Implementing practice change: some guiding principles

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Abstract
Encouraging Best Practice in Residential Aged Care (EBPRAC) Program:

13 two-year projects, each implementing evidence in one area of clinical practice, with total funding of $12 million:

– Nutrition and hydration
– Pain management
– Falls prevention
– Oral health
– PRN medications
– Palliative care (3 projects)
– Behaviour management (3 projects)
– Infection control
– Wound management

Model: lead organisation, each working with a group of facilities.

Keywords
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Sources for the presentation

  - Research question: what mechanisms influence the implementation of evidence-based practice in residential aged care and what are the relationships between those mechanisms?
  - Supervisors
    - Grace McCarthy, Senior Lecturer, Sydney Business School, University of Wollongong
    - Alison Kitson, Professor and Head of School, School of Nursing, University of Adelaide

Encouraging Best Practice in Residential Aged Care (EBPRAC) Program

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EBPRAC – implementation strategies

- Wide range of strategies were employed to implement evidence-based practice but with some common elements:
  - Education
  - Local facilitators
  - Feedback of data to staff
  - Financial incentive for facilities to participate, usually to cover the costs of staff training.

- All projects adopted a multi-faceted approach to change.

- The results of the evaluation indicate that there are no ‘magic bullets’ for successful implementation.
EBPRAC – practice changes

u Tended to be refinements or reinforcements of existing practices rather than new practices.

u Changes required uptake by many staff on multiple occasions:
  – Non-pharmacological interventions for pain management e.g. heat packs, passive/active exercises
  – Application of skin moisturiser after showering residents
  – Use of high fluoride toothpaste for brushing teeth and improved cleaning of dentures.

u In general, the changes to resident care were not conducive to measurement; difficult to quantify the extent to which changes had been implemented.
Establish a common ground for change

- Being somewhere in company with others (‘being on the same page’)

- Equality of interaction (on an equal footing)

- A common language:
  - English
  - Language of practice
  - A set of tools e.g. assessment tool, end-of-life care pathway, concept map, audit tool
Common ground for change

u The framing of care:
  – How something is framed will influence what is seen as important and hence what gets done.
  – How something is framed is reflected in the language that is used.
  – Clinical/non-clinical care (‘Because it’s not clinical, it’s not important. Not all Div 1s, but they have been the major blockers’)

u The framing of change – more important than the evidence *per se* are answers to the questions
  – Does the change make sense?
  – Will the change work? i.e. provide benefits for staff or residents.
Conversing about practice

Involves two or more people talking about some aspect of practice:
- The care of a particular resident
- How to conduct a particular task
- Talking about some improvement that may have taken place
- Asking questions to clarify new information
- Discussing ideas about what to do
- Asking questions about how something might work
- Sharing experiences about a new practice

Characteristics
- Interactive
- Formal/planned or informal/unplanned
- When people are ready to talk (‘opportunistic moments’)
- Make space for conversations (time, physical space, emotional space)
Connecting new knowledge with existing practice and existing knowledge.

Connecting the ‘parts’ of resident care with the ‘whole’ of resident care.

Making a connection between actions and outcomes.

Environments for learning

- Small-group education session
- Mentoring session
- Formal case conference
- Informal review of resident care
- Handover between shifts
- Conversation involving two or more staff.
Reconciling competing priorities

- Daily work – mix of simplicity and complexity

- Anything new, whether evidence-based or not, has to compete with an existing set of constantly shifting priorities

- Competing priorities:
  - Following a routine versus being flexible to the needs of individual residents
  - The tension between providing good clinical care and a home-like environment
  - Some aspects of care considered more important than others – some work must be done
  - Local priority vs a corporate priority
Strategies for reconciling competing priorities

- Changing the way care is framed
- Conversing about practice
- Trying out new practices
- Doing two things at the same time
- Including a new practice at a particular milestone, at regular intervals or for all residents at set times
- Planning, review or reflection to agree on a set of priorities
Routines – a view from the literature

- Routines allow organisations to do four things:
  - provide coordination
  - provide some stability of behaviour
  - economise on the use of cognitive resources (because routines are often followed sub-consciously)
  - store knowledge, including tacit knowledge (Becker 2004).

- Routines cannot be specified in enough detail that would allow those routines to be carried out.

- Routines depend on where they started from and build incrementally from there (there may be a good reason why ‘we’ve always done it that way’!)

Agency

- Agency is a characteristic of individuals
  - individuals make choices
  - individuals wield power and influence others
  - individuals decide whether to act or not
Exercising Agency

- Individual capability to act – knowledge and skills
- Willingness to act (‘willingness’, ‘motivation’, ‘commitment’, ‘enthusiasm’)
- Beliefs about consequences (‘seeing the benefits’ / observability)
- Beliefs about capabilities (confidence, empowerment)

Collective agency (usually expressed as ‘teamwork’):
- ‘not standing alone’, ‘all in it together’, ‘coming together to agree on a particular approach’
- reciprocal influence and synchronising actions
- ‘people’s shared belief in their collective power to produce desired results’ (Bandura 2001, p 14).
Leadership

- Leadership – the ability to influence others.

- Leadership does not have to come from managers but if that is the case it is important that managers support the change.

- Without someone to lead change it is probably not worth starting.

- Leadership should involve more than one person and be ‘distributed’ throughout the organisation (similar concepts: ‘shared leadership’, ‘collective leadership’, ‘collaborative leadership’):
  - facility managers, facilitators, quality managers
  - registered nurses, enrolled nurses, personal carers, allied health staff
Summary

- Establish a common ground for change.
- Foster ‘learning by connecting’.
- Develop strategies for reconciling competing priorities.
- Recognise that individuals can choose to act or not act in a particular way.
- Facilitate the ability of individuals and groups to act.
Any questions?