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# It's the Little Things that Matter: Implementation of Evidence-based Practice in Residential Aged Care

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**Description**
Considerable research has been undertaken in health care about implementing evidence-based practice but there has been little research in residential aged care. Thirteen projects were funded by the Australian Government to implement evidence-based practice in residential aged care, in nine different areas of practice. This study was undertaken to draw on the experiences of those involved in the program to identify the key mechanisms that influenced implementation.

The methodology used grounded theory from a critical realist perspective, involving semi-structured interviews with 51 people in 44 interviews.

Data analysis resulted in the development of a core category and three underlying mechanisms. The findings highlight the importance of having a 'common ground' on which implementation could take place; with a process of learning that connected people, knowledge and practice; within a context of reconciling competing priorities. Human agency, individually and collectively, was the final arbiter of whether changes were implemented.

**Location**
iC - SBS Teaching Facility

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# It’s the little things that matter: implementation of evidence-based practice in residential aged care.

**Malcolm Masso**

## Abstract

Considerable research has been undertaken in health care about implementing evidence-based practice but there has been little research in residential aged care. Thirteen projects were funded by the Australian Government to implement evidence-based practice in residential aged care, in nine different areas of practice. This study was undertaken to draw on the experiences of those involved in the program to identify the key mechanisms that influenced implementation.

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## Introduction

The consistent message arising from research into the effectiveness of strategies to implement evidence-based practice is that all strategies are effective some of the time, but none are effective all of the time (Improved Clinical Effectiveness through Behavioural Research Group (ICEBeRG), 2006, NHS Centre for Reviews and Dissemination, 1999). There are many reasons for this including differing views about what constitutes ‘evidence’, the constantly evolving nature of evidence and the often intractable nature of existing practice. Most of the literature reports studies in health care and the generalisability of findings to residential aged care is largely unknown. The purpose of the study was to contribute to closing this gap in knowledge.

The research was undertaken in the context of the Australian Government Encouraging Best Practice in Residential Aged Care Program (EBPRAC), consisting of 13 projects focused on nine different areas of practice, with funding of approximately $1 million per project.

The findings of a literature review (Masso and McCarthy, 2009) and the ontological perspective of critical realism (Bhaskar, 1975) formed the basis for the research question: what mechanisms influence the implementation of evidence-based practice in residential aged care and how do those mechanisms interact?

## Methods

The study used grounded theory (Glaser and Strauss, 1967) which is compatible with a range of ontological positions, including critical realism. Literature was used to inform all stages of the study.

People were purposively sampled and invited to participate in an interview. Interviews followed a semi-structured format, including general questions about the implementation of evidence-based practice and more specific questions seeking clarification and exploring issues arising from data analysis, the latter known as theoretical sampling.

Two people declined to be interviewed and two people accepted but did not respond to subsequent attempts to arrange a suitable time. Forty four interviews were conducted, involving 51 people. Participants had direct experience of implementing evidence-based practice in 87 facilities in diverse locations. Sampling of people to interview continued until data saturation was reached.

Interviews averaged 51 minutes and took place between September and December 2009 and between April and November 2010. With three exceptions, all interviews were conducted face-to-face. Interviews were recorded using an Olympus Digital Voice Recorder DS-2000 with conference microphone.

The subject of interest was the perceptions of those being interviewed, rather than how those perceptions were communicated, and hence denaturalised transcription (Oliver et al., 2005) was employed. Transcripts were checked by the researcher against the recording to ensure accuracy and generate initial thoughts regarding coding. Each transcript was assigned a code number. Transcripts were imported into NVivo software (version 8) which was used to facilitate data analysis.

Initial coding of the transcripts was based on a generic approach suggested by Saldana (2009). Codes were then categorised using the framework developed by Pettigrew (1985), which differentiates between the context of change, the process of change, and the content of change. A third level of coding was then undertaken to provide the basis for the study findings, involving more abstract concepts which crossed the boundaries between the context, process and content of change,.

The quality of the research was assessed based on the work of Lincoln and Guba (1985) who suggested trustworthiness as the main criterion of quality, with four criteria for judging trustworthiness: credibility, transferability, dependability and confirmability. The research was considered to be low risk and was approved by the University of Wollongong / South Eastern Sydney & Illawarra Area Health Service Human Research Ethics Committee.

## Results

The results were framed by a central category (*On Common Ground*) and three mechanisms – *Learning by Connecting, Reconciling Competing Priorities* and *Exercising Agency.* A series of factors were identified by participants as components of *On Common Ground* – conversation, language, how care was framed, whether a proposed change 'made sense' and whether colleagues were alike or not alike in some way. These factors served to place, or not place, individuals *On Common Ground*.

Participants described learning as a creative process, rather than simply the transmission of information from one person to another. At the core of creating knowledge was *Learning by Connecting*, whereby people were able to make connections in various ways, including:

- Connecting new knowledge with existing practice.
- Connecting new knowledge to what was already known.
- Making a connection between actions and outcomes.

*Learning by Connecting* has similarities to the concept of communities of practice, first coined by Lave and Wenger (1991).

The process of integrating the (new) evidence-based changes with existing practices took place in facilities that were highly structured in terms of routines, technologies, documentation systems, accreditation, funding and staffing. Many of the changes were subtle, and small in scale, largely taking place in 1:1 interactions between staff and residents. Taken out of context the changes were generally quite simple, but took place within a context that was complex, including residents with complex needs. The general picture was one of complex adaptive systems rather than the organisation as a machine (Plsek, 2003). Participants described a situation where anything new, whether evidence-based or not, had to compete with an existing set of constantly shifting priorities. The mechanism by which this took place was conceptualised as *Reconciling Competing Priorities,* an ongoing mechanism that underpinned whether new practices became routine or not.

*Exercising Agency* was a mechanism that bridged the gap between agency and action. It was the human dimension of change which made things happen. *Exercising*

*Agency* encompassed the potential, intention, capability and decision to act, including elements such as motivation and beliefs. *Exercising Agency* was not just about individuals, it also included collective agency, where individuals came together to act collectively, and organisational capability.

## Conclusion

Analysis of the data is nearing completion, with remaining work to refine the interactions between the core category and the three mechanisms to develop a model of change. The various 'parts' of the results are consistent with the findings from other research but the way those parts fit together are novel and will add to current knowledge about how to improve practices in residential aged care. The core category and mechanisms of change open up many possibilities for further research, both within residential aged care and the wider context of health care more generally.

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