International Journal of Nursing Studies 51 (2014) 1014–1026

Contents lists available at ScienceDirect

International Journal of Nursing Studies

journal homepage: www.elsevier.com/ijns

Mechanisms which help explain implementation of evidence-based practice in residential aged care facilities: A grounded theory study

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ARTICLE INFO

Article history:
Received 6 August 2013
Received in revised form 19 October 2013
Accepted 22 November 2013

Keywords:
Aged care
Evidence-based practice
Grounded theory
Implementation science
Nursing homes
Qualitative research

ABSTRACT

Background: The context for the study was a nation-wide programme in Australia to implement evidence-based practice in residential aged care, in nine areas of practice, using a wide range of implementation strategies and involving 108 facilities. The study drew on the experiences of those involved in the programme to answer the question: what mechanisms influence the implementation of evidence-based practice in residential aged care and how do those mechanisms interact?

Methods: The methodology used grounded theory from a critical realist perspective, informed by a conceptual framework that differentiates between the context, process and content of change. People were purposively sampled and invited to participate in semi-structured interviews, resulting in 44 interviews involving 51 people during 2009 and 2010. Participants had direct experience of implementation in 87 facilities, across nine areas of practice, in diverse locations. Sampling continued until data saturation was reached. The quality of the research was assessed using four criteria for judging trustworthiness: credibility, transferability, dependability and confirmability.

Results: Data analysis resulted in the identification of four mechanisms that accounted for what took place and participants' experiences. The core category that provided the greatest understanding of the data was the mechanism *On Common Ground*, comprising several constructs that formed a 'common ground' for change to occur. The mechanism *Learning by Connecting* recognised the ability to connect new knowledge with existing practice and knowledge, and make connections between actions and outcomes. *Reconciling Competing Priorities* was an ongoing mechanism whereby new practices had to compete with an existing set of constantly shifting priorities. Strategies for reconciling priorities ranged from structured approaches such as care planning to more informal arrangements such as conversations during daily work. The mechanism *Exercising Agency* bridged the gap between agency and action. It was the human dimension of change, both individually and collectively, that made things happen.

Conclusions: The findings are consistent with the findings of others, but fit together in a novel way and add to current knowledge about how to improve practices in residential aged care. Each of the four mechanisms is necessary but none are sufficient for implementation to occur.

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http://dx.doi.org/10.1016/j.ijnurstu.2013.11.010

What is already known about the topic?

- How to implement 'evidence' in residential aged care is a relatively under-research area of knowledge translation.
- There is no prescription for implementing evidence-based practice. No strategies to change practices work all the time.
- Previous research has tended to focus on how to change the practices of individuals rather than answer the question of how context influences implementation strategies.

What this paper adds

- The findings include a core category (mechanism) and three other mechanisms. The four mechanisms, and the relationships between the mechanisms, provide a means of understanding and explaining how implementation took place (or did not).
- The findings represent a novel way of understanding implementation within residential aged care. Some elements of the findings are consistent with the results obtained by other researchers.
- Each of the four mechanisms is necessary for practice change to occur but none by itself is sufficient for change to occur.

1. Background

This study aims to make a contribution to knowledge about how to implement evidence in residential aged care facilities (nursing homes), an area that is relatively under-researched. Although the concept of evidence-based practice is well established in health care, what is not so well established is 'how to do it' – how to turn the concept into a reality by using the best available evidence to inform current practice. The evidence from the literature indicates that nothing works all the time. According to an oft-quoted phrase there are 'no magic bullets' that can be used in all circumstances (Oxman et al., 1995).

There are many reasons for this, including differing views about what constitutes evidence, the constantly evolving nature of evidence and the often-intractable nature of existing practice. What at first seems so obvious – to base what is done on what has been shown to work best – is surprisingly difficult to achieve. Previous research has tended to focus on how to change the practices of individuals rather than answer the question of how context influences implementation strategies.

Studies undertaken in Australia focusing on evidence-based practice in residential aged care have been limited, generally conducted over short time frames, in small numbers of facilities, in one area of practice. Factors identified in these studies that might influence the uptake of evidence include local leadership (Austin Health, 2006; Fallon et al., 2006; Lyon, 2007), management support (Grieve, 2006; Moore and Haralambous, 2007), organisational structures and systems (Cheek et al., 2004), skills and knowledge of carers (McConigley et al., 2008) and resources (Lindeman et al., 2003; Lyon, 2007; McConigley et al., 2008). Drawing on a broader literature, a review conducted prior to the commencement of this study identified eight factors that may influence implementation, including context, the nature of the change in practice, the process of implementation and the systems and resources to support implementation (Masso and McCarthy, 2009). However, the factors overlap, little is known about the relationships between factors and much of the research was undertaken in health care rather than residential aged care.

Research on implementing evidence-based practice in residential aged care has been reported from other countries, including the USA (Capezuti et al., 2007; Jones et al., 2004; Resnick et al., 2004), Canada (Timmerman et al., 2007) and the UK (Hockley et al., 2010; O'Halloran et al., 2007). Large-scale research programmes are currently underway in Canada (Estabrooks et al., 2009) and Europe (Seers et al., 2012).

Residential aged care in Australia provides care to approximately 185,000 people in 2760 facilities, of which approximately 60% are not-for-profit and run by religious, community-based or charitable organisations (Australian Institute of Health and Welfare, 2012). The industry is primarily regulated and funded by the Australian Government, catering for older people who are unable to remain in their own homes by providing accommodation and related services such as laundry, meals and cleaning as well as personal care services, nursing care, medical care (by visiting general practitioners) and provision of equipment.

The context for the study was the Encouraging Best Practice in Residential Aged Care (EBPRAC) Programme, which aimed to achieve evidence-based improvements in government-subsidised facilities. The programme had two funding rounds, the first commencing in late 2007 and the second in late 2008, consisting of 13 two-year projects with an average funding of about $AUS 1 million per project. One project focused on each of the following areas of practice: pain management, nutrition and hydration, falls prevention, oral health, use of PRN medications, wound management and infection control. Three projects focused on palliative care and three on behaviour management. Each project consisted of a lead organisation working with a group of facilities, at a total of 108 locations across Australia. The most frequent strategies to implement evidence were payments to participating facilities, education and the use of local facilitators (variously described as champions, link nurses and resource nurses).

All projects adopted a multi-faceted approach to change, with some adopting a 'top down' approach by indicating what should be done, while others used more of a 'bottom up' approach, where staff decided what they would implement and how they implemented it. Residents had little influence on the design and implementation of each project. The best evidence that resident outcomes improved came from projects that focused on behaviour management and prevention (Masso et al., 2011).

The Centre for Health Service Development at the University of Wollongong was funded to conduct an evaluation of the EBPRAC programme (Masso et al., 2011). The impetus for undertaking the study reported here arose