

*Overcoming Barriers in Getting  
Evidence into Practice:  
A Conceptual Framework*

Gill Harvey

Senior Lecturer

Manchester Centre for Healthcare Management

University of Manchester






# *Overview of Presentation*

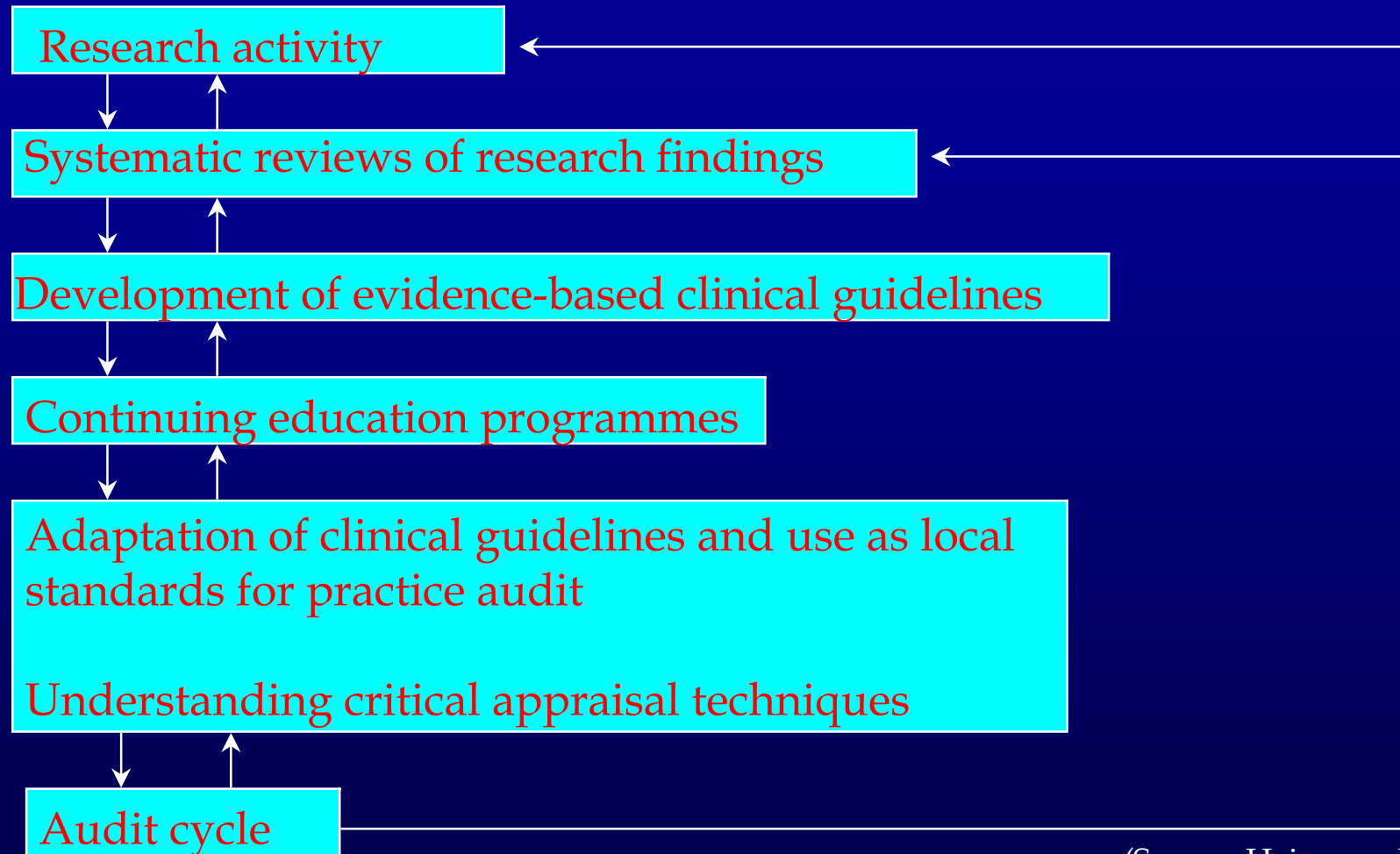
- Background and context
- Development of the framework
- Evaluation and refinement of the framework
- Application and utility of the framework in practice



# *Background and Context*

- Focus on quality, effectiveness and evidence based health care
  - Recognition of variations in practice and the research-practice gap
  - Limited progress in tackling issues of implementation
  - Pre-dominance of linear approaches to implementation
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# *Interactions between research, continuing education and audit*



(Source: Haines and Jones, 1994)



# *The Theory and the Reality of Implementation*

*“Transforming research into practice is a demanding task requiring intellectual rigour and discipline as well as creativity, clinical judgement and skill, organisational savvy and endurance”*

(Horsley et al, 1983)

*“Knowledge without the culture, interest and support to promote, act upon and implement change remains a sterile asset”*

(Peters, 1992)



# *Development of the Framework*

- Inductive origins – experiences in research, quality improvement, audit, practice development
  - Implementing cardiac rehabilitation guidelines
  - Implementing evidence based care in a rehabilitation/respite ward for older people
  - Developing and auditing a set of standard criteria on post-operative pain management
  - Adapting and implementing national standards on nutritional care of older adults





# *The Framework*

**Successful implementation** is a function of the relation between:

- the nature of the **evidence**
- the **context** or environment in which the proposed change is to be implemented and,
- the way or method by which the change is **facilitated**

$$SI = f(E,C,F)$$



# *Evidence, Context and Facilitation*

Evidence	Context	Facilitation
<ul style="list-style-type: none"><li>● Research</li><li>● Clinical experience</li><li>● Patient preferences</li></ul>	<ul style="list-style-type: none"><li>● Culture</li><li>● Leadership</li><li>● Measurement</li></ul>	<ul style="list-style-type: none"><li>● Role</li><li>● Characteristics</li><li>● Style</li></ul>

# Evidence

## RESEARCH

**LOW**

**HIGH**

anecdotal evidence  
descriptive information

RCTs/rigorous research  
systematic reviews  
evidence based guidelines

## CLINICAL EXPERIENCE

**LOW**

**HIGH**

expert opinion  
divided,  
several 'camps'

high levels of  
consensus,  
consistency of view

## PATIENT PREFERENCES

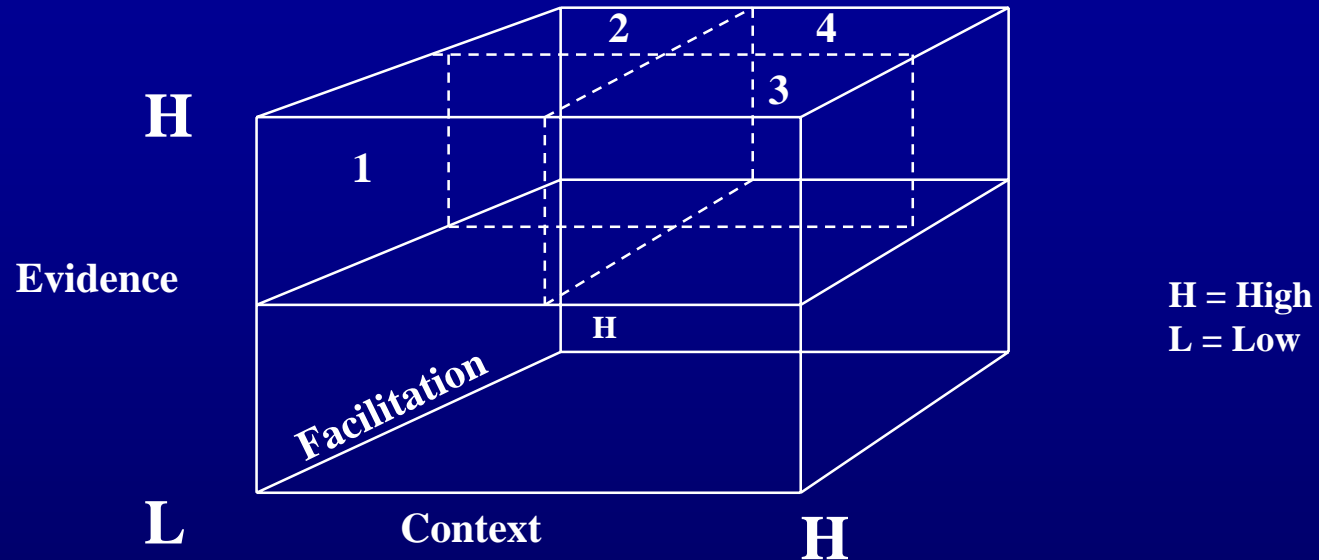
**LOW**

**HIGH**

patients  
not involved

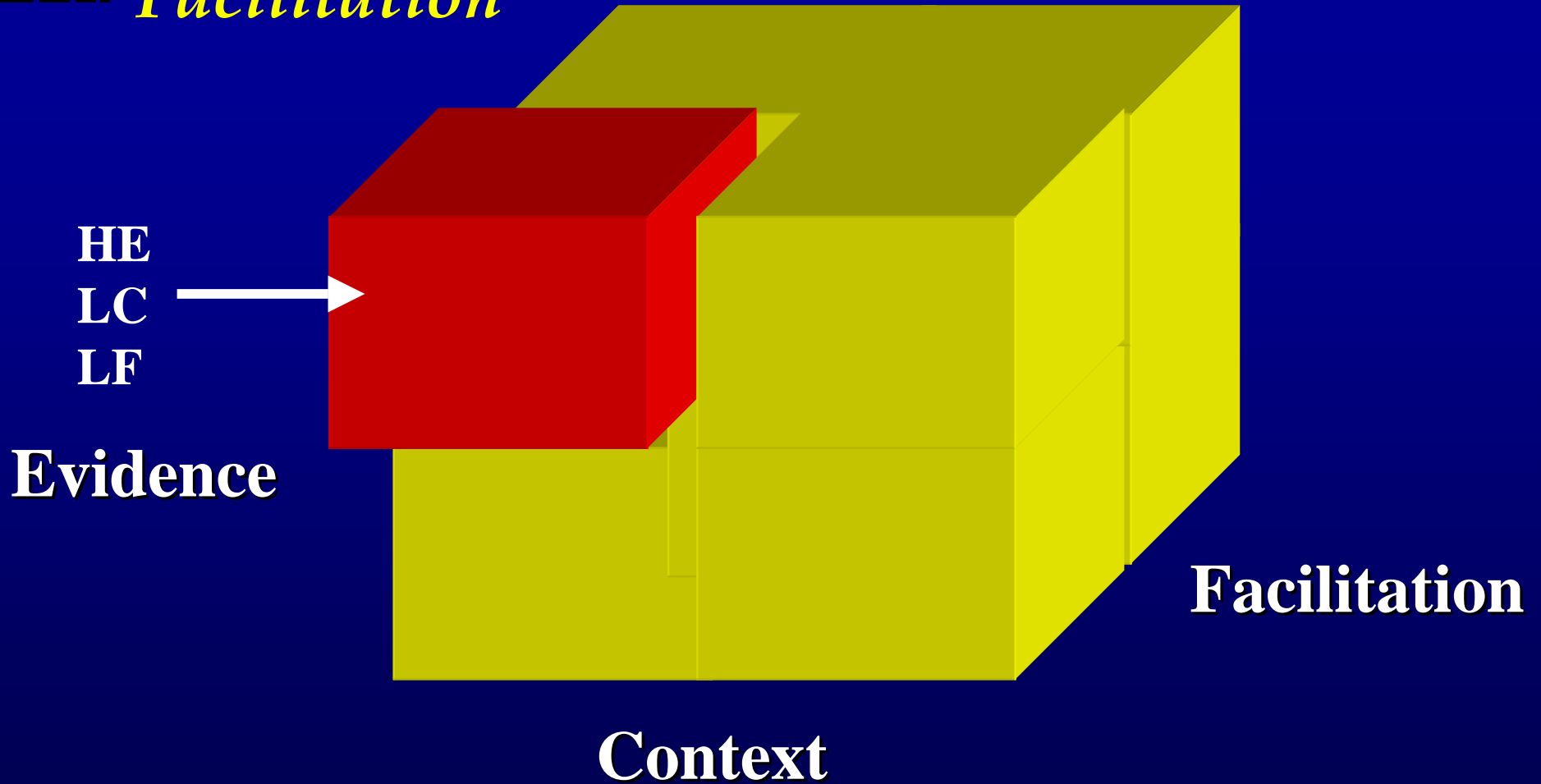
patient partnerships

# Relationship between Evidence, Context and Facilitation (where evidence is high)




- |   |   |            |
|---|---|------------|
| 1 | = | HE, LC, LF |
| 2 | = | HE, LC, HF |
| 3 | = | HE, HC, LF |
| 4 | = | HE, HC, HF |

*High Evidence, Low Context, Low Facilitation*






# *Emerging Hypotheses*

- Linear approach to implementing research into practice is over-simplistic and does not represent the reality of practice
  - Most successful implementation of research will occur when evidence is strong (HE), the context is developed (HC), and where there is appropriate facilitation (HF)
  - Least successful implementation occurs when context and facilitation are inadequate
  - Poor contexts (LC) can be overcome by appropriate facilitation (HF)
  - Chances of successful implementation are still weak, even in an adequate context (HC), but with inappropriate facilitation (LF)
- 



# *Checking out the Framework*

- Conference presentations
  - Group exercises
  - 1998 publication in *Quality in Health Care*
  - Establishing a level of face validity
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# *Evaluation and Refinement of the Framework*

- Concept analysis of key dimensions of framework
- Focus group interviews
- Case studies





# *Concept Analysis*

- Concept analyses of three main dimensions of the framework (evidence, context, facilitation) following methods proposed by Morse (1995) and Morse et al (1996)
  - Aim to analyse the level of maturity of each of the concepts by critically reviewing seminal texts and other relevant literature
  - Concepts partially developed, but in need of delineation and comparison
  - Refinement of the elements and sub-elements within the framework
- 



# Evidence - Information and knowledge upon which decisions about care are based

## Research

LOW

HIGH



Poorly conceived, designed and/or executed research

Well conceived, designed & executed research, appropriate for the research question

## Clinical Experience

LOW

HIGH



- Anecdote, with no critical reflection and judgement.
- Lack of consensus within Similar groups

- Clinical experience & expertise reflected upon, tested by individuals and groups
- Consensus within groups

## Patient Experience

LOW

HIGH



- Not valued as evidence
- Patients not involved

- Valued as evidence
- Multiple biographies used
- Partnerships with health care individuals



# Context - *The environment or setting in which the proposed change is to be implemented*

## Culture

LOW

HIGH

- Task driven organisation
- Low regard for individuals
- Unclear values & beliefs

- Learning organisation
- Values individual staff and clients
- Prevailing and defined values & beliefs

## Leadership

LOW

HIGH

- Command & control leadership
- Lack of teamwork
- Lack of role clarity
- Autocratic decision-making processes
- Didactic approaches to learning/teaching & managing

- Transformational leadership
- Effective teamwork
- Role clarity
- Democratic decision making processes
- Enabling/empowering approach to learning/teaching & managing

## Evaluation

LOW

HIGH

- Absence of any form of feedback
- Narrow use of performance information sources
- Evaluations rely on single rather than multiple methods

- Feedback on individual/team & system performance
- Use of multiple sources of information for feedback
- Use of multiple methods for evaluation



# **Facilitation** - *The process of enabling or making things easier*

**LOW**

**HIGH**

No mechanisms or inappropriate methods of facilitation in place

Appropriate mechanisms for facilitation in place



**Purpose, Role, Skills**





# Facilitation

## Purpose



## Role

**Doing for others**

**Enabling others**

- Episodic contact
- Practical/technical help
- Didactic, traditional approach to teaching
- External agents
- Low intensity - extensive coverage


- Sustained partnership
- Developmental
- Adult learning approach to teaching
- Internal/external agents
- High intensity - limited coverage

## Skills & Attributes

**Task/doing for others**


**Holistic/enabling**

- Project management skills
- Technical skills
- Marketing skills
- Subject/technical/clinical credibility

- Co-counselling
  - Critical reflection
  - Giving meaning
  - Flexibility of role
  - Realness/authenticity
- 



# *Focus Group Interviews and Case Studies*

- Qualitative data collection from focus group interviews with nurses in practice development roles and case studies of two organisations attempting to implement 'evidence-based' change
  - Some key findings
    - Variable role of research in driving changes in practice
    - Importance of match between proposed changes and policy drivers
    - Role of local information in constructing evidence for change
    - Importance of local resources
    - Reinforcement of context and facilitation dimensions of framework
- 




# *Application and Utility of the Framework in Practice*

- As a guide or diagnostic tool/map
- As an evaluative tool





# *Common Themes Across Settings*

- The nature of evidence
    - *Quality and quantity*
    - *Social and historical construction*
    - *Melding a broader evidence base*
  - The context of implementation
    - *Prevailing culture*
    - *Readiness for change*
    - *Knowing where to start*
  - The role of a change agent or 'messenger'
    - *Designated role?*
    - *Appropriate skills, knowledge and experience*
    - *Flexibility and adaptability*
- 



# References

Rycroft-Malone J, Seers K, Titchen A, Harvey G, Kitson A, McCormack B (2004) What counts as evidence in evidence-based practice? *Journal of Advanced Nursing*, 47(1): 81-90.

Harvey G, Loftus-Hills A, Rycroft-Malone J, Titchen A, Kitson A, McCormack B, Seers K (2002) Getting evidence into practice: the role and function of facilitation. *Journal of Advanced Nursing*, 37(6): 577-588.

McCormack B, Kitson A, Harvey G, Rycroft-Malone J, Titchen A, Seers K (2002) Getting evidence into practice: the meaning of context. *Journal of Advanced Nursing*, 38(1): 94-104.

Rycroft-Malone J, Kitson A, Harvey G, McCormack B, Seers K, Titchen A, Estabrookes C (2002) Ingredients for change: revisiting a conceptual framework. *Quality and Safety in Healthcare*, 11(2): 174-180.

Rycroft-Malone J, Harvey G, Kitson A, McCormack B, Seers K, Titchen A (2002) Getting evidence into practice: ingredients for change. *Nursing Standard*, 16(37): 38-43.

Kitson A, Harvey G, McCormack B (1998) Enabling the implementation of evidence based practice: a conceptual framework. *Quality in Health Care*, 7,3: 149-158.

