

Implementing Evidence-Based Practice: A Manger's Perspective

Introduction

The Princess Alexandra Hospital Health Service District (PAHHSD) is a Tertiary teaching hospital located in Brisbane, Australia. The occupational therapy department at the PAHHSD has taken considerable steps towards increasing the utilization of research evidence for clinical practice, particularly with respect to treatment effectiveness. This interview with the 'evidence-based practice project leader' describes the process involved, and provides unique ideas for encouraging associated behaviour change.

Q. How did your department develop such a strong focus on EBP?

A. It started in April 2002, there had been a lot of changes within the department and we were doing an operational plan to direct how we would progress and what we would like to achieve as a department. We were aware that Queensland Health and PAHHSD were moving towards a greater emphasis on evidence-based practice (EBP), and heard similar discussions within the occupational therapy profession and so we wanted to put something in place that would extend our research culture towards more effective use of research evidence in clinical practice.

Q: Could you describe the process your department has used to increase the uptake of evidence?

A: Our director called for staff interested in forming a special 'Evidence-based practice project team' whose purpose was to educate staff and promote a culture of EBP within our department. The project team consisted of 3 members including a project leader, and began by developing a project plan that considered what strategies and resources we would need to educate staff, and then how we would then roll out the use of evidence in practice. We decided to start with a questionnaire to determine staff members' current level of knowledge, skills and use of evidence was. We also used an activity audit form for 1 month that captured the use of the library, use of databases, and access of articles. This showed there was good general knowledge of the concept of evidence-based practice, but a need to develop skills in finding, evaluating and using evidence in practice. Based on this feedback we developed a training program that provided basic introduction to evidence-based practice and critical appraisal skills. We also had 3 library sessions to improve skills in forming clinical questions and accessing appropriate literature.

Q: How have evidence-based practice activities progressed since this educational process and are they carried out on an individual or group basis?

A: As part of the training we did an activity in which we separated into our clinical work areas (our main areas of practice here are spinal injury, acute, aged care including geriatric rehabilitation, brain injury and driving) and we encouraged the staff working in each of these areas to think about clinical problems that come up frequently in their practice that they would like to know the research evidence for. Staff then developed clinical questions from these. We then introduced an Evidence Based Practice Workgroup which created set time and space for interested staff to pursue these questions. We encouraged staff to work in pairs or small groups to share the workload and motivate each other! These project groups looked at collecting all the relevant articles for a particular topic, rather than just one article. The articles were then appraised and time was spent considering how they might apply to our practice. The outcomes of this process are more rigorous than if we were to just look at an individual article and we can really look at the implications for clinical practice.

Around this time the EBP project leader was funded for 1 day per week to help maintain and increase the momentum following the EBP training.

Those not involved in an EBP project still participated regularly in EBP activity by means of a journal club. This ran for half hour on a weekly basis and involved the whole department. It focused on accessing an article in response to a current clinical question they had, and then appraising it. We encouraged staff to start with the highest level of evidence rather than just looking at journal articles that crossed their desk. So they started with trying to locate pre-appraised evidence in Cochrane or OTseeker, to cut down the time needed for critical appraisal. Otherwise if nothing was available through those sources, they would find an article, appraise it themselves and then present it to the group. Staff members were rostered on to present, with one person presenting each week. Following their presentation there was time for questions and discussion.

Q: Over time, have you been aware of change in practice because of information found?

A: Yes and this is an area we are continuing to work on. Early on the staff used a template that cued them as to what to do, right through from developing a question to considering clinical implications of the evidence they appraised. This last part has been the most challenging part of the process: working out how to integrate the information from many articles and determine how it might apply in this setting, and integrating clinical expertise with this as well. At the end of this work we want to have an outcome and we are trying out ways of doing this so we can see the evidence used in practice.

One common product of the EBP projects is evidence-based patient information. For example, one EBP project was 'Return to Activity Following a Cardiac Event'. The results of the evidence-based review have now been integrated into updated return to activity guidelines for patients. This outcome has required a change in practice, and so a process for implementation was required. The EBP review was presented to the doctors on the ward and the other disciplines in the team. This consultation led to a handout which integrated best evidence with clinical expertise.

We are now starting to feed the clinical implications from EBP projects through our departmental quality and safety group to discuss ways to best implement the findings. So we are starting to develop more formal structures for the use of this evidence. We have also had an opportunity to work with the physiotherapy department to develop combined clinical protocols. I keep a progress log of all the projects that have been done and it is encouraging to know that out of a department of approximately 40 staff, over half of them are involved in EBP projects. Over the 3 years we have been doing this we have covered 26 topic areas.

Q: You mention that occupational therapy staff still see evidence-based practice as something extra to their caseload and you are trying to work towards a situation where it becomes part of the culture; just part of what staff do in the same way as other clinical tasks. How will you do this?

A: Although we have had successes with these evidence-based practice projects, they are a quite lengthy process. Ultimately we would like people to be accessing and using evidence on a day to day basis.

An important strategy that we have used is leadership support, demonstrating that time spent on EBP activities is important, valued and expected. The occupational therapy director has been the motivator for the whole process. What we would like to do now is utilize our senior therapists more, and get them to be drivers of what is happening in their own area with

respect to evidence-based practice. For example, when they have staff supervision time, they could model the process so that if a clinical question arises, rather than just relying on clinical experience, they could also use the supervision as an opportunity to do a quick search for evidence. In having this modeled staff may see that it is possible to do a quick search for research evidence as part of their practice.

Another strategy we are starting to develop is to integrate our department's research portfolios with the evidence-based practice projects so that it becomes a two-way process. The evidence-based practice projects can identify areas of practice where there are gaps in evidence and feed this to the research group. In turn, literature reviews for research projects can be more evidence-based and worked on as EBP projects. The process is evolving. Now instead of having the evidence-based practice workgroup, we have linked with the research teams we have in the department and call them Research and Evidence Programs (REP). What we did was look at what research is happening in the department and what evidence-based practice projects were going on and then grouped these into four key areas: catastrophic injury, aged care assessment and rehabilitation, upper limb assessment and rehabilitation, and chronic disease. We then asked staff to align themselves with one of these 4 groups.

In addition to this we've introduced the idea of staff being 'generators' of research, 'participators' in research and/or 'consumers' of research. The 'consumers of research' are those interested in using the research – which is generally where evidence-based practice comes, 'participators' are those who participate in research in such ways as helping with recruiting participants for research projects, and the 'generators' are those who generate the research idea and are the 'doers' or authors of the research. And so we ask staff to identify how they want to participate in the Research and Evidence Program initiatives in the department, so that everyone becomes involved at some level, and this is now an expectation in the department. Next, we would like to encourage someone within each of these groups to become a 'champion', to lead the group, and for that to be someone who is not in a research or evidence-based practice leadership position already. The aim is to try and distribute ownership and help people become involved. We hope these groups will foster the research-EBP continuum.

Q: All of this takes time. What time do people have during work for EBP activities?

A: After the initial education process we knew we also had to deal with the barrier of time, as it had been highlighted in the literature and by our staff as a key barrier. The EBP project team and the occupational therapy director recognized the need for supporting and setting aside dedicated time so staff wouldn't feel guilty taking time away from direct clinical work for evidence-based practice activities. So we set aside time after each weekly staff meeting to have an hour in the library where all staff were welcome to work on EBP skills and to locate research evidence. It was always their choice whether they came and used that time for evidence-based practice activities or not, but at least they knew that protected time was supported by the director of the department.

Staff members are also given one afternoon away from clinical work each month for continuing quality improvement activities. Because EBP activity is encouraged by the leadership of the department, staff feel comfortable using time during work to do EBP and plan this into their schedule as suits them best. Staff are also encouraged to do an EBP project as part of their yearly Performance and Development Plan, so that participating in evidence-based practice activities is an expectation and something they are accountable for. This has provided a bit of motivation for them to use the time for evidence-based practice

activities. Occasionally depending on the budget, the director may provide an afternoon of backfill to release them to pursue their evidence-based practice project.

Q: Some staff and managers would have difficulty finding protected time for this use. I guess this may vary between settings and depend on resources available?

A: Yes, we have been conscious all along that time is a barrier to evidence-based practice. We have made efforts to help staff understand that this is a good use of clinical time and that ultimately it will result in more effective use of time- if you are finding better ways to do things or if you are more confident in knowing why you are doing things.

Q: What sort of resources do you have available to support this process?

A: We are lucky to have good resources to use. Our staff members have access to many journals online as full text through the University of Queensland library as there is a branch on the hospital campus. We also have access to the Queensland Health electronic library 'Clinicians Knowledge Network' that contains the major databases including OTseeker. We have a library room that staff members like to use to get away from the busy clinical setting for their searching.

Q: It seems to me that your leadership structure is very positive towards evidence-based practice as something beneficial. What were the attitudes of staff towards this at the beginning?

A: There was a mixed reaction as there is a range of experience in the department, from new graduates to staff who have been practicing for years. Generally the new graduates were more confident with the components of EBP such as literature searching skills. Overall the occupational therapy staff was quite receptive to it. Following the training we found that some staff were very enthusiastic to work on EBP projects while others still did not feel they could fit it in to their workload. So we had a committed group of people and others who weren't ready to engage in the process. Recently it has been good to see that some of those who were more reticent have started to work on their own project. This is interesting as it seems that a bit of a culture change has occurred, with staff seeing the rewards of knowing and applying best current evidence to their practice.

It has taken three years so far and I guess you have to expect that significant behaviour change is going to take a long period of time. From the start we recognized that we were asking staff to make a significant behavioural change in their work practice as they moved towards EBP. As such we have thought through and utilized principles of change management as we introduced EBP to staff and still now as we continue to work towards a culture of EBP within our department.

Postscript:

In a brief talk with the director of this department, she explains her drive for implementing evidence-based practice:

Evidence-based practice provides opportunities for clinicians to ensure the clinical techniques and strategies they are using provide the best outcomes for patients. It enables clinicians to be the best advocates for patients when arguing for length of stay or equipment resources based on research evidence. As a manager I foresee that it will be useful for managing limited resources. We can argue for additional staffing or consumables with strong research evidence for support or we can use research evidence to inform process e.g. triaging referrals.

As a manager I need to give clinicians time out to evaluate and check what they are doing works. Blocks of time have proven successful as they allow a switch in mind set for people working in busy clinical settings. I also know that my attitude affects others. As a professional leader I need to act as a role model and advocate and I believe that my excitement regarding the opportunities EBP gives us, enthuses others. Now we need to shift from leaders driving it, to it being integrated into day to day practice. It needs to be seen as an important part of practice, not an extra thing to add to a caseload. I think our plans for a continued multifaceted approach and improved integration with the research programme will continue our steps forward down this path.

Interview participants:

This interview was carried out by Sally Bennett from the University of Queensland with Lara Moes (Evidence-based practice project leader) and Mary Whitehead (Director) at the occupational therapy department of the Princess Alexandra Hospital.