

Changing Practice: Finding and Closing the Gaps

Maggie Gibson, Ph.D.
Psychologist
Veterans Care Program
Parkwood Hospital
St. Joseph's Health Care
London, ON, Canada
maggie.gibson@sjhc.london.on.ca

Learning Objectives:

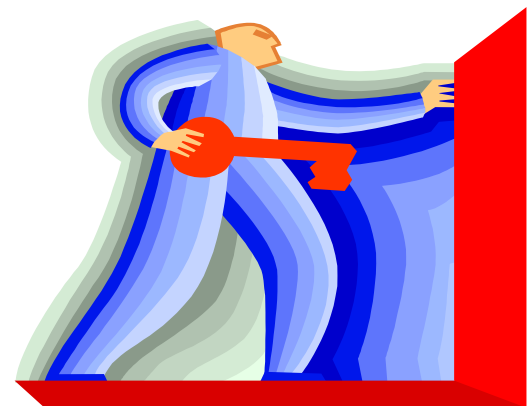
1. Participants will learn about a motivation-based change strategy that can be used to meet the Accreditation standard.
2. Participants will gain an understanding of how strategy implementation is adapted to different long term care environments.

Motivation-Based Change Strategy:

The Transtheoretical Model of Change, commonly known as the “**readiness for change**” model, offers an integrative framework for understanding and intervening in intentional human behaviour change.

Guiding Principle:

“Readiness” for change is a major determinant of success in understanding, implementing and maintaining new attitudes and behaviours.



The model addresses:

Stages of change

Processes of change

Levels of change

Stages of Readiness for Change

- **Pre-contemplation:** not yet convinced there is really a need for change
- **Contemplation:** ambivalent – change may be warranted, but there is comfort in the status quo
- **Preparation:** favouring change, but unsure what to do differently
- **Action:** committed to making changes
- **Maintenance:** living the changes

Processes:

Precontemplation: Literature review and discussion.

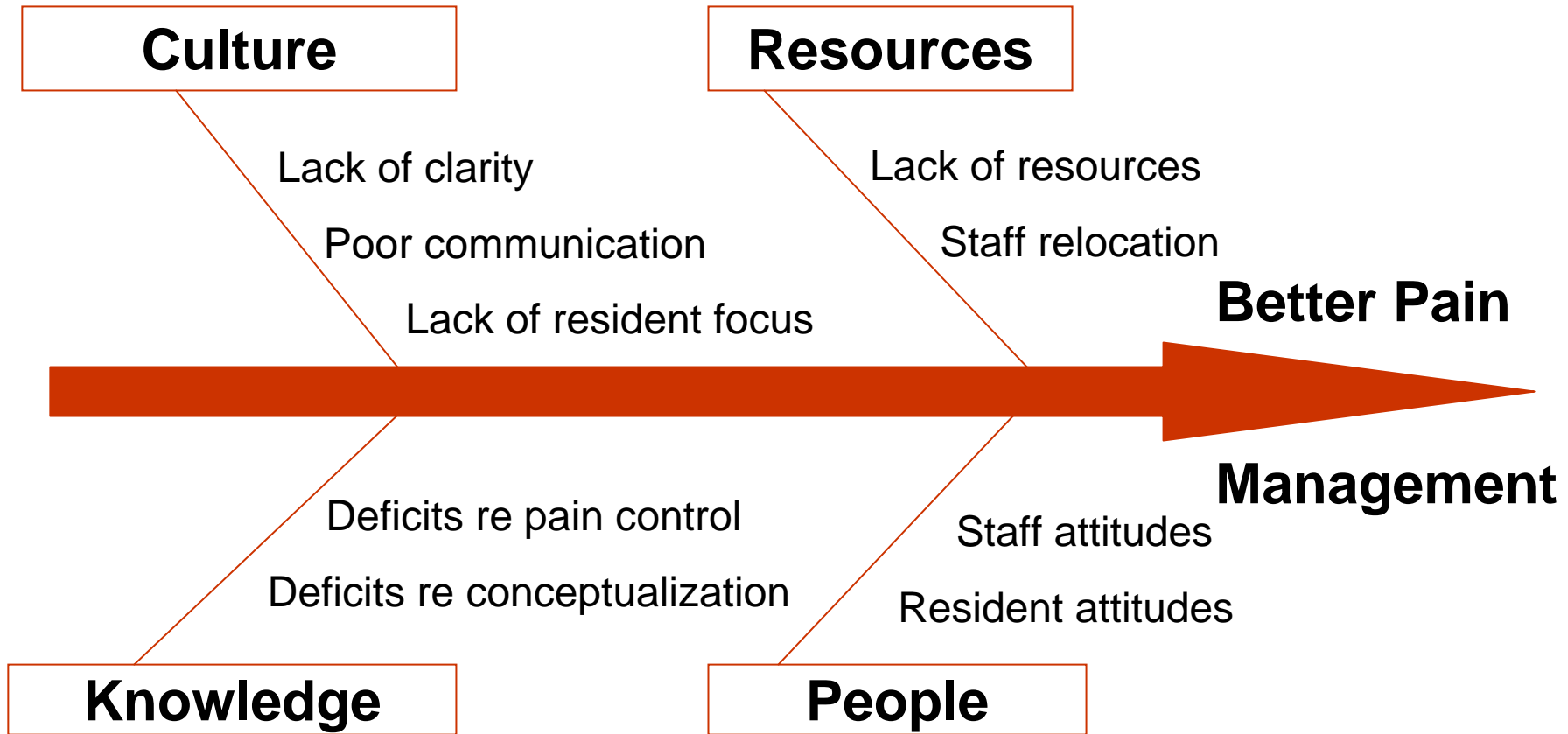
Contemplation: Corporate mission, vision & values, strategic plans; chart audits, stakeholders perceptions and clinical indicators.

Preparation: Case reviews, process flowcharting.

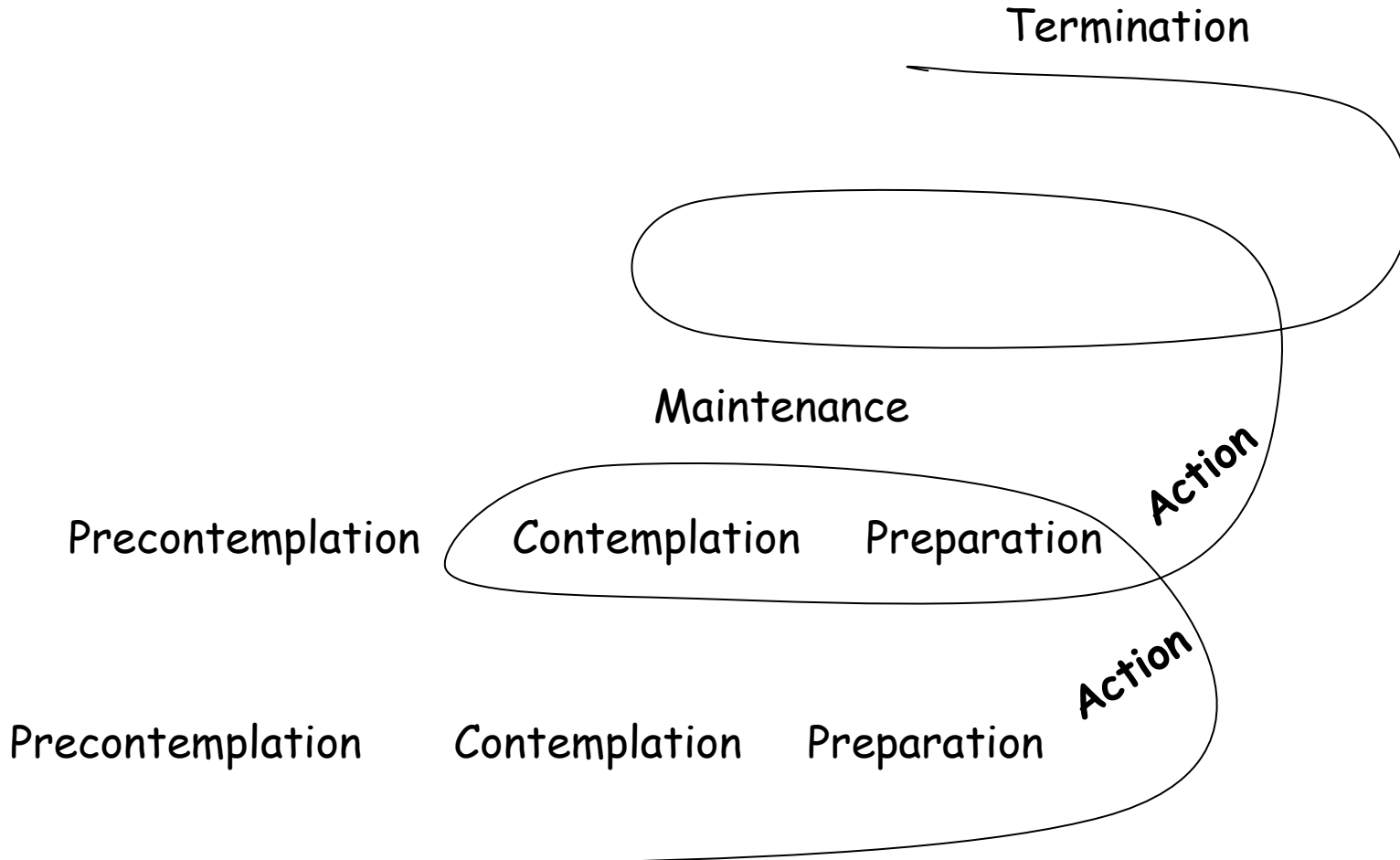
Action: Knowledge transfer strategies; see for example, The Canadian Research Transfer Network (www.crtn.ca).

Maintenance: Corporate Performance Development System, chart audits, clinical indicators, orientation, stakeholders perceptions.

Levels:



The Nature of Change



Context:

The three residential health care settings, within one large health care corporation, involved in this project were:

1. **Complex Care (74 beds)**
2. **Long Term Care (397 beds)**
3. **Veterans Care (310 beds)**

The programs that participated in the project are located within St. Joseph's Health Care, London, Ontario, and are similar in organization, philosophy and goals. Resources, including composition of the interdisciplinary team, and resident characteristics vary.

Resources:

- 2 year (2003 – 2005)
- Grant-funded
- Half-time project coordinator (RN)
- Psychologist team leader
- Epidemiologist project consultant

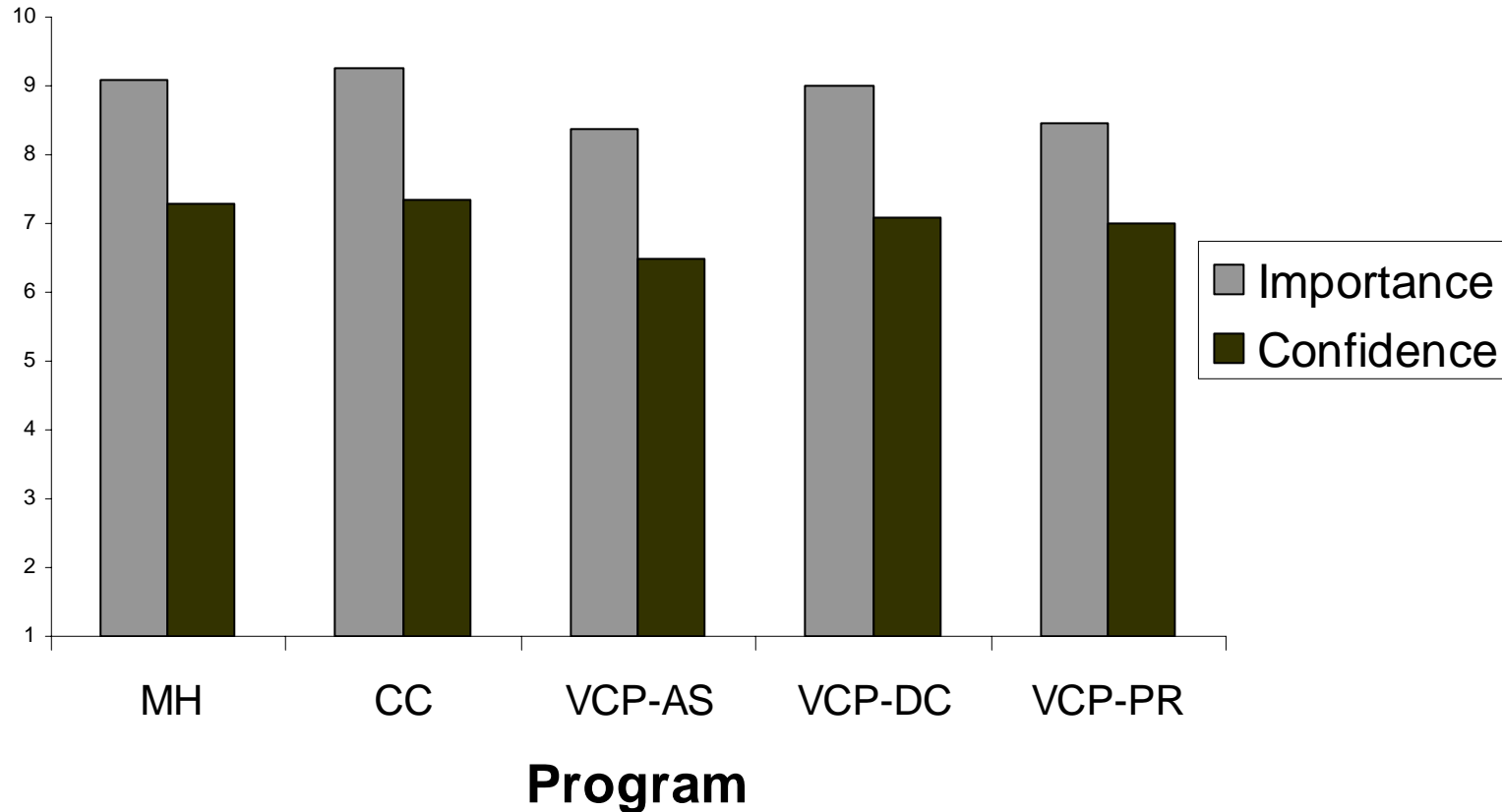
Prerequisites for project implementation included:

- ✓ Development of a blueprint
- ✓ Establishment of an advisory group
- ✓ Validation of the blueprint
- ✓ Focused description of the service settings
- ✓ Determination of the initial stage of readiness

Readiness Profiles

	Low Importance	High Importance
Low Confidence	<p>These people neither see change as important nor believe that they could succeed in making such a change if they tried.</p>	<p>These people are confident that they could make the change if they thought it were important to do so, but are not persuaded that they want to change.</p>
High Confidence	<p>Here the problem is not in willingness to change, for these people express the desire to do so. The problem is low confidence that they could succeed if they tried.</p>	<p>These people see it is important to change and also believe they could succeed.</p>

Our “motivation for change” results (n=78)



Scales were completed at the end of individual discussions with treatment team members.

We elected to begin the intervention at the Precontemplation stage with all programs. This decision was based on the following observations:

- Chart audit, stakeholder perspectives and clinical measures substantiated the need for change.
- At different times in the past, teams were actively involved in behaviour change around pain management, but changes had not been consolidated.
- There were no concrete practice development activities and/or definite plans for future practice development activities in this area at present.

FACILITATION PROCESS:



Observations that indicated teams had moved into the Contemplation stage:

- Invitations to participate in focus groups to discuss the project were accepted by staff
- Increased talk about how change could improve job satisfaction and patient outcomes
- Talk about need for a “culture shift”
- Talk about scope of practice and accountability
- Talk about how this change initiative should focus on sustainability as well as implementation of change
- Verbal commitment to further participation in the process

Observations that indicated the teams had moved into the Preparation stage:

- Formal discussions at staff, council and patient care meetings as well as informal discussions on nursing units were supportive of making changes to align practice more closely with accountabilities.
- Discussions identified processes and performance issues requiring improvement to enable practice change (e.g., communication, documentation, follow-through)
- Initial targets for change were selected based on analysis of chart audit data.

Observations that indicated teams had moved to the Action stage:

- Agreement that pain should be added to the pre-admission screen for all programs.
- Pain assessment tool in use on one program adopted by all.
- Optional case review in-services well attended by staff, well supported by administration.
- Increased discussion and documentation of interventions.
- Specific accountabilities negotiated and formalized.

Observations that indicated teams had moved to the Maintenance stage:

- Formalized Pain Management Process confirmed for all programs – program specific accountabilities agreed upon and specified in process.
 - Documentation tools to support process in place
 - Administrative support for process, including verbal & written reminder/memos for staff and input at staff meetings
 - Increased discussion on how to ensure process is maintained within the program following completion of the Demonstration project (discussion around chart audits, follow-up actions, orientation program, program standard of care, etc).
 - Hospital Accreditation included documentation & discussion in all three programs about the pain management process in place and strategies for maintenance of progress.

	Formula (e.g., numerator and denominator)	Definitions of components in the formula	Data Source(s)	Frequency of Reporting the measure
Chart Audit: Practice Change	# criteria achieved/ comparison standard (23 items)	Chart audit tool derived from AGS (2002) best practice guideline	Patient charts (sample size per unit based on estimated base rate for problems in pain literature)	Pre - Post
Chart Data: MDS Pain Items	# residents per unit with pain/number of patients on unit; # patients with "mild" pain/number of patients with pain pre unit	Per MDS (mandated for chronic care beds in Ontario)	Unit-specific MDS data (computerized entry)	Pre - Post
Self-report: stage assessment	# staff endorsing expected stage/# staff sampled on each occasion (ad hoc and focus groups)	Stage definitions as per readiness model	Staff self-report	When behavioural observations indicated stage shift (four repeat assessments)
Personnel Costs	overall estimated salary costs per unit/number of units	Hourly wage estimates per publicly accessible data	Staff time for involvement in the project (direct and indirect) for each category of staff	Continuous recording of staff contacts by Project Coordinator

Chart Audit: Practice Change

A chart audit was conducted to compare documented pain assessment and management activities to criteria derived from established best practice recommendations (AGS Panel on Persistent Pain in Older Persons, 2002).

Intervention Phase	Timeframe	% Compliance
Contemplation/ Preparation	July 2004	< 50% (across units)
Action/ Maintenance	Oct-Nov 2005	> 75% (across units)

PRE-INTERVENTION

POST-INTERVENTION

Consistent with Best Practice Recommendations

- Pain screening on admission *sometimes*
- Self/proxy report solicited *sometimes*
- Scheduled care review
- Use of pharmaceutical interventions

- Pain screening on admission
- Comprehensive assessment documented *sometimes*
- Self/proxy report solicited where possible
- Multidisciplinary involvement in assessment within resources
- Quantitative pain measurement documented *sometimes*
- Patient/Family pain education provided *sometimes*
- Scheduled care review
- Use of non-pharmacological interventions
- Use of pharmacological interventions
- Documentation of intervention effectiveness *sometimes*

Areas Needing Improvement

- Comprehensive pain assessment if indicated
- Multidisciplinary involvement in assessment
- Quantitative pain measurement
- Use of non-pharmacological interventions
- Patient/Family pain education
- Evaluation and documentation of Intervention effectiveness

- Comprehensive assessment to be documented *consistently*
- Quantitative pain measurement to be used *consistently*
- Patient/Family pain education to be provided *consistently*
- Evaluation of intervention effectiveness to be documented *consistently*

Chart Data: MDS Pain Items

	Pre- Intervention	Action/ Maintenance Stages
Sample MDS files	122 files	200 files
Timeframe	Jan – Mar 2003	Jan – Dec 2005
Frequency (pain present)	50-79%	47-89%
Intensity (“mild” if present)	43-58%	41-62%

How would you describe yourself with respect to this change initiative?

1	2	3	4	5
I am not convinced there is really a need to change my care delivery practices in this area.	I am intending to make changes in my care delivery practices in this area within the next six months.	I am intending to make changes in my care delivery practices in this area within the next month.	I have made changes in my care delivery practices in this area within the past six months	I brought my care delivery practices in this area into line with best practice recommendations more than six months ago.

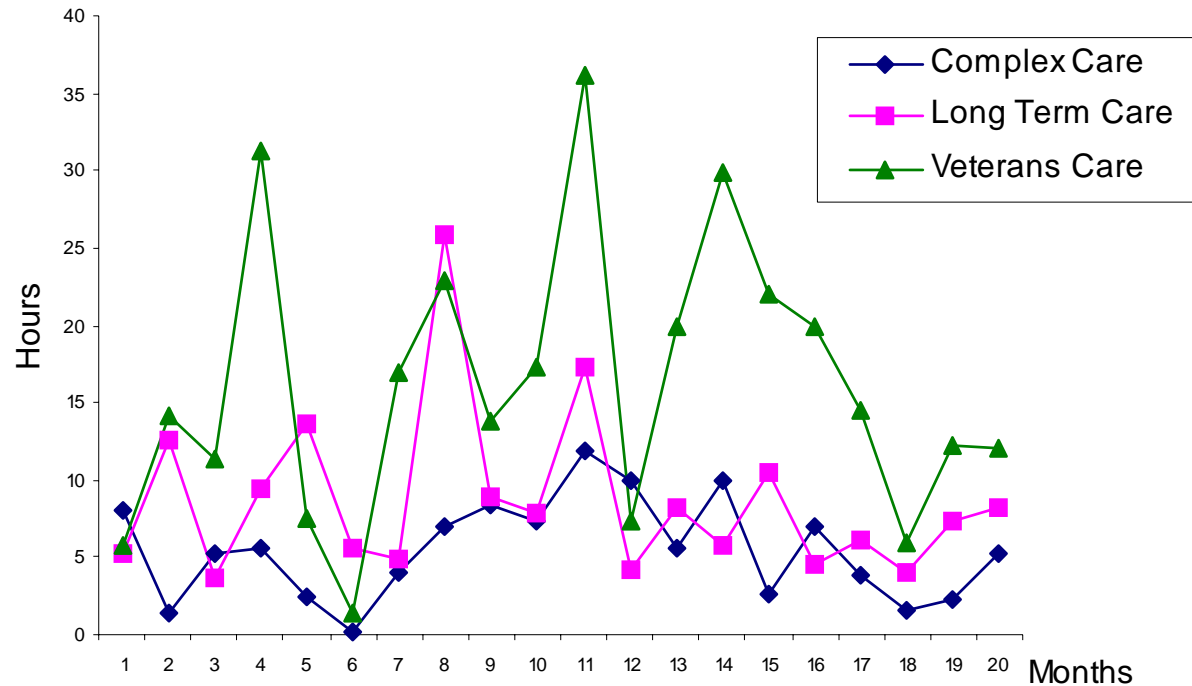
Self-Report: Stage Assessment

Staff opinions were solicited in ad hoc contacts and focus groups at the point where behavioural observations suggested a change in stage of readiness had occurred within the treatment team, in the opinion of the facilitator.

Stage	Frequency	% Agreement
Pre-Contemplation	N/A	N/A
Contemplation	23/29	79 %
Preparation	93/102	91%
Action	60/63	95%
Maintenance	53/55	96%

Staff Time

With nine units (veterans care = 5; long term care = 2; complex care = 2) in three programs in the project, the Project Coordinator spend, on average, **two hours per week per unit.**



Personnel Costs

Staff time was converted using salary ranges, to estimate the in-kind costs (exclusive of the costs associated with supporting the members of the project team itself).

Average direct contact personnel cost per unit for the duration of the project was \$1830.32, or \$107.70 per month; average indirect contact personnel cost per unit for the project was \$23.75 per month.

Overall (all units) estimate for in-kind personnel costs: \$19,598.15

Adapting strategy implementation to different long term care environments

SETTINGS:



**Veterans Care Program
(310 beds)**

Complex Care (74 beds)



**Mount Hope Centre for
Long Term Care (397 beds)**



Don't underestimate the impact of logistical factors in implementation.

Logistical factors include:

- the geographic distance between components of a program,
- whether staff work rotating or permanent shifts,
- whether treatment teams are discrete or integrated, and
- the mandate of support staff.

The time, effort and rework required to move forward in each program were influenced by the physical as well as the organizational structure of the programs.

Involve all staff whose behaviour is expected to change in the change initiative.

- Staffing resources differed across programs in terms of disciplines, positions and accountabilities.
- Project implementation needed to be adapted to the learning and practice needs of the different staff complements in each program.

Processes of change should be tailored to different stages of readiness, but should also target multiple levels (e.g., individual, group, environment).

Consider different models for supporting the practice change initiative.

- Both internal and external approaches to project facilitation were effective.
- The in-kind resources available within each program were the determining factor for which approach was applied in that program.

What appeared to be crucial was that there were good working relationships and clear accountabilities within the project team so that all aspects of the project (mentorship, oversight, implementation, evaluation) were accomplished.

PROJECT OUTCOME:

A toolkit that can be utilized to support practice change initiatives in similar institutional care contexts. Contact

maggie.gibson@sjhc.london.on.ca

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Advisory Committee Members: Brent Peltola, (formerly) Clinical Information Consultant, SJHC; Kim Horrill, Nurse Practitioner, (formerly) Acute Pain Service, SJHC; Karen Perkin, Professional Practice Leader, Nursing, SJHC; Paul Stolee, (formerly) Research Director, Geriatric Program, SJHC; Warren Nielson, Clinical Director, Rheumatology Day Program, SJHC

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