Promoting Evidence Informed Improvements in Care Homes: Nursing Perspectives

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Introduction

Achievement of evidence based practice is seen by many as pivotal to delivering quality services with demonstrably high standards. In the mid 1990's evidence based practice was defined in terms of practitioner decision making that involves the explicit and judicious use of the best available evidence in determining the optimal care for individual patients. The early emphasis on hierarchies of research evidence with randomised controlled trials as gold standard has shifted towards more inclusive views of evidence that recognise practitioner tacit knowledge and patient preference and their application in practice (Booth et al 2007). Promoting a culture where evidence is generated, synthesised and applied is now the contemporary and accepted way forward.

Although evidence informed practice has become the healthcare policy mantra evidence use in practice remains patchy and there are numerous exemplars from care homes, where the influence of evidence is unclear or at worst absent. The evidence practice gap manifests in the failure to implement new approaches and eliminate practices such as the contentious but persistent practice of restraint.

Opponents of evidence based nursing question its viability given the well documented implementation challenges, but it is however difficult to argue against the quest to promote the most effective care and the cessation of practices which are unsafe, ineffective (Rycroft Malone 2008) or breach human rights.

Admission to a care home is usually triggered by complex and enduring health needs, multiple pathology and increasing dependency. A recent trend in research has been to focus on psychosocial aspects including the transitions involved in becoming a cared for resident. The assertion in this paper is that evidence informed improvements to optimise nursing management of prevalent later life conditions must be central to the care home development and research agenda. This requires research not only about condition management but also on effective implementation methods focussed on working with older people who live within care homes. Balance is required to ensure that we advance knowledge about these clinical dimensions of gerontological nursing practice in tandem with advancing conceptual dimensions of care and the promotion of quality of life.

Finding Focus

There is growing recognition among implementation scientists that evidence use in practice is highly contingent on contextually situated decision making (Rycroft Malone 2008). Evidence translation processes and the relationship between evidence use, care experiences, quality of life and overall standards within care homes are poorly understood.

It is beyond the scope of this paper to detail condition specific research priorities but it is important to note increasing calls for nurses who work with older people to demonstrate qualities in the experience of care and in delivering clinical outcomes. This creates momentum for renewed consideration of the meaning of quality nursing within care homes which could extend to the development of nursing sensitive indicators. For example Griffiths et al (2008) persuasively argue that evidence-based indicators which measure outcomes delivered by nurses have the potential to capture trends, allow performance comparisons and targeted improvement interventions. Four promising evidence-based indicators to measure the outcomes delivered by nurses within acute care were identified by the English Taskforce as;

1. Patient safety indicators (failure to rescue associated with preventable deaths, healthcare-associated infections, falls, pressure ulcers).
2. Patient experiences of compassionate care (an important outcome in its own right).
3. Staffing and skill mix indicators linked to patient outcomes.
4. Process indicators.

(Griffiths et al 2008).

The arrival of nursing metrics, signals the beginning of a new era where the nursing contribution can be ascertained in ways that bring together measures of effectiveness, safety and compassion. With global ageing and the predicted increase in the numbers of care home residents it is timely to invest in the development of nursing metrics appropriate to the care home environment. If it were possible to establish universal care home nursing metrics this would permit comparative monitoring of performance trends. Furthermore, the use of metrics would provide common bench marks to identify development priorities and measure the impact of targeted improvement interventions. This would be a challenging but justifiable endeavour in that it would explicitly profile the contribution of nursing to the care of older people within care homes.

Nursing is uniquely positioned to support older care home residents to adapt and adjust to non disease specific later life conditions and prevent and manage geriatric syndromes. Given the potential nursing contribution and high prevalence of geriatric syndromes including delirium, incontinence, cognitive impairment loss of mobility, falls, pain, sensory impairments, pressure ulcers, malnutrition, healthcare associated infections; selected conditions may provide a legitimate focus to anchor care home nursing metrics. The proposed focus on later life syndromes in contrast to specific disease entities is related to rescue and prevention, health promotion and maintenance, functional ability so as to enable older people achieve a meaningful life within a care home. Achieving optimal health and well being and a life experience of an acceptable quality to the older person is not an unreasonable goal.

Developing Capacity & Capability

Many countries are facing nursing workforce shortages and this reality must be recognised in the international care home development agenda. Locating collaborative models that pool and deploys nursing expertise and leadership (nationally or internationally) offer the most affordable routes to advancing evidence informed gerontological nursing. Communities of practice (CoPs) have been identified as key to developing sustainable collaborative capacities for evidence informed practice (Rycroft Malone 2008).

Communities of Practice

A recent systematic review of literature (published 1991-2005) demonstrated the potential of CoPs as an improvement framework calling for further research of effectiveness (Li et al 2009). A major contribution to knowledge about cultivating productive communities of practice to advance evidence informed improvements to nursing comes from a UK longitudinal programme of research (Tolson et al 2006, 2008). Tolson et al completed a series of studies between 2000-2008 which sought to develop in partnership with practitioners and older people a sustainable approach to evidence informed improvements across the range of care environments, including care homes. The research involved cycles of modelling, proof of concept testing, piloting, refinement and impact evaluations of a community of practice framework for improvement. The development phase used a mixed method social participatory design combing action research with realistic evaluation. Data collection methods included group and individual interviews, analysis of online group working behaviours, compliance with evidence linked review criteria and case studies prepared in partnership with older people. Overall the development and pilot phases contributed to raising standards of care within 57 National Health Service sites (hospital wards and community sites) and 26 independent sector care homes. The resultant CoP framework comprised three critical ingredients:

1) an internet enabled communication system and infrastructure,

2) a knowledge conversion process that aligns evidence informed care guidance with an agreed values base,

3) a facilitated transformational learning and development framework focused on changing professional behaviour leading to sustained compliance with evidence linked review criteria.

New ways of working become sustainable through individual and collective responsibilities and actions and the sharing of the CoP know how and resources with the wider practice community associated with CoP members. Achieved changes are more likely to endure as they are a product of changing the way practitioners think and act. This is accomplished by aligning change within an agreed and shared set of values. The strength of this approach is that it has been developed in partnership with practitioners and service users. It is grounded in user experience, has been piloted within Scotland and is theoretically congruent with established organisational change, social participatory and situated learning theories. An impact evaluation testing the CoP improvement model within three contrasting care environments, hospital wards, day hospitals and care homes reported verified percentage improvements of 73-86% in the review criteria at the level of the patient (direct patient care criteria) and 32-41% in facilities level criteria improvements (such as revised unit policies), figures for the care home community of practice were 82% & and 41% respectively. These improvements were observed at 6 months and are indicative of the potential of CoPs to change professional behaviour (Tolson et al 2008).

Research Opportunities

The premise of this paper is that evidence informed improvements within care home nursing need to address both clinical and care giving dimensions. A case has been made to advance the quality and effectiveness of care home nursing through research related to the management of common geriatric conditions, where the nursing contribution is central but currently reliant on a relatively weak evidence base. Suitable condition specific outcome measures will be required and it is suggested that some of these might be included within nursing sensitive metrics. In addition, mindful that evidence use is a highly contingent process vulnerable to contextually situated factors, it is essential that effective evidence implementation methods are developed for care homes and the potential of communities of practice is highlighted.

References

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