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Appendices

References
5.1 Introduction

As an oncology nurse, you are in a good position to take a prominent role in implementing these guidelines. This final section is written as a practical guide for those interested in implementing guidelines within their own organisations.

Section 1 ("What is a guideline?") covers the need for guidelines and how they can positively impact on healthcare and patient outcomes. This section follows on from Section 1 by expanding on the tools and processes that are required for you to ensure that the guidelines in Sections 2 to 4 are successfully implemented.

Specifically, this section provides information to help overcome some of the challenge of implementing guidelines in practice, including some of the theories and background information that has been collated in recent years, to help with your plans and strategies.

In addition, two practical examples have been included at the end of this section to help you understand some of the more complex parts of guideline implementation.
5.2 How can guidelines be implemented in practice?

Now that you are familiar with the three sets of guidelines and the evidence supporting them, you are in a good position to help decide how they can be disseminated within your clinical environment (e.g. decide who receives the information and how).

Before taking these guidelines into your own practice, it is important to consider all the factors that have played a role in successful implementation efforts in the past. Successful implementation of clinical guidelines requires a significant amount of planning beforehand – in fact, the bulk of the work in the implementation process could take place before any procedural changes are implemented in the clinic. Ideally, the process of local guideline implementation should fall into three broad phases:

1. Preparation
2. Implementation
3. Evaluation

Each phase consists of a series of steps, which should be undertaken for the successful implementation of clinical guidelines (Figure 1). This detailed outline and the information that follows should provide you with a basis from which to start the guideline implementation process in your own practice.
5.3 Steps for successful implementation of clinical guidelines

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Figure 1. Steps for successful implementation of clinical guidelines.
Step 1: Set up a team

Recruit an implementation team

Choose a team leader

Determine individual roles

Recruit an implementation team

It is important to build local consensus within the environment where the guidelines are to be implemented. To do this, you should try to assemble a team to help you to plan and implement the guidelines in your practice. Some important things to consider when forming a team include:

- **Size:** Though there are no upper or lower limits on the size of the group, it should be large enough to deal with the task of implementing the guidelines. Experience would suggest that too large a group could become unwieldy.

- **Composition:** The team should be multi-professional in composition from all patient-care areas to plan for change comprising nurses from all areas (e.g. pharmacist, staff nurse, ward manager, university professor, nurse researcher, clinical educator, nurse practitioner).

In selecting the committee members, try to select local opinion leaders (ward-based nurses) with expertise and the respect of their peers to take the lead for the change in practice.

You can also use feedback from physicians and other members of the healthcare team to modify the documentation and to include information that would be helpful for the multi-disciplinary team.

Choose a team leader

As a team, you should come to a consensus on who will act as the team leader. The leader will be responsible for calling and chairing any meetings, facilitating discussions, coordinating the rest of the team, and generally keeping the momentum of the project going.

Determine individual roles

Next, identify roles for all the members of the team. These roles pertain to the times you meet together as a team, as well as roles to perform individually to help the project progress. Some possible roles to consider include:

- Note taker – responsible for capturing information from your meetings
- Awareness liaison – responsible for creating awareness
- IT specialist – responsible for computer-related issues
- Protocol coordinators – responsible for development of one of the protocols
- Administrative support

Return to summary of steps
Step 2: Evaluate current practices

Evaluate the care environment

Map the current care for the disease/condition

Identify internal barriers

Identify external barriers

Identify enabling factors

The Promoting Action on Research Implementation in Health Services (PARIHS) framework

How to use the diagnostic analysis

Evaluate the care environment

Before implementing guidelines to change practice, it is important to consider your starting point. To do this the team should evaluate the local environment, considering people, systems, structures, and internal and external influences. The team should try to identify all groups involved in, affected by or influencing the proposed change(s) in practice, and assessment their preparedness to change.

Map the current care for the disease/condition

As part of the survey, the team should look at the care itself, including how care is currently delivered in your practice; the timeframe in which care is delivered; and, how and when decisions are made under normal circumstances. An analysis of case notes may also offer a good insight into how care is delivered under the current arrangements. It may also be helpful to use one-to-one interviews with key stakeholders, and group sessions with patients and staff, to get a wide perspective on service provision.

Identify internal barriers

Based on knowledge of the guidelines to be implemented, try to identify elements within the guidelines themselves that could hinder their implementation in practice (e.g. if the guidelines call for a test you don’t have access to).

In order to implement the guidelines and evaluate them within the context of your hospital, the team may wish to review and independently appraise the guidelines. The team can then decide whether to use one guideline exclusively or adopt recommendations from one or more guidelines/protocols, based on levels of evidence, clarity etc.
Whilst evaluating internal barriers, it is also important to realise that the guidelines were originally written for physicians, and, as such, there may be important differences that may influence the transferability of an effective intervention in medicine to the practice of nursing. For instance, the level of autonomy in clinical decision making of hospital nurses is highly related to, and driven by, organisational policies and procedures. Therefore, strategies that are successful with physicians may not be effective with nurses.

Identify external barriers

Based on the earlier assessment of the practice, identify elements in the clinical environment (external to the guidelines) that could hinder their implementation. For example:

- Structural factors (e.g. financial disincentives)
- Organisational factors (e.g. inappropriate skill mix, lack of facilities or equipment)
- Peer group
- Individual skills (e.g. knowledge, attitudes, skills)
- Professional-patient interaction (e.g. problems with information processing)

Identify enabling factors

Based on the earlier assessment of the practice, identify elements in the clinical environment that could help in the implementation process (e.g. resources, skills).

The Promoting Action on Research Implementation in Health Services (PARIHS) framework

Several papers and reviews have been written on the implementation of guidelines in clinical practice. The PARIHS framework in particular provides some background and evidence to support the evaluation of clinical guidelines and the environment in which they are to be implemented.

The PARIHS framework addresses the interplay and interdependence of factors that play a role in successful implementation, including:

- **Evidence** – the most successful implementation seems to occur when evidence is scientifically robust and matches professional consensus and patients’ preferences
- **Context** – the most successful implementation occurs when the context is receptive to change with sympathetic cultures, strong leadership and appropriate monitoring and feedback systems
- **Facilitation** – the most successful implementation occurs when there is appropriate facilitation of change with input from skilled external and internal facilitators

Information from the framework may help you to complete Step 2 of the implementation process. For more information on each of the factors identified in the framework (evidence, context and facilitation), please refer to Appendix 1, 2 and 3, respectively.
How to use the diagnostic analysis

Once completed the results of the ‘diagnostic analysis’ can be used to inform the design and content of the dissemination/implementation strategy.

Experience has shown that it is more likely to be effective if it focuses directly on the professional and the patient (e.g. restructuring patient records, patient specific reminders and patient-mediated interventions). Strategies that are nearer the end user and integrated into the process of health care delivery are more likely to work.

Return to summary of steps
Step 3: Set objectives

**Set objectives for improvements in care**

**Set deadlines**

It is important to have clear, specific objectives for the implementation process. After these are selected, they should also identify targets that are achievable, but sufficiently challenging to lead to real service improvements.1

Next, the team should set targets based on the more general objectives. Targets should be achievable, but sufficiently challenging to lead to real service improvements. The targets should also be measurable, so that it is easier to evaluate success later on.1

An example of an objective could be to reduce overall hospitalization. A target could be set based on this objective (e.g., 50% reduction).1

**Set deadlines**

Before starting the work, set deadlines for different stages of the project. These deadlines should be realistic goals, which the team as whole strives to meet.

Although there is no set time that the implementation process should take, experience with successfully implemented guidelines suggests that it is reasonable to expect the process to take approximately three to six months.1

Return to summary of steps
Step 4: Prepare the way for implementation

**Create awareness**

**Deal with identified barriers**

**Create awareness**

It is important to ensure that the guidelines are met with a positive and receptive attitude when you introduce them to your local practice. The team should develop a strategy to market the guidelines to the stakeholders – informing and presenting the new guidelines to appropriate wards and multidisciplinary leaders.

To do this you may consider presenting to the hospital board and senior management; presenting the project at nursing, medical, surgery and research rounds; holding information sessions in the cafeteria; publishing announcements in a hospital newsletter; sending e-mail announcements.

**Deal with identified barriers**

At this stage, it is important to start dealing with any barriers the team has identified. For example, it may be important to educate the staff, or attempt to change an existing attitude. In addition, it may be possible to acquire new equipment or go about accessing services in a different way.
Step 5: Plan the implementation process

Develop implementation tools

Develop a detailed implementation plan

These tools are key to the uptake of the guidelines. Following the initial burst of educational activities, these tools will provide the primary source of information on the local implementation of guidelines.

Typically, documents that translate international or national guidelines to a local level are referred to as protocols. Protocols are detailed descriptions of the steps taken to deliver care or treatment to a patient. They are designed at the local level to implement national/international standards taking into account local considerations. In general, protocols should:

- Be short, concise and follow a logical sequence
- Be easy to use and make information easy to find
- Contain information about all aspects of the care and treatment

Successful protocols are simple documents that guide staff through the process. They are not comprehensive documents that describe how each procedure is delivered to the patient. An example protocol has been included to help you in the development of one for your own clinical setting.

Develop a detailed implementation plan

The plan for the implementation of the guidelines should identify areas for improvement and agree on priorities and specific practice guidelines for implementation. In general, the plan should highlight responsibilities for the completion of each part of the plan. It should also adhere to the existing objectives and targets.

The plan should also address details of the planned communications and activities that the team want to plan over the course of the implementation process. The team should try to use activities that actively engage participants. The list of activities could include workshops, presentations and tutorials. It may also help to identify a range of activities already taking place in the organisation as a basis for implementation activities.

The communication plan is key and might include posters, newsletters or e-mail reminders.

Please see Step 7 for more information on communications and activities and their effectiveness.

Return to summary of steps
Step 6: Get feedback on the tools

It is important to make sure that staff who will be using the protocol fully understand it and have received any training they need to use it. Once the team has developed the tools for implementation of the guidelines, they should be field tested with various people in the clinical setting. This could include a pilot of the protocol with important members of the intended audience, including a selection of nurses from the clinical setting.¹

Return to summary of steps
Step 7: Implement the plan

Introduce the plan into clinical practice

Now you are at the implementation stage, it is time to ensure the intended audience – including support and training for the staff who will use it – is ready and willing to implement the guidelines as well. Successful strategies may include:

- **Interactive educational sessions** – present an education day to train ward-based staff nurses. Present an educational half-day for all nursing staff and interested allied-health staff. Provide patient and family education.

- **Presentations or short seminars** – present to key groups of staff, patients’ forum members and board members to raise awareness of the benefits of the guidelines.

- **Educational outreach visits** – encourage the care providers on each ward to provide one-to-one ongoing consultation, feedback and encouragement to nursing staff. Conduct one-to-one visits between members of the nurse representatives committee and the staff nurses.

- **Patient-mediated interventions** – provide pamphlets about the new guidelines to patients and family members.

Studies have noted that multifaceted interventions (a combination that includes two or more initiatives) are consistently effective in implementing new practices and changing existing behaviours among healthcare professionals.

 Maintain momentum and commitment

Having already created awareness of the guidelines and the implementation activities, it is important to maintain the interest and momentum that was generated:

- **Reminder messages** – develop a document depicting the guidelines and include it in the admission chart as a reminder to admitting staff nurses to complete. It may be useful to place a bulletin board on each ward to remind staff of the new programme, or send reminder e-mails.

Considerations for successful implementation of clinical guidelines

Studies have shown that simple tools can help drive real change in the workplace. Evidence-based medicine has increasingly broad-based support in health care, but it still remains difficult to persuade healthcare providers to actually practice it. The impact of decision support has been studied across a broad range of domains using information systems. Ten common elements important for success have been highlighted by physicians involved in research within the area.
1. Speed – the parameter that users value above all else
2. Anticipation and delivery in real time – applications must anticipate the needs of the healthcare professional and bring information at the time it is required
3. Fit within a workflow – integrate suggestions with the user’s own practice
4. Appreciation that little things can make a big difference – usability matters and it must be easy for healthcare professionals to follow guidelines
5. Recognition of resistance – physicians strongly resist suggestions not to carry out an action when there is no alternative offered, even if the action they are about to carry out is virtually always counterproductive
6. Understanding that changing direction is easier that stopping – the computer is an enormously powerful tool for getting physicians to ‘change direction’
7. Simplicity – if you cannot fit a guideline on a single screen, healthcare professionals will not be happy about using it
8. Understanding when to ask for additional information (e.g. only when you really need it) – data that are not already in the information system and can only be obtained from the clinician are frequently required to implement guidelines (e.g. weight of a patient)
9. Monitoring feedback and response – if reminders are to be developed there should be a reasonable chance that they will be followed, although this will depend on the type of reminder
10. Management and maintenance of knowledge-based systems – maintaining the knowledge within a system is critical to successful delivery of decision support

Return to summary of steps
Step 8: Evaluate the progress

It is important to monitor change in response to the guidelines. Among other things, monitoring can help to:

- Measure and quantify benefits to patients and staff
- Ensure that objectives continue to be met and remain appropriate
- Ensure that all new staff receive training
- Keep up-to-date with new information and changes in clinical practice

Return to summary of steps
5.4 Detailed examples

Assessing postoperative pain management in practice

Developing local protocols from guidelines – G-CSF use in neutropenia

5.4.1 Assessing postoperative pain management in practice

Through a review of literature aimed at exploring the empirical evidence available for an ethnographic study into pain management practices with older people admitted for colorectal cancer, authors explored the factors that had a significant influence on getting evidence into practice using the Promoting Action on Research Implementation in Health Services (PARIHS) framework and then put them into the context of postoperative pain practices.7

- Evidence – pain assessment practices, knowledge/insight and strategies to cope with episodes of uncontrolled pain, and organisation of care, along with ward culture, were identified as having an inhibitory effect on pain management in older people.

- Context – three major themes within the ward culture led to inadequate pain management practices: pain assessment and practice, knowledge/insight and strategies to deal with episodes of uncontrolled pain and organisation of care to be developed.

- Culture – nurses wanted to be valued in terms of their expertise and autonomy in the decision-making process concerning their patients and they wanted to be respected and appreciated by physicians and management teams.

- Leadership – leaders required; emotional intelligence, rationality, motivational skills, empathy and inspirational qualities, the intellectual qualities of strategic sensing, analytical skills, self-confidence in public presentation, the ability to guide practice and actively promote the implementation of strategies to develop questioning reflective practitioners to improve care.

- Evaluation – effective pain management is a quality issue and relies on both the efforts of the clinical nurses as well as of staff nurses; so, it should become part of staff performance appraisals. Central to evaluation is the development of a culture that embraces peer review, user-led feedback and reflection on practice.

- Facilitation – there was no available evidence relating to facilitation and pain management in the literature.
Using the three key constructs, as explained previously (evidence, context and facilitation), the need for the following was identified:

- For healthcare professionals to draw upon clinical opinion, patient experience and research evidence to develop person-centred pain practices
- To obtain clarity relating to the many diverse and conflicting cultures that operate within the organisational context – exploring further the way in which these cultures impact upon pain management and clinicians’ decision-making practices
- To explore leadership issues – clarifying the role of the central nervous system (CNS) and if or how CNS influence impacts upon pain management practices
- To assist individuals and/or teams to focus on pain management issues and develop appropriate change strategies through facilitation
- To adopt a systematic and rigorous approach to action research, using conceptual frameworks (PARIHS) as a guide to improve pain management practices

5.4.2 Developing local protocols from guidelines – G-CSF use in neutropenia

As has been emphasised in this section, guidelines are only useful if they are properly implemented in the place of practice. Step 5 stresses the need for a detailed plan including materials to be used in the clinical environment. Below is an example of how guidelines (Figure 1), can be translated into more practical instructions for nurses and other care providers. Each guideline has been broken down into components, each of which is further broken down into details of things to be included in a possible protocol document.

Once the exercise of analysing the guidelines has been done in this way, listing all relevant instructions, it may be possible to consolidate several individual protocols into one larger protocol or into an easy to follow treatment algorithm specific to your own clinical environment.
Recommendation 1: Patient-related risk factors for increased incidence of FN

Patient-related risk factors should be evaluated in the overall assessment of febrile neutropenia (FN) risk prior to administering each cycle of chemotherapy. Particular consideration should be given to the elevated risk of FN for elderly patients (aged 65 and over). Other adverse risk factors that may influence FN risk included: advanced stage of disease; experience of previous episode(s) of FN; lack of granulocyte-colony-stimulating factor (G-CSF) use and lack of antibiotic prophylaxis. (Evidence grade B)

Recommendation 2: Chemotherapy regimens associated with increased risk of FN

Consideration should be given to the elevated risk of FN when using certain chemotherapy regimens, summarised in Table 4. (Evidence grade A/B) It should be noted that this list is not comprehensive and there may be other drugs or regimens associated with an increased risk of FN.

Recommendation 3: G-CSF to support chemotherapy

In situations where dose-dense or dose-intense chemotherapy strategies have survival benefits, prophylactic G-CSF should be used as a supportive treatment. If reductions in chemotherapy dose intensity or density are known to be associated with a poor prognosis, primary G-CSF prophylaxis should be used to maintain chemotherapy. Examples of this could be when the patient is receiving adjuvant or potentially curative treatment, or when the treatment intent is to prolong survival. Where this is not crucial, use of less myelosuppressive chemotherapy or dose/schedule modification should be considered. (Evidence grade A)

Recommendation 4: Impact of the overall FN risk on G-CSF use

When using a chemotherapy regimen associated with FN in 20% patients, prophylactic G-CSF is recommended. FN risk should be assessed individually for each patient and should take into account patient-related risk factors (recommendation 1), the chemotherapy regimen (recommendations 2 and 3) and treatment intent (recommendation 3). When using chemotherapy regimens associated with FN in 10-20% patients, particular attention should be given to the assessment of patient characteristics that may increase the overall risk of FN. (Evidence Grade A)

Recommendation 5: G-CSF in patients with existing FN

Treatment with G-CSF should be considered for patients with ongoing FN, who do not respond rapidly to antibiotics, where there is an increased risk of FN-related complications. In these cases, G-CSF use may reduce the risk of infection-related mortality or morbidity. (Evidence Grade B)

Recommendation 6: Choice of formulation

Pegfilgrastim, filgrastim and lenograstim have clinical efficacy and we recommend the use of any of these agents to prevent FN and FN-related complications, where indicated. While additional efficacy may be achieved with pegfilgrastim, this requires further clarification and there are few clinically important differences between the three agents. (Evidence grade A)
Recommendation 1: Patient-related risk factors for increased incidence of FN

Identify FN risk factors to be screened for

- Make a short checklist including the most important risk factors based on the evidence available (Figure 2)
- Refer to the full list of risk factors for FN (Section 3, Appendix 2)

Describe the immediate steps to take if a patient is at risk of neutropenia

- Document findings and inform the medical team
- Draw up a plan for prophylactic measures, including information on G-CSF use
- Include details in the patient chart

Explain the next steps

- Detail the procedure for seeking treatment or other care
- Describe approaches for patient education
- Direct the care provider to the management protocols (i.e. recommendations 2–6)

Figure 2. Febrile neutropenia risk screener.9

Prophylactic G-CSF (First cycle)
Protocol/Ordering
Advanced Medical Specialties
Miami, Florida
Revised 7/1/05

Patient name:___________________________Physician:___________________________Date:___________________________

According to 2005 NCCN guidelines, the above patient meets at least one of the following criteria for primary prophylactic G-CSF (circle all that apply):

- > 65 years of age
- Dose-dense chemotherapy regimen
- Bone marrow involvement by tumor
- Prior radiation to marrow sites containing > 20% BM (e.g., pelvis)
- Proximal neutropenia (ANC <1000)
- Receiving chemotherapy regimen with an expected incidence of FN > 20% (see attached chemotherapy regimens)
- Poor performance status (ECOG ≥ 2)
- Significant comorbid condition (AIDS, heart disease, renal disease, diabetes, liver disease, COPD)
- Serum LDH > 460 IU/L (NHL)
- Serum albumin ≤ 3.5 g/dL (NHL, MM)
- Active infection/open wound

Figure 2. Febrile neutropenia risk screener.9

Return to recommendation summary
Recommendation 2: Chemotherapy regimens associated with increased risk of FN

Steps to take

Determine the risk of FN based on the patient’s prescribed chemotherapy

Examples

- Determine patient’s risk of FN based (Figure 1)
- Refer to the full list of risk factors for FN (Section 3, Appendix 3)

Explain the next steps

- Outline care necessary based on selected chemotherapy regimen/dosing schedule (if necessary)
- Direct the care provider to the procedure for prophylactic G-CSF treatment (i.e. recommendation 3)
- Direct the care provider to further management protocols (i.e. recommendations 4–6)

Return to recommendation summary
### Recommendation 3: G-CSF to support chemotherapy

- Identify the FN risk of the patient’s chemotherapy regimen
  - Refer the care provider to recommendation 2

### Recommendation 4: Impact of the overall FN risk on G-CSF use

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<tr>
<th>Steps to take</th>
<th>Examples</th>
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</thead>
<tbody>
<tr>
<td>Describe the steps to take for a patient receiving therapy with &gt;20% FN risk</td>
<td>• Detail the procedure for prophylactic G-CSF treatment, including dosing schedule and choice of therapy (recommendation 6)</td>
</tr>
<tr>
<td>• Monitor temperature and absolute neutrophil count (ANC)</td>
<td>• Monitor chemotherapy</td>
</tr>
<tr>
<td>Describe the steps to take for a patient receiving therapy with 10–20% FN risk</td>
<td>• Include an assessment of patient risk factors (recommendation 1)</td>
</tr>
<tr>
<td>• Determine whether this increases the risk of FN</td>
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<tr>
<td>Describe the steps to take for a patient receiving therapy with &lt;10% risk</td>
<td>• Include an assessment of patient risk factors (recommendation 1)</td>
</tr>
<tr>
<td>• Determine whether this increases the risk of FN</td>
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**Recommendation 5: G-CSF in patients with existing FN**

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<th>Examples</th>
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<td>Identify patients with FN</td>
<td>• Establish a brief checklist for assessments/tests to be carried out to diagnose FN, including temperature, ANC</td>
</tr>
<tr>
<td>Describe the immediate steps to take if a patient has FN</td>
<td>• Alert the medical team, and seek assistance if necessary</td>
</tr>
<tr>
<td></td>
<td>• Include details in the patient chart</td>
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<td></td>
<td>• Include an assessment of FN complications</td>
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<td>• Include information on infection control, including antibiotic treatment, wound care, etc.</td>
</tr>
<tr>
<td>Explain the next steps</td>
<td>• Outline any steps for modifying/changing a chemotherapy regimen/dosing schedule (if necessary)</td>
</tr>
<tr>
<td></td>
<td>• Direct the care provider to the procedure for G-CSF treatment, including dosing schedule and choice of therapy</td>
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<tr>
<td>Detail the follow-up procedures</td>
<td>• Monitor temperature and ANC</td>
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<td>• Monitor ANC</td>
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*FN refers to febrile neutropenia.*
Recommendation 6: Choice of formulation

Steps to take

Establish the need for G-CSF treatment

- Refer the care provider to recommendations 1–5

Outline the benefits of each treatment

- Outline the reasons for opting for one treatment over the others, including: efficacy, cost/access, dosing/convenience, safety/tolerability

Explain the next steps

- Direct the care provider to the procedure for G-CSF treatment, including dosing schedule

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Appendix 1. The importance of evidence.

Effective nursing practice can only be achieved by using several sources of evidence. However, ‘evidence’ includes a variety of permutations:
- Evidence-based practice
- Evidence-based nursing
- Evidence-based guidelines
- Evidence-based decision-making
- Evidence-based policy-making
- Evidence-informed patient choice.

In order to decipher one set of ‘evidence-base’ from another it is important to appreciate what constitutes ‘good clinical evidence’. A broader definition of evidence should be embraced.

According to the Promoting Action on Research Implementation in Health Services (PARIHS) framework there are four different types of evidence base available for use in clinical practice:
- Research evidence
- Clinical experience
- Patients, clients and carers
- Local context and environment

Research evidence

Research evidence has assumed priority over other sources of evidence in the delivery of evidence-based health care. In addition, it is assumed that research provides watertight answers to questions. Whilst the role of research is undoubtedly critical, it should be viewed as an evolving process, which does not necessarily encompass all social processes. Therefore, rolling out research evidence to clinical practitioners is unlikely to improve practice on its own.

Guidelines look at the evidence available and grade them according to how robust and reproducible the data are (i.e. level I evidence would include data from high-power randomised, controlled clinical trials or meta-analysis of multiple, well-designed, controlled studies; whereas level V evidence would include data from case studies or clinical examples). Recommendations within the guidelines are therefore made according to the level of evidence known.

It is acknowledged that evidence-based practice encompasses more than research evidence, and nurses will need to enlarge their repertoire for finding, appraising and applying evidence in its broadest sense. However, more needs to be done to assess the value of evidence and its influence on clinical practice.
Clinical experience

This knowledge is expressed and embedded in practice, and often tacit and intuitive. For clinical common sense to be disseminated, critiqued and developed, it needs to be evaluated to the same extent as the evidence from trials – in order for an individual practitioner’s experience and knowledge to be considered credible as a source of evidence it needs to be explicated, analysed and critiqued.10

Practical know-how is an important source of knowledge that makes up the evidence base of professional practice; but it is not tidy or clear cut.

Personal experience: patients, clients and carers

The third source of evidence is the personal knowledge and experience of patients and clients. This actually gives you two sources of evidence: evidence from patients’ previous experiences of care and evidence derived from patients’ knowledge of themselves, their bodies and social lives.

There are several examples of collective involvement in evidence-based practice-related activities to ensure patient and carer representation in national guidelines development.

Local context and environment

In addition to evidence gained from research, clinical and patient experience, the context of care contains sources of evidence. Practitioners may incorporate:10

- Audit and performance data
- Patient stories and narratives
- Knowledge about the culture of the organisation and individuals within it
- Social and professional networks
- Information from 360º feedback (i.e. feedback from the fullest possible constituency of stakeholders)
- Local and national policy
Appendix 2. The importance of context.

There is inconsistency in the use of the term ‘context’ and this has an impact on claims of its importance. In the PARIHS framework, context refers to the environment or setting in which people receive healthcare services or the context of getting research evidence into practice. Simply put, the physical environment in which clinical practice takes place (i.e. the oncology ward). There are key characteristics of the environment that are conducive to bringing about change and these include:

- Clearly defined boundaries
- Clarity about decision-making processes
- Clarity about patterns of power and authority
- Resources
- Information and feedback systems

In addition, the need to understand organisational culture in the context of practice is essential to appreciate how best to change culture. Many diverse and conflicting cultures can operate within the organisational context and dominant organisational culture can have a significant impact on the ability of ward leaders to bring about changes in practice.

Evaluation (or monitoring and feedback) is an essential aspect of an environment wishing to implement evidence-based practice. Multiple methods and sources of feedback should be incorporated into an organisation’s evaluative frameworks.13

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Appendix 3. The importance of facilitation.

Facilitation is defined as, ‘a technique by which one person makes things easier for others.’ Within the PARIHS framework, facilitation is achieved by carrying out a specific role to help others. Facilitators are individuals with the appropriate roles, skills and knowledge to help individuals, teams and organisations to apply evidence in practice (e.g. staff nurse on the oncology ward).

There are distinguishing factors that make a facilitator distinct from other roles:

- An appointed role rather than an opinion leader, who acts through their own personal reputation and influence
- The role may be internal or external or both
- The role is about helping and enabling rather than telling or persuading
- The focus of facilitation can encompass a broad spectrum of purposes from helping to achieve a specific task to enable individuals and teams to review their attitudes, habits, skills, ways of thinking and working
- A wide range of facilitator roles is possible with corresponding skills and attributes needed to fulfil the role effectively

A key attribute of a facilitator is to be flexible and to be able to recognise the requirements of any given situation and to adapt accordingly.
References


