

Development of a Practice Change Model to Incorporate Tradition-Based Nursing Practices

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Investigators, Funding & Objectives

Authors/Investigators

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Learning objectives

1. Differentiate between tradition-based practice and evidence-based practice
2. Discuss a new model for nursing practice change that incorporates tradition-based practices and de-implementation

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Background & Significance

- Evidence-based practice (EBP) is gold standard
- Tradition-based practices (TBP) not evidence-based (Titler, 2011)
 - Rituals or sacred cows (Greenway, 2014; Makic et al, 2013)
- Tradition-based practices may be inefficient or potential for harm (Prasad and Ioannidis, 2014)
- De-implementation: termination of a tradition-based practice (Prasad and Ioannidis, 2014)
 - May require reduced dose or frequency

Background & Significance (2)

- Replacement of TBP may require independent changes
 - 1) EBP implementation
 - 2) TBP de-implementation
- De-implementation of tradition-based practices may facilitate implementation of EBP
- No theoretical models address concept of de-implementation
- No previous studies in critical care or with nurses

Study Purpose

- Aims

- 1) Explore factors that influence the continued use of tradition-based practices by critical care nurses and barriers to stopping these practices

- 2) Identify processes that facilitate de-implementation of tradition-based practices

- Goal

- Develop de-implementation model for critical care nursing

Study Design

- Approved by IRB
- Descriptive, qualitative approach (Sandelowski, 2000)
- 1-hour personal telephone interviews & 1 focus group
- Thematic content analysis used to code & categorize interview data in two phases
- Questions about clinical practice, tradition & evidence-based practices, & processes for practice change.

Study Design: Interviews

- Interviews recorded & transcribed
- Interviews ceased when data saturation was reached
- Two researchers reviewed interview data separately & together to reach consensus on coding & derived themes
- HyperResearch software used for data management

Data Analysis

- Data collection ends with data saturation
 - Similar codes and categories emerge
- Demographics
 - Descriptive statistics
- Interview data
 - Thematic content analysis to code & categorize data (Saldaña, 2013)
 1. First cycle
 - Structural and subcoding
 2. Second cycle
 - Focused & axial coding
 - Synthesize data into categories, concepts & themes

Participants

- 22 critical care nurses (1 acute care)
 - 18 staff nurses & 4 nurse leaders
- All employed full time
- One male
- Age: mean 35 years (25-60 years)
- Nursing experience: mean 10 years (1-39 years)
- BSN or higher degree: 77% (17/22)
- Currently enrolled in a nursing degree program: 18% (4/22)
- Specialty certification: 73% (16/22)
- Received formal EBP training: 59% (13/22)

Results

- Data collection March 15-July 12, 2016
- 38 codes: 5 themes
- Themes consistent across all participants
 - 1) Uncertainty
 - 2) Facilitators
 - 3) Barriers
 - 4) Desire to Know
 - 5) Acquire Evidence

Uncertainty about Scientific Underpinnings

- Major theme
- Ambiguity voiced throughout interviews & focus group
- Unsure how to differentiate EBP vs. TBP
 - *“I think if they were evidence-based that it would say that it is ...and we have done our homework to make sure that it is evidence-based”*
 - *“...right now, it’s a little confusing as to which ones we are using”*
 - *TBP is “...a practice handed down from nurse to nurse because that’s just the way they have been doing it”*

Desire to Know

- Genuine concern regarding effects of nursing practice & desire to optimize patient outcomes
- Expressed openness toward changing practice
- Realistic about potential for resistance to change
 - *“I think sometime it is difficult because nobody really likes change. But I think definitely, if you see something that could work better, if it is in the best interests of the patient and it’s going to be best for them, then I’m all about it”*

Acquire Evidence: Professional Organizations

- Sources of information satisfy desire to know, motivate practice change & relieve uncertainty
- Professional organizations
 - American Association of Critical Care Nurses (AACN)
 - American Association of Neuroscience Nurses (AANN)
 - Journals
 - “As an AACN member, I get several different magazines...and see how things have worked at certain places”

Acquire Evidence: Leadership

- Trust & rely on for guidance when evidence not readily available
 - Learning specialist, Clinical Nurse Specialist (CNS), charge nurse, manager, Unit Practice Council
- Gemba boards: most frequent code, mentioned by all
 - “I think **it engages the team**. It teaches them to start thinking differently and to put their ideas up there and see if an idea comes to fruition”.
 - “If they have an idea for how to improve something. They encourage us to put it on there. That way **we can discuss it with any of the stakeholders** who might be involved”.
 - “I see **patients reading over it and look at it**”.

Acquire Evidence: Formal Nursing Education

- Formal EBP training in course work
- Outdated information & assumptions
 - “A lot of times I still go back to my textbooks from college. I still look at the rules and what is already in place...I will pull up policies and look at them. If I am concerned about medications, I still go back to the...drug book.”
 - “...it is kind of like assumed that once you have learned something in nursing school then it is maybe based on evidence and so everybody just carries on with making that assumption.”
 - “...I am also in school. So that keeps me up on things as well.”

Facilitators

- Communication, strong leadership, elimination of TBP
 - Suggestion box, email, Gemba board, daily huddle, & peer to peer reminders
 - “I think **you have to have a leader that is willing to use evidence-based research, explain the whys** and really go into depth as to why we are changing the practice. **You have to have good, strong leadership** to do that, to be able to speak to that.”
 - “Evidence that it does not work, that it does not make a difference and can actually cause harm... **I am very into safety**... if something can be done better, it is always a good thing.”
 - “I know **my unit in particular takes pride in seeing the numbers rise and seeing us do better**...”

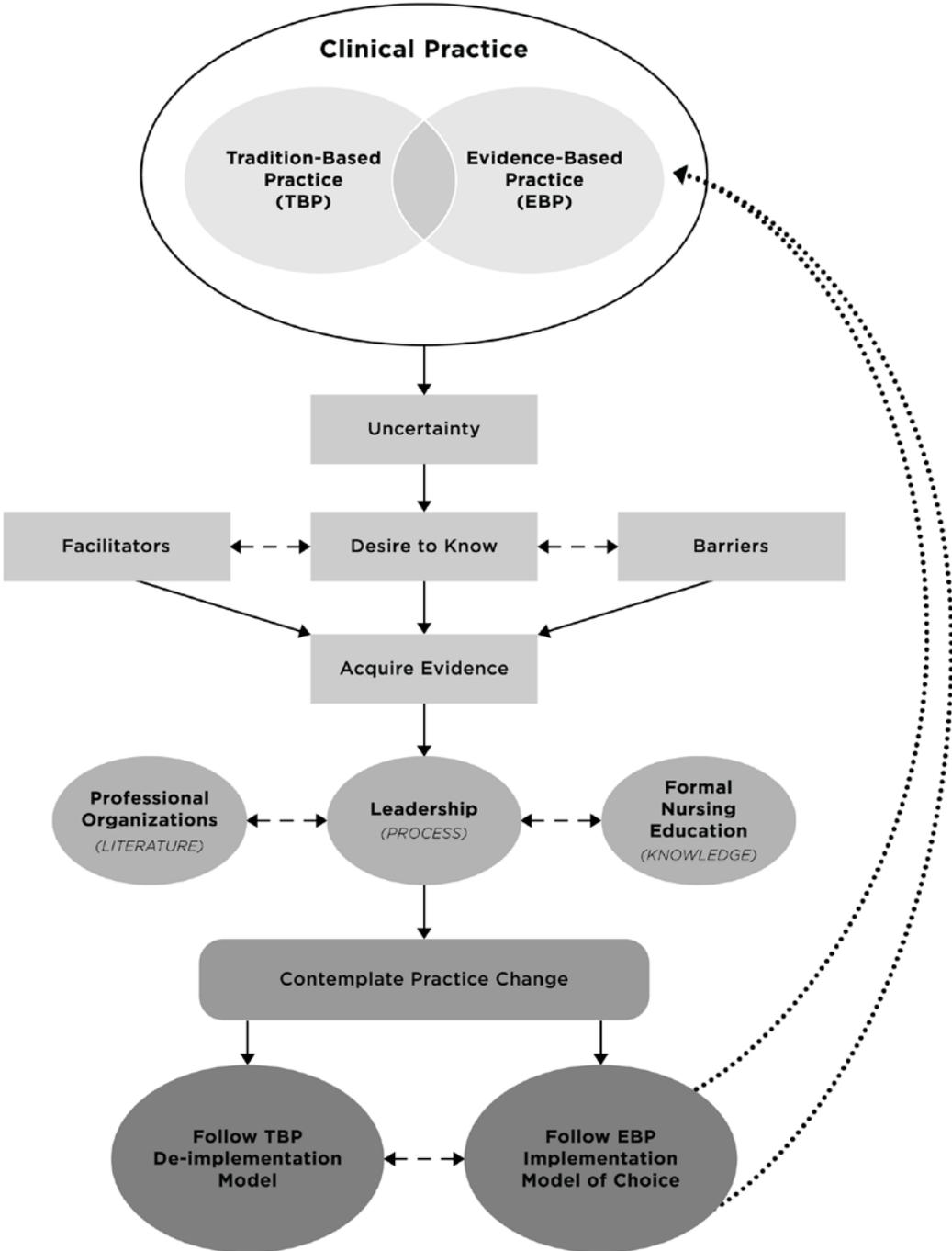
Barriers

- Resistance to change, no perceived benefit, overwhelmed with changes
 - *“Unless there is somebody kind of teaching what’s out there to know what’s best, then they [staff nurses] are probably more inclined to TBP because it is just what is being used, it’s easier. **It is hard to change what you’re used to.** So, in order to get somebody to really want to change, **they need to see a true benefit.** Actually, if a group of people have been there for a long time, it’s hard to get TBP stopped or converted.”*
 - *“**Sometimes it can be overwhelming** because if you have too much of it coming at you at one time or, if it is such a continual thing that it is always happening. **You feel you are getting confused** because there are too many changes.”*

Model Development

- UCF Practice Change Model
- Purpose
 - Illustrate relationship between TBP & EBP
 - Increase awareness of TBP and possible need for de-implementation
- Practice change decisions may involve EBP implementation and/or de-implementation
- Existing EBP models guide implementation process
- De-implementation processes & models require further research and development

UCF Practice Change Model



Discussion/Conclusion

- Aim 1:
 - Lack of awareness of TBP & de-implementation
 - Uncertainty: scientific underpinnings of clinical practice
- Aim 2: not met
- Education needed: academic & practice settings
- For change to occur, nurses need to perceive benefits, understand evidence-based rationale, & have leadership support
- Research needed: Efficacy of Gemba boards, de-implementation process, test model
- UCF Practice Change Model compliments existing EBP models

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Questions?

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