

Benchmarking for factors that promote evidence-based practice.

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Introduction:

There exist both political and clinical imperatives for all healthcare professionals to be able to demonstrate that they are aware of the current research evidence that is relevant to their practice. It is not expected that all healthcare staff should be research-active, but it is deemed that they should be active users of research (Culyer, 1998). In the UK this requirement has been adopted as mandatory for all clinicians within the National Health Service (NHS); with additional expectations on the healthcare organisations and professional bodies to facilitate this shift towards embedding a research-aware culture (Department of Health, 1997 & 1998). The government's agenda of clinical governance emphasizes the responsibility of each individual healthcare professional to follow a model of evidence-based practice (EBP), in addition to placing the onus on clinical departments, NHS Trusts and all of the professional bodies. All clinicians and service managers are thus expected to use the best current research evidence to inform their clinical decisions and for planning services. One of the key stipulations is that "evidence-based practice is supported and applied routinely in everyday practice" (Department of Health, 1998, p36). Additionally, EBP is now a mandatory registration requirement for all member groups of the UK Health Professions Council (HPC). The Standards of Proficiency statement for Speech and Language Therapists (SLTs) includes the criteria that all therapists should be able to conduct evidence-based practice and that they should be able to "evaluate research and other evidence to inform their own practice" (HPC, 2003, 2b.1). In the international context, research utilisation, embedded within evidence-based practice, is also a key standard of professional competencies for Speech and Language Therapists in the US (ASHA, 2005), Canada (CASLPA, 2005) and Australia (SPA, 2001).

There is a recent growing acknowledgement that individual clinicians do not work in isolation and that their professional behaviour is mediated by the organizational context within which they work and make their clinical decisions (Kitson et al, 1998; Ferlie et al, 2000; Stetler, 2003). It has been noted that in nursing in particular there has been a call for a shift of emphasis from the individual to the organisational level (MacGuire, 2006). Rogers' (1995) model of the diffusion of innovations highlights the interactions between characteristics of the individuals, the organisation, the proposed change and the way in which the information relating to the change is communicated. In the context of promoting increased use of research evidence, relevant characteristics of individuals would include specific knowledge and skills for finding and appraising studies, in addition to a positive attitude towards EBP. Relevant characteristics of the organisation would include access to IT facilities, electronic databases and copies of full research papers, in addition to an actively supportive research-aware culture. Features related to the change itself would comprise aspects of the quality and presentation of the research; plus strategies for the dissemination of the research findings. It has been emphasised that there is an inherent

unpredictability in this interplay of factors, which could be sensitive to small changes in any one of the key elements (Plsek & Greenhalgh, 2001).

Organisational culture:

Organisational context refers to the structures, systems and processes that create the environment in which a research culture is developed (McCormack et al, 2002). The inherent challenge for healthcare organisations is to ensure that a positive culture is facilitated that will promote the use of research by clinicians. There is an emerging literature to guide the development of organisational culture in medicine and in nursing, but a dearth of research specific to the Allied Health Professions (AHP). A recent study of research use in seventeen UK Speech and Language Therapy departments (Pennington et al, 2005) has demonstrated the importance of departmental culture in supporting staff to participate in research implementation activities. This is a salient study for the profession, comprising the first report of a training intervention to promote the use of research evidence by SLTs. The findings of this study demonstrated that SLTs' engagement in the use of research evidence (in the form of evidence-based clinical guidelines) is specifically influenced by the department in which they work. A further interpretative study of those SLT departments (Roddam et al, submitted for publication) identified a number of relevant factors that were perceived by the therapists as influencing the research culture in their departments and clinical teams. These factors related to the processes of embedding the research aware culture, leadership roles and other change agent influences. The subsequent proposal for a benchmarking project was underpinned by recently developed conceptual models for considering the determinants of diffusion, dissemination and sustainability of innovations in health services delivery (Greenhalgh et al, 2004); in evidence-based practice (Stetler, 2003); and in change management (Rycroft-Malone et al, 2004). These models identify the range of organisational characteristics that impact on and support an individual's receptiveness and capacity to respond to new knowledge.

Aims of the benchmarking project:

Benchmarking has been used in the UK NHS to support the development of new practice. The process comprises consensus development of evidence-based standards of good practice, followed by cycles of comparative audit and feedback. Thus progress against these standards is evaluated formatively and strategies for development towards best practice may be shared. The aims of this project were to identify the aspects of organisational culture that enable AHP departments to deliver evidence-based practice, plus to highlight exemplars of good practice in local contexts.

Construction of the benchmark tool:

A comprehensive and systematic literature search of electronic databases was performed for tools relating to the measurement of organisational factors influencing research use, research activity and evidence-based practice in health care. The search was designed using a framework of concepts identified from organisational literature in medicine, nursing and wider sources outside healthcare. Further papers were identified from article reference lists. The tools were critically appraised to ensure that only constructs and items from validated tools were used to develop the benchmarks. An analysis of the tools relating to organisational factors supporting or inhibiting research use extracted components relevant to organisational influences and

operational at the level of the full organisation, directorate or team was completed. Only processes or structures that were amenable to change were included. A second literature search was conducted relating to research use and evidence-based practice specific to AHPs, to determine which organisational factors identified from the first search could be supported empirically. The literature included surveys and qualitative research of factors supporting or inhibiting research use, activity or evidence-based practice, plus process data from trials of interventions or implementation strategies for the uptake and use of research. A draft benchmark tool was constructed using the factors identified from the literature review.

Potential participant AHP departments were invited to express interest in participating. Fifteen positive responses were received and four organisations were selected to participate in the project based on a representative sample of professional groups, organisation types and geographical areas within the SHA. Managerial and clinical representatives from each organisation were invited to a conference event for the purpose of validating the items in the benchmark framework. Participants were provided with written information supported by verbal explanation. Individuals were asked to rate and justify the relevance and importance of each factor to achieving evidence-based practice in their own organisation and to highlight any factors that were thought to be important but not included in the framework. All the factors identified from the literature search were rated as 'very important' or 'important' by the majority of participants and none of the factors were rated 'not important' by any of the participants. Consensus was reached that each of the seventeen benchmark factors were discrete and distinctive, following some agreed minor changes to the descriptors. Hence, all the proposed factors were included in the tool used in the benchmark cycle based on this validation process.

Conduct of the benchmark process:

Following the consensus conference, link-workers from each participating department or team facilitated one questionnaire-based benchmark cycle in their own department. This process comprised scoring each of the seventeen benchmark factors by group consensus on a 5-point Likert scale, providing a textual justification and collating supporting local and current evidence for their score. It was intended that the evidence would inform the indicators and scoring continuum for the final benchmark tool. Four NHS organisations participated in the benchmark cycle, including both Acute Trusts and Primary Care Trusts. The participants in this benchmark cycle comprised sixty eight AHP clinicians and operational managers. These staff represented seven uni-professional departments plus two multi-professional teams. The professions represented were: Dietetics, Occupational Therapy, Orthoptists, Physiotherapy, Podiatry, Radiography and Speech and Language Therapy.

A second conference event was held to present the results of the analysis so that participating departments were able to identify their individual strengths and weaknesses, as well as comparing their results to the median scores across all the participating departments. Examples of good practice were also shared in this forum. A framework was then provided for departments to construct an Action Plan to improve their culture for evidence-based practice and this process was facilitated by the project team.

Outcomes of the study:

The project outcomes include a validated benchmark measure and toolkit. The median and range of scores across the participating departments was calculated for each of the seventeen factors. Additionally the departments provided descriptive indicators to justify their self-rating scores and collected relevant supporting evidence. It was noted that the range of scores across departments was low for all of the benchmark factors. The frequency and range of the textual descriptors to support each factor were also analysed. The supporting evidence submitted by each department was also examined. These analyses were utilised to inform the final refinement of the benchmark measure and toolkit. Account was also taken of the qualitative feedback received from the participating departments relating to the benchmarking process.

Discussion:

These findings are highly relevant and timely for a range of healthcare organisations, especially where services are undergoing restructuring, as in the UK NHS. Undertaking the benchmark process allows departments to identify their local strengths and weaknesses, plus to compare their own ratings with the median scores for other therapy services. The Action Plan format also provides a structured framework, which departments may use to consider how they may enhance their evidence-based practice culture. All of the participating departments indicated that they intended to repeat the benchmark process and the SHA committed to roll-out across all their Trusts.

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