Insights into Implementation: What, Why, and How Care Protocols are implemented in Ontario Nursing Homes

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Study Motivation

- Our study responds to calls for knowledge translation research (Niessen et al., 2000; Richardson et al., 2001) that affords insights into factors and processes relating to the uptake and implementation of new knowledge (Greenhalgh et al., 2004), specifically that embodied by care standards, guidelines and care practices (Sekimoto et al., 2006; Estabrooks et al., 2004; Grimshaw et al., 2004a; Grimshaw et al., 2004b; Dijkstra et al., 2006; Kastner et al., 2011), ***and*** to calls for work that informs the development of strategies to improve the uptake of care practice standards and guidelines.

Study Aims

- The ***primary aim*** of our study was to better understand how care protocols are implemented in LTC homes operating in Ontario, and what processes, structural mechanisms, and knowledge sources are relevant to their implementation
- We focused on the implementation of care protocols relating to six clinical issues in Ontario LTC homes, and addressed the following questions to Directors of LTC homes:
  - What motivates decisions to use/select care protocols?
  - How are protocol selection decisions made?
  - What information sources are regarded as important to protocol implementation?
  - How is staff prepared to implement protocols? and,
  - What structural-process factors contribute to successful protocol implementation?
- A ***secondary interest*** was to study the influence of context on approaches to implementation, and to examine relationships between implementation approaches and a modest set of organizational characteristics shown to influence knowledge uptake in health care (Emmons et al., 2011; Dijkstra et al., 2006; Grimshaw et al., 2004) and in other settings

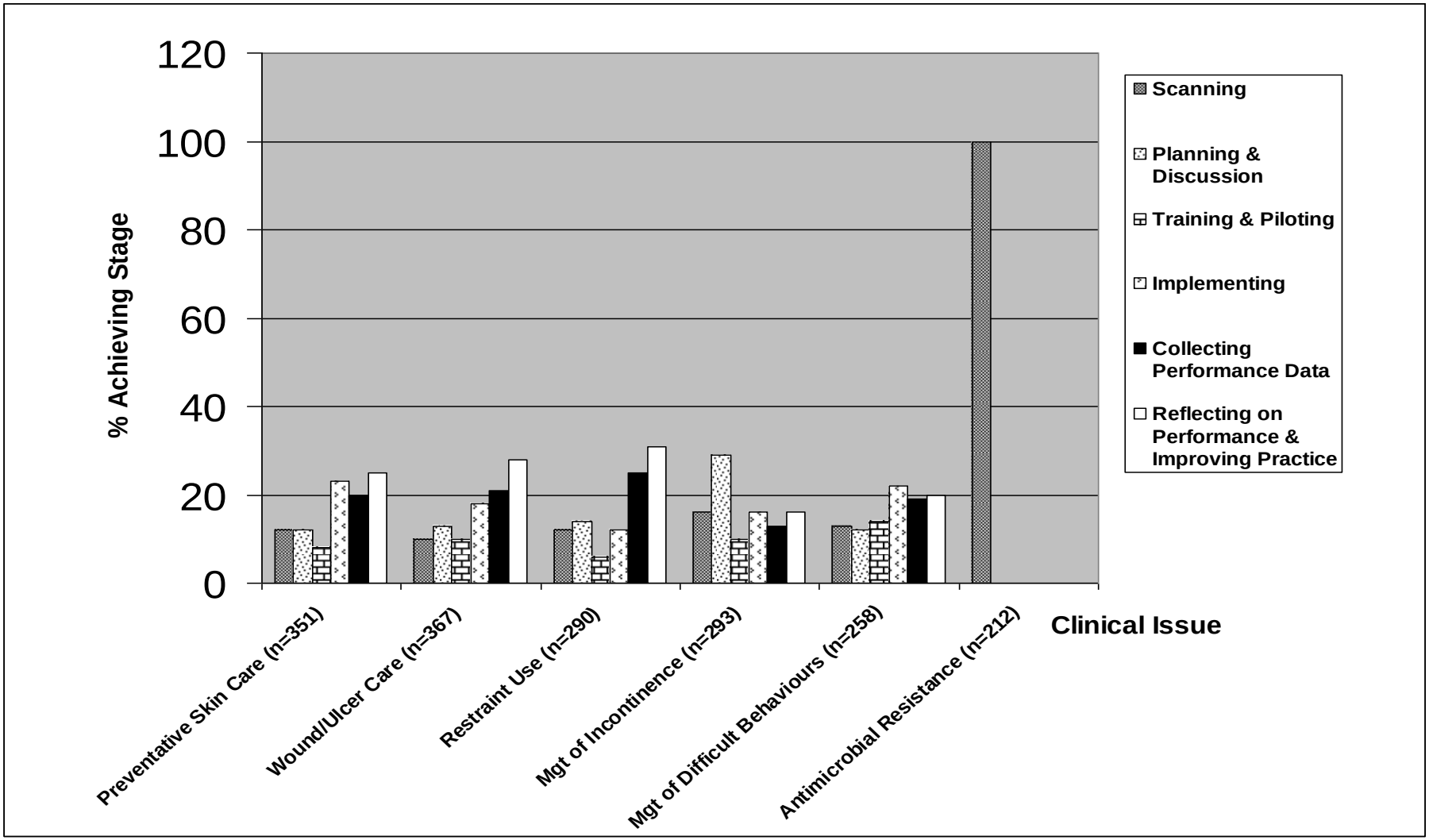
Methods

- Developed & administered a survey to 547 Directors of Care of Ontario LTC homes
  - Informed by prior qualitative phase of larger study, and expert advisory committee
  - Piloted survey at 2 LTC sites
  - Final version contained 9 questions
- Dillman approach for survey administration
- Focused on 6 clinical issues:
  - preventative skin care, wound/ulcer care, restraint use, management of incontinence, management of difficult behaviours, and antimicrobial resistance
- Supplemented survey data with secondary data from Statistics Canada to examine the influence of organizational factors of aspects of protocol implementation including:
  - rural/urban location, home size, chain membership, type of ownership, and accreditation status

Findings – Respondents

- 72% response rate (n=392)
- Facility level characteristics of returned surveys reflected the composition of the LTC industry at the time; in our sample:
  - 76% of facilities were located in urban areas
  - 43% were chain-owned homes
  - non-profit homes comprised 19% of respondents
  - 64% were for-profit homes
  - 17% were government-operated homes
  - large (>150 beds) facilities comprised 33% of respondents, medium-sized facilities (>50 and <150 beds) were 61% of respondent total, small (<50 beds) were 6% of respondents
  - 66% of responding facilities were accredited while 34% were not accredited

Findings – Reported Protocol Usage & Stage of Implementation



Findings – Motivations for Care Protocol Use/Selection

A. Selection of care protocols is influenced or motivated by this item:	Mean Score	Standard Deviation	N (%Valid)
1=*Never Influential*; 2=*Sometimes Influential*; 3=*Influential*; 4=*Often Influential*; 5=*Always Influential*			
We believe in continuous improvement of resident care	4.78	0.603	389 (99.2)
We believe in evidence-based care	4.48	0.806	388 (99.0)
We want to standardize care practices across our facility	4.40	0.818	389 (99.2)
Our objectives around care practices can be met by standardized care protocols	4.29	1.037	382 (97.4)
Reputation for high quality achieved in part with use of the most up-to-date care protocols	4.21	0.958	387 (98.7)
We want to be viewed as an innovative facility in a competitive market	4.19	1.072	386 (98.5)
Clinical issues in need of improvement…can be achieved through the use of care protocols	4.05	1.075	384 (98.0)
Head office or chain headquarters instructs us to use care protocols	3.95	2.250	333 (85.0)
Staff members who attend conferences promote the use of care protocols back at our facility	3.86	1.084	387 (98.7)
Accreditation standards for Long Term Care	3.72	1.385	383 (97.7)
We reduce costs by using care protocols	3.69	1.179	385 (98.2)
Our compliance advisor suggests using care protocols to achieve compliance	3.67	1.411	376 (95.9)
Other local facility(ies) with a reputation for high quality care relies on care protocols, and we thought we would try them	2.89	1.916	367 (93.6)

Findings – How Care Protocol Selection Decisions are Made

B. Protocol selection decisions are made this way:	Mean Score	Standard Deviation	N (%Valid)
1=*Never*; 2=*Sometimes*; 3=*About Half of the Time*; 4=*Most of the Time*; 5=*Always*			
Once a protocol is selected by management, our staff participate in planning the protocol's implementation	3.48	1.275	386 (98.5)
Our management use staff input on the alternative protocols to select one	3.39	1.343	384 (98.0)
Our management ask staff to identify care protocols to address a clinical issue	3.23	1.394	383 (97.7)
A "champion" (a designated leader) is selected for a clinical area and he/she recommends a particular care protocol	3.03	1.703	377 (96.1)
Our management selects CPGs or protocols and notifies staff of their decisions	2.98	1.639	380 (96.9)
We are instructed to implement care protocols by head office or chain headquarters	2.97	2.086	363 (92.6)
We have a "quality improvement" committee that is responsible for selection of care protocols	2.95	1.746	379 (96.6)

Findings – Information Sources for Care Protocol Implementation

A. This information source for care protocol implementation is:	Mean Score	Standard Deviation	N (%Valid)
1=*Not Important*; 2=*Somewhat Important;3=Important; 4=Very Important;* 5=*Essential*			
Expert consultants (e.g., Enterostomal Therapy Specialists, Psychogeriatric Resource Consultants, Public Health Nurses)	4.13	0.791	392 (100)
The external organization that developed the care protocol (e.g., the RNAO)	4.10	0.828	391 (99.7)
Internal staff with expertise in the clinical issue addressed by the protocol	3.93	0.895	389 (99.2)
Our compliance advisor	3.44	1.143	390 (99.5)
Internet and literature searches	3.43	1.018	391 (99.7)
Suppliers (e.g., wound care & incontinence product manufacturers)	3.35	1.001	392 (100)
Contacts from other LTC facilities using the same care protocol	3.32	1.013	391 (99.7)

Findings – Staff Training & Education Relating to Care Protocol Implementation

B. Staff training and education relating to care protocol implementation is:	Mean Score	Standard Deviation	N (%Valid)
1=Not Done this Way; 2=Sometimes Done this Way; 3=Done this Way Half of the Time; 4=Mostly Done this Way; 5=Always Done this Way			
Host in-services for the new care protocol	4.52	1.249	373 (95.2)
Use training materials e.g., pocket cards, flow sheets, videos, policies and procedures, manuals	3.84	1.522	373 (95.2)
Use external experts for in-services (e.g., Enterostomal Therapy Specialists, Psychogeriatric Resource Consultants, Public Health Nurses, etc.)	3.70	1.472	374 (95.6)
Appoint a mentor or resource person for staff to consult regarding the protocol(s)	3.68	1.637	374 (95.5)
Use reminder and feedback techniques to inform staff about their performance	3.58	1.623	373 (95.2)
Send staff to conferences	3.22	1.554	374 (95.5)

Findings – Factors Important to the Success of Care Protocol Implementation

- Adequate resourcing against implementation
- Contextualization of impending practice change
- Ensure staff are afforded opportunities to input
- Underscore the benefits of practice change to staff and residents
- Consider staff literacy and experience levels
- Demonstrable and unambiguous connections between practice change(s) and outcomes
- Foment collaboration and sharing of experiences among staff, across units
- Make available implementation aids, including training and education

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Future Research

- Ownership-related differences that we observed related to motivational differences for protocol use, approaches to protocol selection, and to differences in approaches to staff preparation for care protocol implementation.
  - In our view, these differences merit further exploration from the standpoint of what the implications of these differences are, in the long term, for protocol-related sustainability and performance
  - For example, do those protocols selected and implemented through more inclusive/participative processes afford superior performance and longevity? And so are larger organizations behooved to try to replicate the processes developed by their smaller counterparts?
- Beyond ownership-related differences, questions of sustainability are highly relevant to the area of guideline implementation, and to knowledge application generally. Recent work by Stirman et al. (2012), and the work of Greenhalgh et al. (2004) reinforces the importance of studying the long-term sustainability of innovations.