education is necessary but not sufficient to change practice (attend to both knowledge and skills)

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Realities

- Interdisciplinary and trans-disciplinary perspective of the EB practice (multiple disciplines)
- Who will be influenced by the EBP? Who will be users of the EBPs? Stakeholders
- Patient centered

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Reality: Communication factors that influence adoption

- Interpersonal communication channels
- Methods of communication
- Social networks of users

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Communication

The Stickiness Factor:
There is a simple way to package information that, under the right circumstances, can be irresistible. Memorable ideas spur us to action.

(Gladwell, 200)

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DID YOU KNOW?

Each year, 610 people are hospitalized for Traumatic Brain Injury (TBI) in Alaska



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Reality: Strategies for adoption r/t communication


- Interactive education is more effective than didactic education alone.
- Clinicians need the knowledge and skills to carry-out the EBPs.
- Must consider patient and family values, culture, preferences, and stories
- Key messages at the site of care

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Posters

IMPORTANT FACTS



DID YOU KNOW?

- Accidental falls are the **most** commonly reported patient safety incident in the hospital
- U.S. hospitals report 1 million patient falls each year
- One in 5 adults ages 65 and older fall each year
- 20-30% of adults who fall suffer moderate to severe injuries
- Older adults are hospitalized for fall related injuries nearly 5 times more often than for any other reason

CONSEQUENCES OF FALLS


- Fear, anxiety, and decreased physical activity.
- Increased length of stay and higher rates of discharge to skilled nursing care.
- Fractures and soft tissue injuries.
- In 2000, total direct costs of all fall injuries exceeded \$19 billion.

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URINARY INCONTINENCE AND PATIENT FALLS



PROBLEM

- Urinary incontinence is an important risk factor for recurrent falls and hip fracture.
- Urinary incontinence and the need for toileting is a universal phenomenon and is most often overlooked.

FACTS

- More than 50% of falls are associated with toileting activities.
- The combination of urinary frequency and the need for frequent assistance with toileting is much more of a fall risk factor than incontinence itself.

WHAT YOU CAN DO

- Regularly scheduled toileting of high-risk patients with impaired gait and mobility can **reduce falls by 50%-70%**

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DATA PREVENTION

STAFF EDUCATION



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Reality: Communication Strategies

- Opinion leaders
- Change champions – in unit/clinic
- Educational outreach/academic detailing – topic expert; meets one-on-one with practitioners in their setting (“site visits” with rounding)

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Opinion Leaders



- Clinical experts who are influential among their peers and set the standard
- Effective in changing behaviors of clinicians because their colleagues trust them to evaluate the EBP and local situation
- Practitioner within specific discipline, (e.g. RN or MD)

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Identifying an Opinion Leader

- May need an opinion leader from each discipline
- Viewed by colleagues as technically competent
- Well-respected and influential
- Trusted to judge the fit between the innovation and the local situation

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Role of Opinion Leaders

- Model practice
- Influence their peers
- Oversee and plan for education of staff
- Alter the norms or expected behaviors of the group
- Affect organizational structure to support practice

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Change Champions



- Practitioners within the local group setting (clinic, unit) who are passionate about promoting the EBP
- Partners with opinion leaders to foster the use of EBPs by their peers, educating and demonstrating use of the new practice in everyday care

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A change champion believes in an idea; will NOT take no for an answer; is undaunted by insults and rebuff; and above all, persists.

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Selecting Change Champions

- Clinical experts
- Passionate about the EBP topic and committed to providing quality care
- Positive working relationships with other healthcare professionals
- Persistent about implementation of the EBP
- Focus at the unit, clinic, CBO level

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Role of Change Champions

- Encourage peers to adopt the innovation
- Arrange demonstrations
- Orient staff to the EBP
- One-on-one point of care coaching
- Act as “resident expert” in the EBP, modeling the practice
- Coordinate with opinion leaders to foster adoption of the EBPs

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Educational Outreach

- Educated person who meets 1:1 with practitioners in their setting to provide information about the EBPs, address questions, and provide positive comments about aligning practice with the evidence .
- Feedback on provider performance
- Consultation on issues
- Who does this?
- Opinion leader
- **Consistent person/consistent message**

Greenhalgh et al 2005, Feldman et al 2005, Horba et al 2004, Jones et al 2005, McDonald et al 2005, Murtagh et al 2005, Titler et al 2006b, O'Brien et al 2006

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Outreach visits

- *What I was thinking is her site visits. ... was very inspirational to the staff. ... is very inspiring and it really motivated people to think outside the box, or "How can we be better at this?"*
- *And after she rounded on the units, we would meet in a room and talk more about our audits that we would provide her and looking at our really risk factors and our interventions and how we were doing with those. That was useful for the team.*

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Implementation

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Myths

- Clinicians will adopt EBPs at about the same pace
- I just have to get those resistors on board.
- Focus on the resistors first and others will follow
- "If I build it, they will come" AKA: If I tell them, they will do it!

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The Faces of Resistors

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Reality

"Because implementation of a new practice almost invariably requires changing how things are done, it affects multiple individuals from multiple specialties and their interrelationships"

(Lucian Leape, 2005)

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Reality: Implementation Requires Partnerships, Relationship Building and Collaboration

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Reality: Who are/will be the Users of the Evidence-Based Practice

- Nurses
- Physicians
- Patients
- Family caregivers
- Respiratory Therapists
- Physical Therapists
- Pharmacists
- Others

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Reality: Diffusion

- Diffusion is the process by which (1) an *Innovation* (2) is communicated through certain *channels* (3) over *time* (4) among the members of a *social system*

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Rogers, E.M. (1995). Diffusion of Innovations (4th Ed.). New York, NY: The Free Press.

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Reality: Implementation Strategies to address users of the EBP

- Performance gap assessment – beginning of the change; indicators related to EBP topic.
- Audit and feedback – during the practice change. Discussions rather than passive reports
- Trying the practice –plan as part of the implementation process.

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Performance Gap Assessment

- Recommended practice compared to current practice
- Key indicators - do not try to assess all performance measures.
- **Do early in process/beginning**
- Get the data to those providing care/discussion
- Positive effect on changing practitioner behavior

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(Baskerville et al. 2001; Davis et al 1995; Flore et al. 1996; Hobar et al. 2004; Titler et al. in review)

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Performance Gap Assessment – Pain Management

Metric	Benchmark	Hospital A	Hospital B
ATC analgesia	~50%	~75%	~25%
Pain intensity <3	~75%	~50%	~35%
Demerol use	~10%	~70%	~85%
PCA	~80%	~20%	~25%

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Reality: Audit and Feedback

- Effective Strategy
- Improved effectiveness in combination with other strategies
- Keep feedback actionable
- Link with organizational quality improvement structure and processes
- Data perceived by the clinician as important and valid.
- Timely, individualized, non-punitive feedback

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Bradly et al. 2004; BootsMiller et al. 2004; Dranitsaris et al. 2001; Dulko D. 2007; Hysong et al. 2006; Morrison et al. 2006; Pineros et al. 2004; Wright et al. 2007

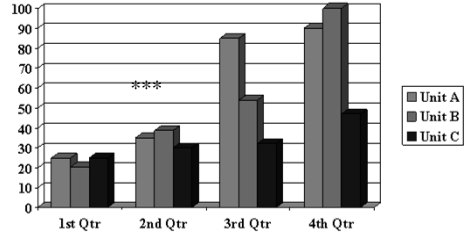
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% of Patients with Every 4 Hour Pain Assessment during first 48 hrs. – Postop surgery

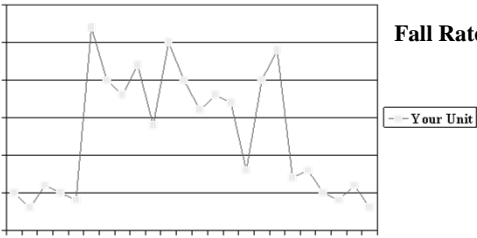


Quarter	Unit A (%)	Unit B (%)	Unit C (%)
1st Qtr	~25	~20	~25
2nd Qtr	~35	~40	~30
3rd Qtr	~85	~55	~35
4th Qtr	~95	~90	~50

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Audit Feedback Example



Fictitious data. Leading the way.

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Patient Engagement in EBP



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Pre and Post Elective IOL

PRE	POST
<ul style="list-style-type: none"> My doctor has been good all along with the whole pregnancy. I trust him and this was the option that he thought was the best. You know. I am going with that. I am apprehensive about the induction because of the risks but I am miserable and so uncomfortable. I can't breathe. 	<ul style="list-style-type: none"> I hate to say it but the induction was kind of a non-decision. We were led to believe that the induction was what was needed to prevent risks to him ... We were not prepared for any of it because we did not make the decision. We did not have all of the information.

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Elective Induction of Labor

Original Article

Moving Toward Patient-Centered Care: Women's Decisions, Perceptions, and Experiences of the Induction of Labor Process

Jennifer E. Moore PhD, RN Patient-Centered Outcomes Research Fellow^{1,2}, Lisa Kane Low PhD, CNM, FACNM Associate Professor and Midwifery Program Coordinator³, Marita G. Titler PhD, RN, FAAN Associate Dean, Professor and Division Chair⁴, Vanessa K. Dalton MD, MPH Associate Professor⁵ and Carolyn M. Sampselle PhD, RN, FAAN Professor and Director⁶

Birth Volume 41, Issue 2, pages 138-146, June 2014

Article in Press

Transforming Patient-Centered Care: Development of the Evidence Informed Decision Making through Engagement Model

Jennifer E. Moore, PhD, RN^{1,2,3}, Marita G. Titler, PhD, RN, FAAN, Lisa Kane Low, PhD, CNM, FACNM, Vanessa K. Dalton, MD, MPH, Carolyn M. Sampselle, PhD, RN, FAAN

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Women's Health Issues, 2015 25(3), 276-282

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Principles

- Engagement of key stakeholders in EBP is important to address issues important to them.
- Evidence-informed consumers of healthcare is essential part of translating research into practice.
- Engagement of patients in shared decision-making about healthcare treatments is needed to improve quality of care.

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Implementation Model

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    graph LR
      A[Characteristics of the Innovation] --> B[Communication Process]
      B --> C[Social System]
      B --> D[Users of Innovation]
      C <--> |Communication| D
      C --> E[Rate & Extent of Adoption]
      D --> E
      E -.-> C
      E -.-> D
  
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Titler & Everett, 2001

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Myths

- “One size fits all”
- Practice cultures are the same or similar in our organization.
- Changing practice is the NM's responsibility

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Context matters

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Reality: Organizational factors that affect adoption

- Learning culture
- Leadership
- Capacity to evaluate the impact of the EBP during and following implementation
- Effective implementation needs both a receptive climate and a good fit with intended users needs and values

(IOM 2001, McGlynn et al 2003, Stetler 2003, Rogers 2003a, Bradley et al 2004a, Ciliska et al 1999, Morin et al 1999, Fraser 2004a, 2004b, Vaughn et al 2002, Anderson et al 2003, Anderson et al 2004, Anderson et al 2005, Batalden et al 2003, Denis et al 2002, Fleuren et al 2004, Kochevar & Yano 2006, Litaker et al 2006, Cullen et al 2005a, Redman 2004, Scott-Findlay & Golden-Biddle 2005)

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Creating Capacity: Learning Organizations

- Successful learning organizations have leaders who are devoted to developing capacity for the future and EBP.
- Development of people in the organization is a major factor of looking beyond the moment, and moving beyond reactive approaches to problems.
- Systems approaches to addressing challenges and opportunities

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Reality: Culture of Learning

- External mandates – may provide a **first burst** of energy to examine practices. Not likely to address clinical culture for adoption of EBPs.
- Healthcare's **reliance on accreditation criteria to force change in practice will not create** the learning environments essential for EBP to thrive (Senge, 1990).
- Generative learning cannot be sustained in an organization where **event thinking** predominates (e.g. Review of SEs: purpose of the review about this event or are we reviewing SEs to learn?).

(Sams et al. 2004, JONA (34): 9) Leading the way.

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Model of Categories and Organizational Attributes (French et al 2009)

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Reality: Organizational Strategies to Promote Adoption of EBPs

- Professional roles – expect EBP in each role
- Performance criteria aligned with use of EBPs.
- Multidisciplinary teams
- Policies/procedures/documentation
- Technology for knowledge management to support patient care

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Reality: Resources and Governance Structure

- Access to experts
- Knowledge and skills to promote EBP with staff nurses (e.g. APN)
- Know process to follow
- Primary accountability – in which group/committee/council does this work reside?

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EBP Role Model and Beginner Sites

- Beginner Site**
 - Drivers of change: external demands, traditional QI
 - Few in nursing with in depth knowledge of concept and processes of EBP
 - Physicians knowledgeable but few other disciplines were
 - Low receptivity to EBP
- Role Model Site**
 - EBP-related staff driven issues & professional practice improvements.
 - Key leadership role played by nursing in EBP activity.
 - High receptivity

(Stetter et al. 2009) Leading the way.

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“Institutionalize” EBP as a Normal Part of Work (Stetler et al, 2009)

- Role model site: Deliberately and strategically building the capacity to implement and institutionalize EBP over a period of 5 years.
 - Why/motivation for EBP clear
 - How or methods of strategic EBP change
 - What including operationalized infrastructures for EBP
- Beginner site: EBP rarely seen as an ongoing explicit priority or vision.

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Role model site: Context to create and sustain EBP

<p><u>Management</u></p> <ul style="list-style-type: none"> • Creating and sustaining a clear vision • Role modeling • Developing supportive relationships • Mentoring 	<p><u>Leadership</u></p> <ul style="list-style-type: none"> • Beyond isolated projects • Fabric of organization <ul style="list-style-type: none"> – Building structures – Provision of resources – Monitoring progress – Providing feedback – Changing formal leaders who did not “fit” with the strategic vision.
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Transformative

- *We've really transformed the culture ...*
- *I think as a system, we're so much better now*
- *I think this has created a teamwork that I've not seen before.*
- *But I personally feel we've made a much safer place for our patients, because we've made people aware for multiple different ... you know all of the different disciplines that work with the patient are now much more aware of the fall risk of the patient.*

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- HIGH PERFORMING UNITS



- Managers of high performing units discussed their active participation in translating research findings to their staff.
 - Part of staff nurse's EBP team
 - Finding the research to support an initiative


Shever et al

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Expectations for Nurse Managers


- Only managers of high performing units (4 of 5) discussed expectations that were set for them - low performing units did not.



Shever et al

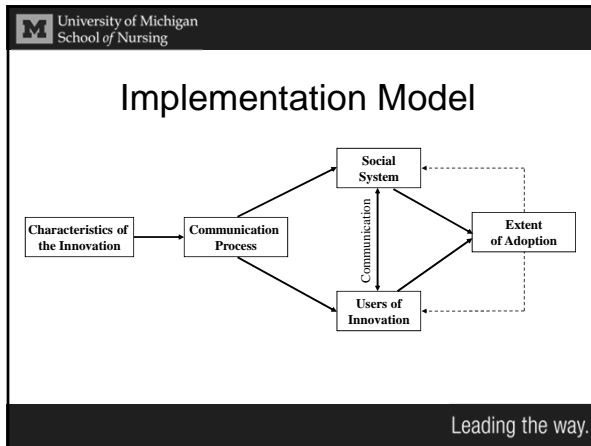
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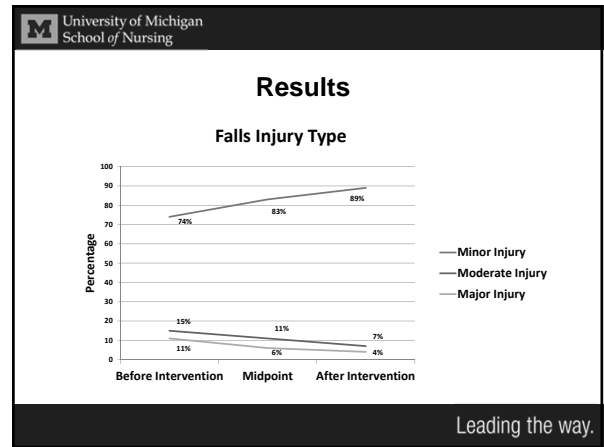
Clinical Context for Evidence-Based Practice
Bridie Kent and Brendan McCormick

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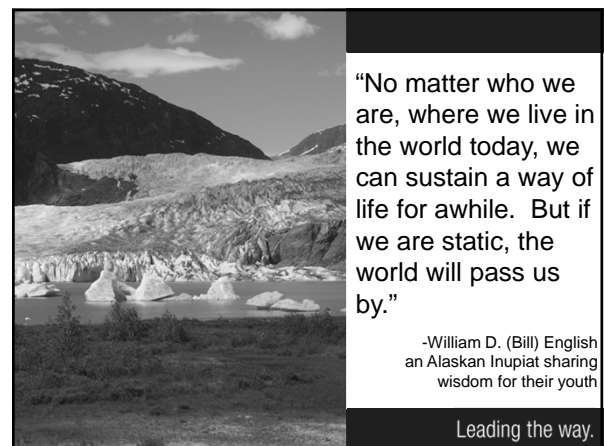


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- ### Myths
- Evaluation is not that important
 - I can inform others verbally
 - I just know we are doing better
 - Stories tell the impact
- Leading the way.

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- ### Reality: Need to Evaluate & Demonstrate Impact
- Outcomes – decrease VAP
 - Processes – e.g. oral care, HOB elevated
 - Staff knowledge and attitudes
 - Cost savings; cost avoidance
 - Qualitative impact: patient stories
 - Part of QI program
- Leading the way.



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- ### Summary
- Noted multiple myths about EBP work
 - Presented realities of EBP work especially for implementation
 - EBP work requires partnerships, teams and engagement of all key stakeholders
 - Sticky messages
 - Implementation is a process not an event requiring multiple strategies
- Leading the way.



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A Big
**THANK
you!**

Questions and Comments



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