

Dialogues in Best Practice



October 10th, 2006:

What IS Best Practice? How Do We Know What We Know?

Facilitated by:

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Welcome and Introductions

Welcome: Anne Basting, Director, Center on Age & Community

Anne welcomed everyone to the first Dialogue of the 06/07 academic year. She informed people that the schedule for the remaining Dialogue sessions can be found on the center's website, and that we plan to alternate between campus and community locations for the events.

Introductions: We went around the room so attendees could say their names and affiliations. In attendance were quite a few students from the Graduate Certificate in Applied Gerontology, and a mix of faculty, academic staff, and people from community aging organizations.

Dialogue

Sarah Morgan, co-facilitator, opened the discussion by referencing research on Best Practice. Data suggests that when evidence-based practices are used, patient outcomes improve almost three-fold (Melnyk & Fineout-Overholt, 2005).

Best Practice:

- 1 Rests on a continuum of scientific rigor
- 2 Quality can fluctuate based on the evidence
- 3 Targeted at a specific population
- 4 Applied in context
 - I Burden of illness
 - II Beliefs about the value of the intervention
 - III Cost/benefit
 - IV Barriers to implementation

Sarah then posed the question to the audience, “What does Best Practice mean to you?”

ANNE: One of the challenges of Best Practices is that what makes a best practice for one setting might not for another...so much depends on adapting this to one’s unique setting/staffing/clients issues.

JEANNE PROCHNOW, CO-FACILITATOR: The research part might be the easiest...actually MAKING the change is the hardest – you can mandate changing an activity to a “best practice” model, but you need buy-in, to educate staff as to why it’s important, and you need time to change.

AMY AMBROSE: Is there a Best Practice for making change?

SARAH: There are several models, including: Diffusion of Innovation (Rogers, 2003). The field of organizational change is a whole field unto itself (Schein, 1992).

ANNE: The disability movement is far ahead of Long Term Care (LTC) in this regard.

ANNE: Also, one of the things we learned in *TimeSlips* is that, since it is an organized, national program unto itself, it is easier for people to feel like they are part of something bigger, something that provides momentum for individuals trying to make change in an organization. I think the Pioneer Network is doing this for culture change. *TimeSlips* tries to serve as that entity for creativity folks. That way, as people encounter resistance within their organizations, they can still feel supported on a national scale. They can point to a larger group that legitimizes their efforts.

SARAH: It’s hard to find change makers who can affect policy in their organizations.

PAT NOONAN: It’s good to figure out what kind of changes people can make – they can change forms, or philosophies, even if they can’t rewrite major corporate policies.

JEANNE: The idea of finding a best practice for adopting best practice is very important...

Sarah cited more research to suggest the following about Best Practice:

When benchmarking for best practice, first ask... “What is the source of evidence, where does it ride on the opinion vs. evidence continuum?” (*Academic Center for Evidence-Based Practice (ACE)* (<http://www.acestar.uthscsa.edu/>))

Evidence-Based Clinical Decision-Making is derived from:

- 1 Clinical knowledge
- 2 Research/evidence-based perspectives, and expert opinion
- 3 Data from history and physical
- 4 Individual patient needs and values

(*Melnyk & Fineout-Overholt, 2005*).

SARAH: There are five little steps of Evidence-based practice...but it’s not so easy to implement!

She then outlined the five steps:

Melnyk and Fineout-Overholt (2005) identify five steps of evidence-based practice, including

- 1 Ask the clinical question
- 2 Collect best evidence
- 3 Evaluate the evidence
- 4 Integrate all sources of data in making clinical decision and
- 5 Consider and evaluate the clinical decision

Since there are numerous methods by which to conduct research, Melnyk and Fineout-Overholt (2005) outline a rating system for the hierarchy of evidence, which might be useful in determining best practices.

- LEVEL I Evidence from a meta-analysis or systematic review of relevant randomized controlled trials (RCTs)
- LEVEL II Evidence gathered from a minimum of one well-designed RCT
- LEVEL III Evidence from non-randomized controlled trials
- LEVEL IV Evidence from well-designed cohort and case-control studies
- LEVEL V Evidence from reviews of qualitative studies
- LEVEL VI Evidence from a single qualitative study
- LEVEL VII Evidence from expert opinion

Sara raised questions for thought related to how the Best Practices process she outlined could be applied to issues in aging.

- 1 What are the burning questions right now in aging?
- 2 How would you start the process?
- 3 Where do you go for evidence?
- 4 What are the barriers and facilitators?
- 5 Is this something new or just new terminology?
- 6 How do we bring together clinicians, researchers and students to ensure best practice?

JEANNE: How do we know what the best research is? How do we collect evidence? This might be where the university partnerships come in – because we don't always have access to what academics do.

ANNE: And the added challenge is that sometimes you might be a nurse, and the information you want is actually in architecture or social work. Or you might be a social worker and your answers are in nursing. The fields all speak different languages and it can be hard to decode them. We ran into that with our Kohler consulting project – we hired 4 people to do 4 reviews of literature: from nursing; architecture; occupational therapy; and social work/sociology. All to answer the question: why do people leave their homes?

Jeanne illustrated how one organization can begin to apply ideas of Best Practice by reviewing the project she is working on at Community Care for the Elderly on urinary incontinence. She discussed her sample clinical guidelines for urinary incontinence and a bit of their research/evaluation process.

JEANNE: We can make an impact on the lives of the people we serve – but it's crucial that we use the best information we have to do it right.

Jeanne added that her organization has formed a partnership with Sarah to look at how pain is handled among the people they serve, particularly in dementia. They will be writing proposals to support this project in hopes of determining Best Practices for addressing the issue.

More Information

<http://www.acestar.uthscsa.edu>

<http://www.cochrane.org/>

<http://www.rnao.org/>

<http://www.guidelines.gov/>

<http://www.mdx.ac.uk/www/rctsh/ebp/main.htm>

http://www.urmc.rochester.edu/hslt/miner/resources/evidence_based/index.cfm

References from Presentation

Melnyk, B.M. & Fineout-Overholt, E. (2005). *Evidence-based Practice in Nursing and Healthcare: A Guide to Best Practice*. Philadelphia: Lippincott, Williams & Wilkins.

Rogers, E.M. (2003). *Diffusion of Innovations*, Fifth Edition. New York: Free Press.

Schein, E.G. (1992). *Organizational Culture and Leadership*. San Francisco: Jossey-Bass.

Other References

Malloch, K. & Tim Porter-O'Grady, Editors. (2006). *Introduction to Evidence-Based Practice in Nursing and Health Care*. Boston: Jones and Bartlett Publishers