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

Evidence-Based Practice

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

Why Listen to Bowel Sounds?

Project Director:
Diane Madsen, RN

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

(see December 2005 AJN)

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)
- Monitoring bowel sounds does not serve to indicate recovery of motility s/p abdominal surgery patients (Huge, et al, 2000)
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

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

Myth or Reality

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

Reality

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

Myth or Reality

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

Reality

Must critically appraise all evidence sources
Myth or Reality
• I know how to conduct research, therefore I know how to do evidence-based practice.

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.

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

Myth or Reality
• EBP guidelines are trustworthy – no need to critique or critically appraise them

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

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

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

Model to Guide Implementation
(Rogers, 1995, 2003; Titler and Everett, 2001; Titler, 2008)

Characteristics of the EBP
Communication Process
Social System
Rate & Extent of Adoption
Users of the EBP

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

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.

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
Realities about the EBP Topic or Innovation

The Topic Matters

“I just realized something. This study isn’t that important.”

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.

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.

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.

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.

Fall Prevention in Hospital Settings

Legend: Individual Interventions

- Fall Risk
- Fall upon rising
- Type of Fall Injury

Figure 2. Fall Prevention Interventions in Hospital Settings

Hints and Tips

- Most effective from PT (adequate weight bearing, balance, trunk movement)
- Maximizes the patient’s confidence and reduces the risk of falling
- Most patients transfer and ambulate with assistive devices and mobility in a hierarchical approach.
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
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)

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

Reality: Communication factors that influence adoption

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

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)
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
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)

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

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
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

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

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

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

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
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.

Implementation

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!

The Faces of Resistors

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)

Reality: Implementation Requires Partnerships, Relationship Building and Collaboration
Reality: Who are/will be the Users of the Evidence-Based Practice
• Nurses
• Physicians
• Patients
• Family caregivers
• Respiratory Therapists
• Physical Therapists
• Pharmacists
• Others

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

![Percentage of Adoption Graph](image)


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.

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

Performance Gap Assessment – Pain Management

![Performance Gap Assessment Graph](image)


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
Audit and Feedback

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

***Change begun

Audit Feedback Example

Fall Rate

Year Unit

Patient Engagement in EBP

PRE and Post Elective IOL

PRE
- 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.

POST
- 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.

Pre and Post Elective Induction of Labor

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

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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)

Model of Categories and Organizational Attributes

(French et al. 2009)

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

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?

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

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

Role model site: Context to create and sustain EBP

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<tr>
<th>Management</th>
<th>Leadership</th>
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<tr>
<td>Creating and sustaining a clear vision</td>
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<td>Role modeling</td>
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<td>Developing supportive relationships</td>
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<td>Beyond isolated projects</td>
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<td>Fabric of organization</td>
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  - Building structures
  - Provision of resources
  - Monitoring progress
  - Providing feedback
  - Changing formal leaders who did not “fit” with the strategic vision.

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.

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.
Implementation Model

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

Characteristics of the Innovation
Communication Process
Users of Innovation

Extent of Adoption

Social System

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

Results

Falls Injury Type

Minor Injury
Moderate Injury
Major Injury

Before Intervention Midpoint After Intervention

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

“No matter who we are, where we live in the world today, we can sustain a way of life for awhile. But if we are static, the world will pass us by.”

-William D. (Bill) English
an Alaskan Inupiat sharing wisdom for their youth