Overcoming Barriers in Getting Evidence into Practice: A Conceptual Framework

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Overview of Presentation

- Background and context
- Development of the framework
- Evaluation and refinement of the framework
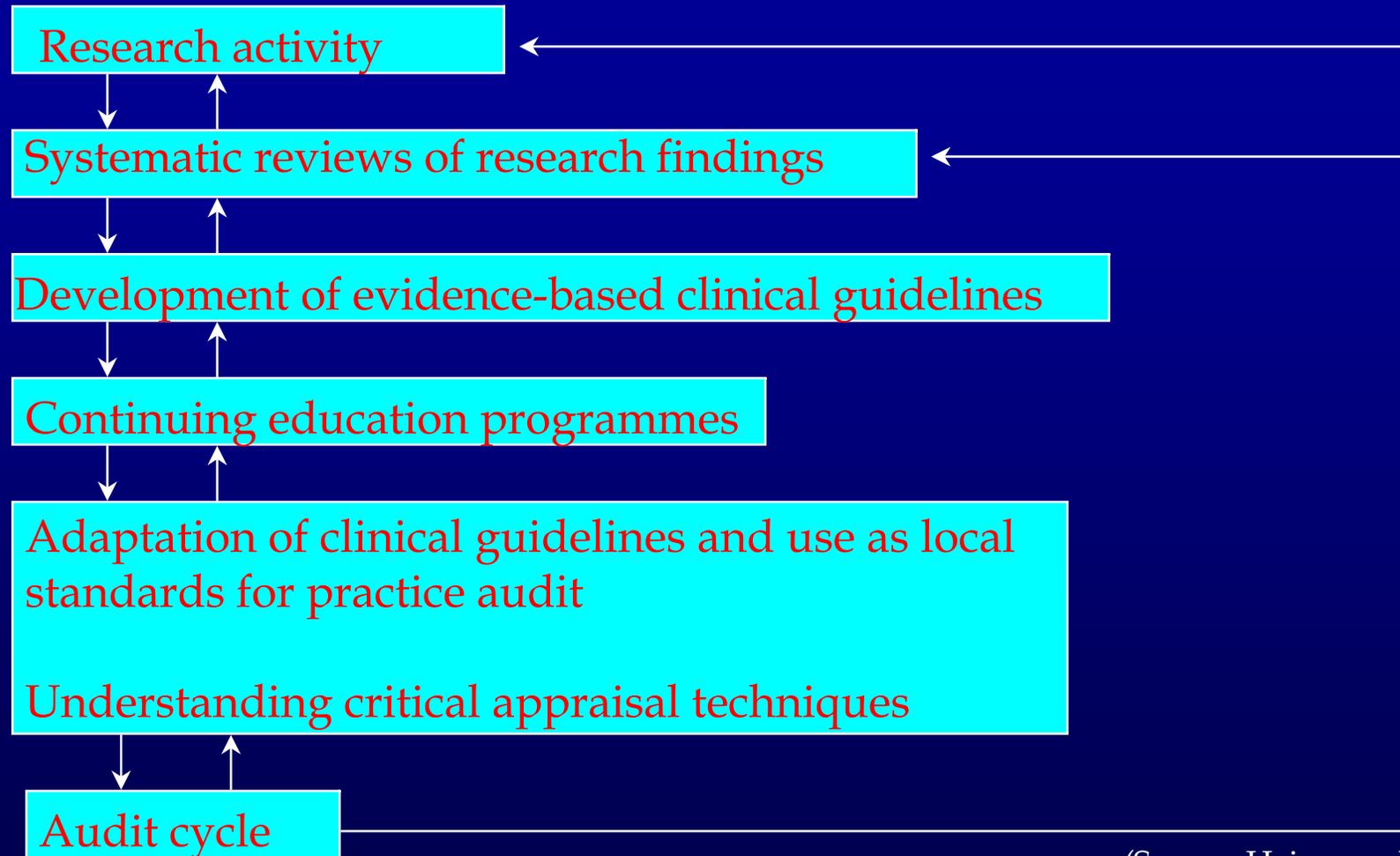- Application and utility of the framework in practice

Background and Context

- Focus on quality, effectiveness and evidence based health care
- Recognition of variations in practice and the research-practice gap
- Limited progress in tackling issues of implementation
- Pre-dominance of linear approaches to implementation

Interactions between research, continuing education and audit

Research activity

Systematic reviews of research findings

Development of evidence-based clinical guidelines

Continuing education programmes

Adaptation of clinical guidelines and use as local standards for practice audit

Understanding critical appraisal techniques

Audit cycle

(Source: Haines and Jones, 1994)

The Theory and the Reality of Implementation

"Transforming research into practice is a demanding task requiring intellectual rigour and discipline as well as creativity, clinical judgement and skill, organisational savvy and endurance"

(Horsley et al, 1983)

"Knowledge without the culture, interest and support to promote, act upon and implement change remains a sterile asset"

(Peters, 1992)

Development of the Framework

- Inductive origins – experiences in research, quality improvement, audit, practice development
    - Implementing cardiac rehabilitation guidelines
    - Implementing evidence based care in a rehabilitation/respite ward for older people
    - Developing and auditing a set of standard criteria on post-operative pain management
    - Adapting and implementing national standards on nutritional care of older adults

The Framework

Successful implementation is a function of the relation between:

- the nature of the evidence
- the context or environment in which the proposed change is to be implemented and,
- the way or method by which the change is facilitated

$$ SI = f(E,C,F) $$

Evidence, Context and Facilitation

Evidence	Context	Facilitation
- Research - Clinical experience - Patient preferences	- Culture - Leadership - Measurement	- Role - Characteristics - Style

Evidence

RESEARCH

LOW   HIGH

anecdotal evidence   RCTs/rigorous research
descriptive information   systematic reviews
                                              evidence based guidelines

CLINICAL EXPERIENCE

LOW   HIGH

expert opinion   high levels of
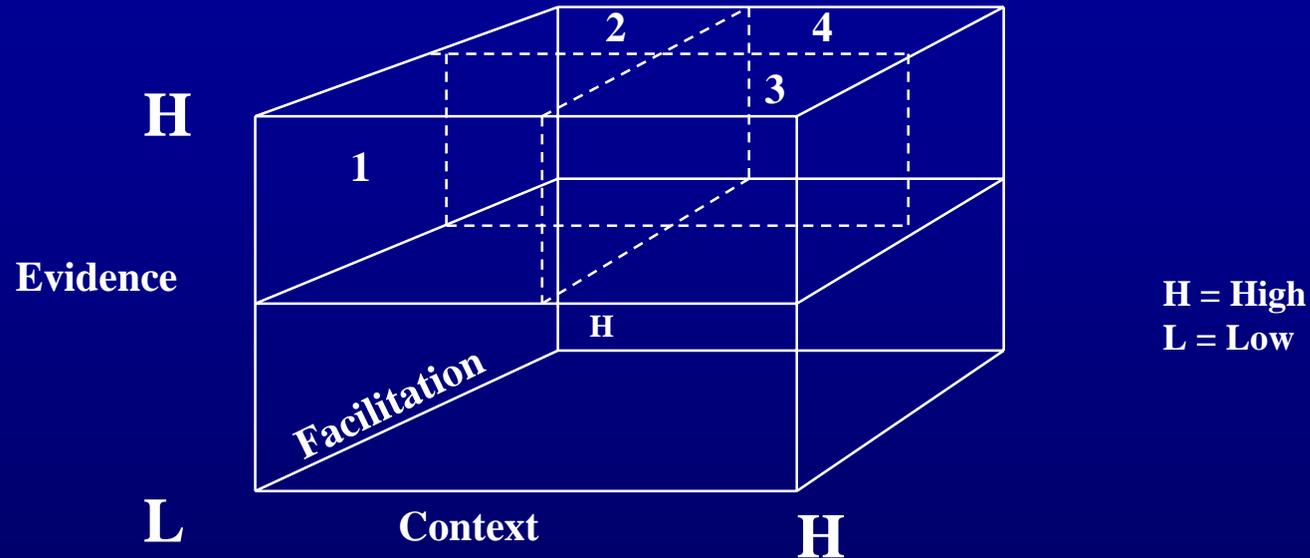divided,   consensus,
several 'camps'   consistency of view

PATIENT PREFERENCES

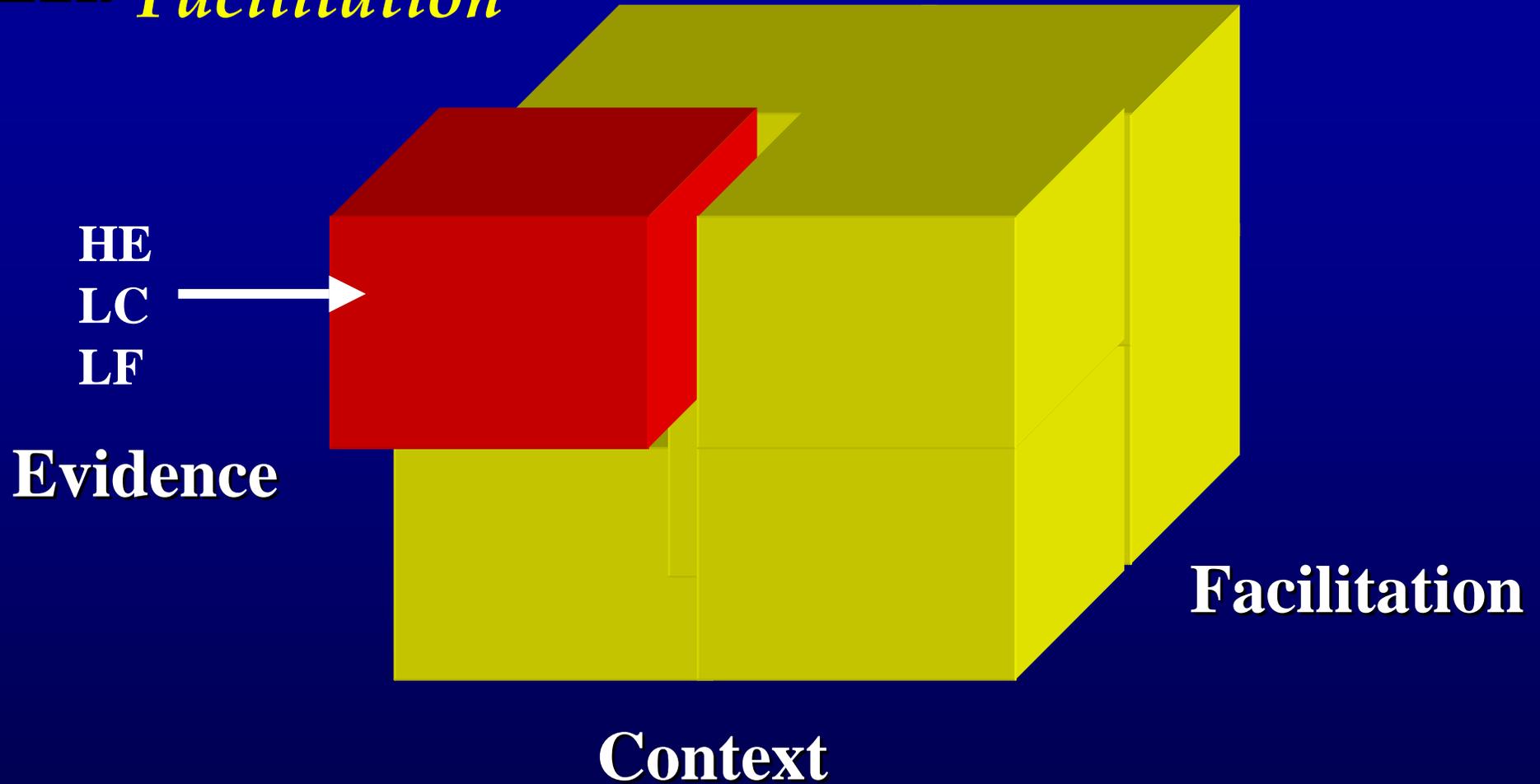   HIGH

LOW

patients   patient partnerships
not involved

Relationship between Evidence, Context and Facilitation (where evidence is high)

H

Evidence

Facilitation

L

Context

H

2

4

3

1

H

H = High
L = Low

1	=	HE, LC, LF
2	=	HE, LC, HF
3	=	HE, HC, LF
4	=	HE, HC, HF

High Evidence, Low Context, Low Facilitation

HE
LC
LF

Evidence

Facilitation

Context

Emerging Hypotheses

- Linear approach to implementing research into practice is over-simplistic and does not represent the reality of practice
- Most successful implementation of research will occur when evidence is strong (HE), the context is developed (HC), and where there is appropriate facilitation (HF)
- Least successful implementation occurs when context and facilitation are inadequate
- Poor contexts (LC) can be overcome by appropriate facilitation (HF)
- Chances of successful implementation are still weak, even in an adequate context (HC), but with inappropriate facilitation (LF)

Checking out the Framework

- Conference presentations
- Group exercises
- 1998 publication in Quality in Health Care
- Establishing a level of face validity

Evaluation and Refinement of the Framework

- Concept analysis of key dimensions of framework
- Focus group interviews
- Case studies

Concept Analysis

- Concept analyses of three main dimensions of the framework (evidence, context, facilitation) following methods proposed by Morse (1995) and Morse et al (1996)

- Aim to analyse the level of maturity of each of the concepts by critically reviewing seminal texts and other relevant literature

- Concepts partially developed, but in need of delineation and comparison

- Refinement of the elements and sub-elements within the framework

Evidence – *Information and knowledge upon which decisions about care are based*

Research

LOW   HIGH

Poorly conceived, designed and/or executed research

Well conceived, designed & executed research, appropriate for the research question

Clinical Experience

LOW   HIGH

- Anecdote, with no critical reflection and judgement.
- Lack of consensus within Similar groups

- Clinical experience & expertise reflected upon, tested by individuals and groups
- Consensus within groups

Patient Experience

LOW   HIGH

- Not valued as evidence
- Patients not involved

- Valued as evidence
- Multiple biographies used
- Partnerships with health care individuals

Context - *The environment or setting in which the proposed change is to be implemented*

Culture

LOW — HIGH

•Task driven organisation
•Low regard for individuals
•Unclear values & beliefs

• Learning organisation
•Values individual staff and clients
•Prevailing and defined values & beliefs

Leadership

LOW — HIGH

•Command & control leadership
•Lack of teamwork
•Lack of role clarity
•Autocratic decision-making processes
•Didactic approaches to learning/teaching & managing

• Transformational leadership
•Effective teamwork
•Role clarity
•Democratic decision making processes
•Enabling/empowering approach to learning/teaching & managing

Evaluation

LOW — HIGH

•Absence of any form of feedback
•Narrow use of performance information sources
•Evaluations rely on single rather than multiple methods

• Feedback on individual/team & system performance
•Use of multiple sources of information for feedback
•Use of multiple methods for evaluation

Facilitation - *The process of enabling or making things easier*

LOW   HIGH

No mechanisms or inappropriate methods of facilitation in place

Appropriate mechanisms for facilitation in place

Purpose, Role, Skills

Facilitation

Purpose

Task   Holistic

Role

Doing for others   **Enabling others**

•Episodic contact   • Sustained partnership
•Practical/technical help   •Developmental
•Didactic, traditional approach to teaching   •Adult learning approach to teaching
•External agents   •Internal/external agents
•Low intensity - extensive coverage   •High intensity - limited coverage

Skills & Attributes

Task/doing for others   **Holistic/enabling**

•Project management skills   • Co-counselling
•Technical skills   •Critical reflection
•Marketing skills   •Giving meaning
•Subject/technical/clinical   •Flexibility of role
credibility   •Realness/authenticity

Focus Group Interviews and Case Studies

- Qualitative data collection from focus group interviews with nurses in practice development roles and case studies of two organisations attempting to implement 'evidence-based' change
- Some key findings
  - Variable role of research in driving changes in practice
  - Importance of match between proposed changes and policy drivers
  - Role of local information in constructing evidence for change
  - Importance of local resources
  - Reinforcement of context and facilitation dimensions of framework

Application and Utility of the Framework in Practice

- As a guide or diagnostic tool/map

- As an evaluative tool

Common Themes Across Settings

- The nature of evidence
  - *Quality and quantity*
  - *Social and historical construction*
  - *Melding a broader evidence base*

- The context of implementation
  - *Prevailing culture*
  - *Readiness for change*
  - *Knowing where to start*

- The role of a change agent or 'messenger'
  - *Designated role?*
  - *Appropriate skills, knowledge and experience*
  - *Flexibility and adaptability*

References

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