HHS Public Access

Author manuscript

Am J Hosp Palliat Care. Author manuscript; available in PMC 2015 March 26.

Published in final edited form as:

Am J Hosp Palliat Care. 2010 September ; 27(6): 369–376. doi:10.1177/1049909109358695.

Implementing Evidence-Based Practices: Considerations for the Hospice Setting

Sara Sanders, PhD, MSW,
University of Iowa, School of Social Work, 425 North Hall, Iowa City, Iowa 52242

Melissa Lehan Mackin, MSN, RN,
University of Iowa, College of Nursing, 50 Newton Road, Iowa City, Iowa 52242

Jimmy Reyes, MSN, RN,
University of Iowa, College of Nursing, 50 Newton Road, Iowa City, Iowa 52242

Keela Herr, PhD, RN, FAAN, AGSF,
University of Iowa, College of Nursing, 50 Newton Road, Iowa City, Iowa 52242

Marita Titler, PhD, RN, FAAN,
University of Michigan, School of Nursing, 400 North Ingalls, Suite 1343, Ann Arbor, Michigan 48109

Perry Fine, MD, and
University of Utah, School of Medicine, Pain Research Center, Suite 200, 615 Arapeen Drive, Salt Lake City, UT 84109

Chris Forcucci, BSN, RN
University of Iowa, College of Nursing, 200 Newton Road, 2139 Westlawn, Iowa City, Iowa 52242

Abstract

With tighter regulations and greater scrutiny of outcomes, hospice programs are being challenged to consider the implementation of Evidence-Based Practices (EBPs). This study reports the findings from interviews conducted with hospice directors and focus groups with the staff at eight experimental site hospice programs that occurred following the completion of a multifaceted translating research into practice (TRIP) intervention designed to promote the adoption of evidence-based pain management interventions. The purpose of this paper is to provide a background in the use of EBPs, to report the facilitators and barriers to overall implementation of evidence-based pain practices in the hospice setting, and to provide recommendations for hospices interested in improving use of EBPs in this setting. It was determined that hospice programs need to evaluate three main factors prior to the start of an EBP initiative: Community culture, Agency culture, and Staff culture. Recommendations for implementation of EBPs in hospice organizations are provided.

Corresponding author: Sara Sanders, PhD, MSW, University of Iowa, School of Social Work, 425 North Hall, Iowa City, Iowa 52242, Phone: (319) 335-2079, Fax: (319) 335-2836, sara-sanders@uiowa.edu.

Keywords

evidence-based practices; hospice; pain; culture change; implementation process

Hospice agencies currently serve over 1.4 million dying individuals and families each year and provide community leadership about how to best meet the needs of the dying and their grieving family members[1]. With the implementation of the new Conditions of Participation (COP), hospices are required to provide greater support and justification for the way they assess patient and family needs and how treatments are delivered. One way of providing support and justification for the care received by patients and families is through the use of evidence-based practices (EBPs), defined as the use of innovative and methodologically robust research in combination with both clinical expertise and patient and family input to best inform the treatment decisions made by health care professionals and interdisciplinary teams[2,3].

EBP in Hospice Setting

The Hospice and Palliative Nurses Association (HPNA)[4] has issued a position statement that supports the use of evidence, such as practice guidelines and recommendations, reports based on evidence-based research, and clinical pathways to help inform the end-of-life care for dying individuals and their family members. While multiple areas within healthcare and social services have seen growth of EBPuse and recognition, as well as demonstrations of improvement in care practices [5,6,7,8], the use of EBPs in hospice care has not been widely embraced[9]. Cliff, Harte, Kirschling, and Owens (2004) argue that notwithstanding the adoption of evidence-based practice within various nursing domains for over 2 years, hospice and palliative care programs have been particularly slow to implement initiatives to integrate EBPs recommendations into their practice protocols. However, with the new COP, there now exists both a strong impetus for increasing the use of EBPs in hospices and a need to understand the factors impacting successful adoption of new research findings and evidence-based guideline recommendations in order to move hospice care delivery forward in a way that meets regulatory and quality care expectations.

Implementing EBP

Without a body of literature on the use of EBPs within hospice, hospice programs interested in implementing these initiatives must learn from the experiences of other healthcare organizations. Following is a discussion of learned strategies from these organizational settings. Along with changing practice protocols, implementing EBPs involves a systematic culture change within organizations as new practice behaviors are adopted. It has been posited that the implementation of EBPs creates the difference between what is considered to be good versus excellent care[6]. For the implementation of EBPs to be successful, new practices need to be integrated into every aspect of clinical work, as well as the organizational structure, to ensure sustainability. This requires “persistence, patience, and perseverance”[6]. Research in other health care settings on the implementation process of EBPs has identified several critical considerations for organizations as they begin this cultural change process.

Organizational commitment

Organizational commitment includes two essential components: support from leadership and openness to expert assistance. Organizational commitment is a function of frank and overt support from agency administration and Boards of Directors. It is important that these parties communicate a clear vision for the types of changes within the environment that are desired and why they are needed to improve practice[6]. While organizational leaders may not necessarily identify themselves as having a role in the creation of new knowledge through EBPs[10], they need to be able to recognize how the knowledge obtained from the implementation of EBPs can improve patient care. Leadership within organizations should be able to communicate their support of the EBP process, and motivate nurses and other healthcare providers to buy into the process, and then communicate its importance to other team members[11]. Organizational commitment also relates to the administration being open to the assistance of others, particularly those individuals who are outside of the organization, but have expertise in certain areas of the EBP and are willing to share this expertise during the implementation process[6]. These outside individuals play an important role in educating staff about the research pertaining to new practices. Other research[12] has found that some nurses, educated prior to research and EBP movements being incorporated into academic programs, do not have the ability to find and review research on EBPs given limited knowledge on interpreting findings and evaluating what constitutes sound research. This is a greater challenge if the agency does not have access to research-related resources, such as academic journals and research professionals. The support of expertise from outside the agency by an individual, group, or organization can also help in providing user friendly educational resources about the EBPs.

Staff support

Supporting staff is a critical component of successful EBP implementation. Staff support[6], such as providing them with time, resources, and verbal encouragement and assistance, facilitates and ultimately assures, that staff become and remain open to the introduction of new practices, as well as being willing to assume leadership roles in the implementation process. One of the greatest challenges for implementing EBPs is staff turnover. Each time a staff member leaves the organization, particularly during the implementation phase of EBPs, the implementation process is impacted. Attention shifts from the implementation process to the need to educate and train new staff on more primary care processes, as well as the EBP and how to adhere to the intervention protocols[13]. In addition, these new staff must receive an orientation to the agency and their new roles. While organizational theory suggests that staff turnover would likely be higher during the implementation process of EBPs, others have found that there was greater staff retention when implementing EBPs[13]. This counter intuitive finding is thought to result from new staff finding their organization’s commitment to implementing EBPs as stimulating, rather than threatening, and even as a point of professional pride that enhances, rather than erodes, morale. Anticipating and proactively addressing staff concerns that are associated with EBP implementation in advance, such as attendance at required trainings and educational programs, additional work responsibilities, and a perceived lack of flexibility to complete job-related responsibilities, may help increase staff retention.

Additional factors

Other factors can impact the success of EBP implementation. For some staff, there is concern that protocol changes will adversely impact their workload[13], which may already be higher than what staff believe can be appropriately managed. Time pressure and management have been found to be important factors to consider whenever EBP implementation is being undertaken[12]. Learning and implementing the new protocols take extra time for staff, but like any change in policy or procedure, this will dissipate once they learn the new practices. Other staff are more comfortable maintaining the status quo and keeping familiar practices and protocols intact. While elements of traditions in nursing care are important, they may adversely impact patient care if they obstruct updating to more effective treatment protocols[14]. Change can also create anxiety about one's performance and overall expectations, which may make implementing EBPs more difficult. Cost is another factor that could impact the implementation of EBPs. This may be observed particularly when the cost of working with a consultant or expert is required to help the organization through the implementation process[11]. Time, availability of education, flexibility in one's workload, negative perceptions about research and research activities and overall culture of change are all additional factors that need to be considered as organizations prepare to implement EBPs[7].

While much has been learned about implementing EBPs in a variety of settings, little is known about implementing EBPs in hospice. The purpose of this paper is to present findings from interviews with hospice directors and focus groups with staff from eight hospices participating in a translating research into practice, multifaceted intervention study (TRIP-CA) to facilitate use of EBPs for pain assessment and management in older adults with cancer in community-based hospice settings We focus on key factors conveyed in the interviews and focus groups about the facilitators and barriers to implementing evidence-based pain practices in the hospice setting. Despite the primary focus on pain practices, the goal of imparting this knowledge is to increase awareness of potential barriers or facilitators that may impact overall adoption of EBPs in any arena of EBP implementation.

Methods

The interviews with hospice directors and focus groups with hospice staff were conducted as part of a large multisite randomized controlled trial testing the effectiveness of a multifaceted TRIP intervention designed to facilitate the use of EBPs in the assessment and treatment of cancer pain in older adults in 16 community-based hospices. The TRIP intervention consisted of the following elements: 1) Identification of a Pain Facilitator, Nurse Champion, and Physician Champion, 2) Expert nurse consultation from the research team, 3) Resource tools and guidelines about the assessment and treatment of pain, 4) Performance Gap Assessment with ongoing Audit and Feedback, 5) Educational programs, 6) List serve support, and 7) Monthly teleconference. More detailed information about this larger intervention study have been presented elsewhere[15, 16]. This paper includes findings from interviews with hospice directors and focus groups conducted after the intervention completion at each of the eight experimental site exploring perceived barriers and facilitators to use of EBPs experienced.

Recruitment of subjects

The recruitment for this study took place in two waves. First, directors from the experimental hospice sites were sent a letter requesting that they participate in an in person interview about their impressions of the EBP implementation process. Follow-up calls were made to the directors to schedule a time for the interviews. Second, a general invitation was made to the eight experimental hospice sites for up to eight staff members to participate in a focus group session to share their thoughts and ideas on the process of promoting pain EBPs improvements in their hospice, as well as perceived facilitators and barriers to implementation. The invited individuals included the Pain Facilitator, Nurse Champion, and Physician Champion that served as agency leaders in implementing TRIP intervention. These persons identifed other key players in the implementation process to participate in the focus groups. Reminder contacts via e-mail and telephone were made in an attempt to increase participation of staff and perspectives on the implementation process involved in the EBP initiative.

Sample

A total of eight hospice directors were interviewed and 41 individuals participated in the focus groups, which ranged from three to eight participants per site. Six of the eight focus groups included the Nurse Pain Facilitator and the Nurse Champion. The other participating individuals were members of the hospice interdisciplinary team involved in the process of changing pain practices. While the majority of attendees were nurses, four social workers, one physician, one home health aide, one volunteer coordinator and three hospice administrators also participated in the focus groups.

Due to the moderate turnover rate of staff since the initiation of the multifaceted TRIP-CA intervention, the original Pain Facilitator and Nurse Champion were not always present during the focus group interviews. In these cases, the individuals who assumed these leadership roles were present. At two sites, the Pain Facilitator and Nurse Champion were not present due to competing work related demands. Only one Physician Champion across the sites participated in the focus group sessions. Additionally, one of the hospice directors who was interviewed joined the hospice agency after the start of the implementation process and was not familiar with the early stages of the process.

Data collection

The data from the director interviews and focus groups was collected by a masters prepared nurse with previous experience conducting research interviews and focus groups. This nurse was not involved in the research activities associated with the study and had limited knowledge about the components of the TRIP intervention. The interviews and groups were co-facilitated by a doctoral nursing student who served as a research assistant on the project. He was responsible for describing and obtaining informed consent, fielding questions about components of the intervention, managing the audio-recording, and taking notes during the interviews and focus groups.

The director interviews and focus groups were each conducted at the experimental hospice agencies and each lasted approximately 90 minutes. As part of the larger study, a semi-

structured interview guide was used to solicit feedback from the directors and focus group participants on what they viewed as the facilitators and barriers to each of the TRIP-CA intervention components, as well as the ways that pain management practices changed as a result of the intervention. Participants were also asked to provide perspectives on how pain management may change at the hospice in the future as a result of the intervention. The focus groups were audio-recorded and professionally transcribed. Presented in this paper are the qualitative data regarding overall barriers and facilitators to implementing EPBs for pain management in the hospice setting.

Data analysis

Qualitative description[17] was used to analyze the interviews with the hospice directors and focus group data given that this method best highlights the factors that impacted the implementation of evidence-based pain practices in hospices. The goal of these analyses were to identify the experiences of the hospices that impacted implementation of EBPs. The terms “facilitators” and “barriers” were used to guide these analyses.

Three individuals were involved in the data analysis process: one PhD researcher with a focus on qualitative methodologies and two PhD nursing students. The analysis of the focus group data involved several steps. First, the transcripts were read without any coding to obtain a sense of the data and the language that was used during the focus groups. Next, the transcripts were read and segments of text were coded as either ‘facilitators” or “barriers” to implementing EBP for pain assessment and management. Third, coded segments by each individual were compared for areas of consensus and discrepancy. For the purpose of this analysis, consensus was reached if two coders identified a segment of text the same. Discrepancies within the data analysis process were discussed at a face-to-face meeting with the coders, as well as other members of the research team to ensure agreement on what was considered to be a “facilitator” or “barrier” to the implementation process. Finally, the different “facilitators” and “barriers” were grouped into larger categories to identify themes that describe the factors that enabled or hindered the implementation of the pain EBPs. The three individuals who conducted the analysis followed the same procedures.

The interviews with the hospice directors were analyzed by the PhD researcher, using the same steps that were outlined for the analysis of the focus group data. The researcher presented the findings to the other authors for feedback and discussion.

Results

The results of director interviews and focus group analysis highlight three broad themes that should be considered by hospice staff prior to the start of an EBP initiative. The three areas include: 1) Community culture, 2) Agency culture, and 3) Staff culture. These three themes emerged as factors that either facilitated or served as a barrier to the agency’s success in adopting EBPs for cancer pain assessment and management in older persons in community-based hospice settings. Table 1 provides a summary of the results with recommendations for both patient care and systemic change.

Community culture

Community culture refers to the values and perceptions of the communities the hospice served that impacted the implementation of the EBP. In this particular study, hospice nurses encountered values and perceptions about reporting and treating pain among both patients and physicians that impacted their ability to use the EBP. For instance, one nurse indicated that the more rural, conservative nature of the community inhibited some patients from reporting their pain. She stated, “if you ask a patient if they’re having pain, they will tell you no and then you ask them to rate it from 0 to 10 and it’s not a zero.” This was followed up by another staff identifying this as the values of “good stoic Iowans”, meaning that patients had a value of not sharing problems or complaining. Another nurse echoed a value seen among her patients related to medication usage. “You say the word ‘morphine’ and people think that they’re going to die any day now…that is one barrier that we continue to face.” The values and perceptions that patients had about pain impacted their willingness to participate in certain aspects of the pain treatment intervention. According to one nurse, “[Pain diary] is not something that has even really caught on to a great degree and I think some of this might be the nature of the patients that we serve who are ….unwilling to do a pain diary.” Other nurses found that there were certain perceptions about pain, such as patients who sleep are not in pain or people with dementia cannot exhibit symptoms of pain, that needed to be addressed prior to implementation of EBP. Considering the values and perceptions of individuals who will be receiving the EBP was important for implementation to be successful.

Community culture was also related to the values and perception among physicians about the use of pain medications and integrating the EBP recommendations into their own practice. Some hospices identified that the physicians were not “willing to learn” about the EBPs, which was discouraging and frustrating to the nurses. Nurses reported that while the hospice and the hospice administration and staff were supportive of the new pain practices, some physicians were resistive and would not consider implementing a treatment regime that was new. Despite the education that the nurses were trying to provide, physicians were more comfortable using treatment approaches they had used in the past. Other nurses found that physicians within their communities did not value the opinions of nurses and when challenged to consider a different treatment option became more resistive to trying the EBPs. One nurse stated, “One of our medical directors is sometimes our hardest physician to get orders from. And that is sometimes frustrating because of any of the physicians, he knows where we are at.” Considering the way that other professionals may respond to the EBPs implementation was important.

Agency culture

Agency culture refers to the organizational factors that impacted the ability of a hospice to implement the EBPs. In this study, the culture of the agency played a crucial role in the implementation process and for some hospices dictated if the implementation of EBPs was successful. We included agency leadership, staff characteristics, relational events, and resources as areas related to agency culture.

Agency leadership played a significant role. For the nurses and other staff to embrace the process of implementing EBPs, the hospice leadership, including the Board of Directors, had to be supportive. According to one director, “I think it’s the culture of really wanting us to get better and providing an environment for that to happen. That’s the senior administrator’s role.” One nurse further articulated this by saying, “Staff need to understand that this is a priority and when you do give clear direction on things that you’re going to do, that you follow-up with it to prove that it is a priority.” Another nurse echoed this by stating, “Follow-up is the way you institutionalize change.” However, when the hospice administration did not assume a leadership role, implementation of the EBP was challenging. One nurse exemplified this by indicating, “This hospice at that time was going through some significant personnel and leadership challenges and really was focused on getting the basics done and not anything else.” Another nurse echoed the impact of lack of agency leadership and said, “People were in survival mode; it wasn’t that people weren’t interested; it wasn’t that they didn’t want to do it. They just didn’t have the time or the focus.”

Another factor related to agency culture was the issue of staff turnover. Hospices who experienced a high staff turnover rate found implementing EBPs difficult. These hospices expressed that while they had hired new nurses to fill empty positions, they did not have time to train these nurses in the EBPs because of the need to orient them to patient care. Incorporating EBPs into orientation was another way hospices found to promote buy-in to the initiative. While turnover among field nurses was challenging and adversely impacted the implementation process, it was more detrimental when a nurse who had a leadership role on the EBP initiative left the agency. This resulted in the implementation process either slowing down or stopping completely while the position was in flux. If the “replacement” was not supportive of the initiative, then the EBP implementation ended, which was the case for one hospice.

Agency culture also impacted the implementation of EBPs as a result of competing priorities with other agency initiatives or agency responsibilities, as well as unexpected circumstances that impacted individuals personally and professionally. Large agency initiatives, such as moving locations or building a hospice house, created additional stressors for staff as they were trying to fulfill their job responsibilities while also implementing the EBPs. As indicated by one nurse, “Right when we started this project was right when we were moving out here and opening the house. Any other year, I think we would be much better having all of this than we are.” Another hospice was part of a public health care organization. As a result, the nurses were responsible for not only attending to their hospice patients and the implementation of the EBPs, but also fulfilling their responsibilities with public healthcare patients. These competing priorities made it difficult for the nurses to feel they were doing anything well. Another competing priority that impacted the implementation process was rapid census growth. While most hospices expect an ebb and flow of hospice patients over the course of a year, a sudden growth of hospice patients created challenges for the continued progress of implementing EBPs. As one hospice stated, “We were growing rapidly at that time [implementation of EBPs].” This shifted the focus from the implementation process to meeting the needs of the patients. The nurses expressed that the only way these situations could be managed was having strong agency support that

recognized the impact of change on staff. Other hospices encountered unforeseen circumstances during the implementation of EBPs, such as the natural disaster of significant flooding. The floods, which impacted individuals personally and professionally, became the focus for the hospice agency, which resulted in the pain initiative being placed on hold until the lives of hospice staff and the agency stabilized. During each of these situations, the agency became distracted from the implementation of EBPs, which delayed some hospices in getting the new protocols implemented.

Another aspect of agency culture that can impact the ability for hospices to implement EBPs is overall availability of resources within the agency and within partner agencies that provide patient care. Staff at some of the hospices had difficulty participating in all elements of the EBPs because of lack of technology resources, particularly email and computer availability. This prevented staff from accessing the list serve, which contained content posted by pain experts, and prevented them from posting their own questions about pain assessment, treatment, and patient care. Other more rural hospices did not have access to needed community resources. For instance, some hospices had patients that resided more than 40 miles from the nearest pharmacy. As a result, the nurses struggled to provide medications in a timely manner to patients in pain crises. According to one nurse, “I’m sure there are patients that we’ve ended up having to send to the emergency room for symptom management that maybe if we had the right medicines at the right time we could have avoided that.” These resource deficiencies made implementing certain aspects of the EBP intervention challenging.

Staff culture

Staff culture played an important role in the implementation of pain EBPs, and for some hospices, it was the staff that determined the success of the implementation. Most importantly, the hospices found that they needed to have the correct staff composition at the time of EBP implementation to be successful. For instance, some hospices found that they had too few staff and the need to implement EBPs put too much stress on the nurses that were already overextended. They expressed, “you have to have the resources in order to implement things, if you don’t have the people resources it is hard to implement.” Other hospices found that they had too “many new staff.” While this was a positive in that the new nurses were engaged and excited about their role, many did not have enough knowledge about hospice care and pain management to be able to fully participate in the EBP implementation. One nurse described this by saying, “Over the weekend we had a new nurse on and I would ask her all these questions and she didn’t have the answers to any of them. I know that if [a more experienced nurse] would have called me she would have had them all [answers to questions].” Other hospices found that the more experienced nurses were less open to the implementing EBPs because they were comfortable with familiar practices and unwilling to learn new ways of providing patient care.

The hospices also found that staff attitude and openness to the new practices played a critical role in the implementation process of EBPs. Sentiment, such as “why do I have to do more” or “why do I have to ask more questions [during assessment],” prevented or delayed the implementation process. It often took more to educate staff on why a new pain initiative was

important, which postponed the actual work needed to improve practices. One nurse indicated, “People hold back, I don’t want to change, I don’t want to change” but she continued by saying, “but they knew things had to change.” To combat staff resistance, hospices found that perseverance, particularly with the leadership of administration and nurse committed to the project, was critical, as well as integrating the EBP protocol into all aspects of the agency. One hospice stated, “She believed in it…you could tell she was very vested in it.” One of the hospice directors stated, “Anybody hired has had to listen to EBPs as part of their orientation. So, they know what [we] are involved in…it creates a tone for the value of research activity.” The hospices identified that “once you [get the staff on board], then it [EBP] becomes part of the culture” of the agency. However, when the “leaders” of the EBP initiative did not fully engage in the project, the nurses recognized this and also did not feel invested.

Finally, the hospices indicated that other responsibilities associated with the role of the hospice nurse impacted the implementation of pain EBPs. The issue of time was critical to the implementation process. Some hospice nurses did not feel that they had enough time to add one more responsibility to their workloads. Between the demands of patient care, documentation, and on-call schedules, many did not feel that adding new responsibilities through the EBP initiative was feasible. Addressing these concerns required strong leadership by the individuals responsible for implementing the EBPs, with some nurses on the leadership teams leading by example and being the first to implement the changes.

In summary, when the hospices were able to recognize and address community, agency, and staff culture, the process of implementing EBPs became invigorating for the agency. Staff were able to generate enthusiasm and momentum for the intervention and the way that this was able to improve patient care. As stated by one director, “This pain program was our first big project and we liked it so much you kind of think, what’s next? What is the next big thing you want to take on?”

Discussion

The use of EBPs is a health care emphasis that is growing in the United States and other industrialized countries[18]. While other areas of healthcare have embraced the use of EBPs, hospice programs have yet to implement widespread initiatives, despite professional hospice organizations, such as the National Hospice and Palliative Care Organization and Hospice and Palliative Nurses Association endorsing and encouraging such efforts. As hospice continues to grow in the United States and serve more individuals, the need to stay on the cutting edge of research-based care initiatives is going to be even more pressing and will be a key factor in differentiating hospice organizations. As stated in other research on EBP in healthcare[18,19], hospice organizations and their staff must be ready for the work involved in implementing EBP, as well as the types of changes that accompany EBP initiatives. The implementation of EBP is not a project that can be completed if and when time allows. Instead, the hospice agency and its staff must view the EBP initiative as a priority, with time specifically designated to creating this culture change. Those initiating EBP changes must be prepared for some initial resistance as staff are determining how the new practices will impact them and their daily routine. This study provides hospice administrators and staff

with important factors to consider when deciding if they are ready to implement an EBP program.

Research has suggested that an assessment of agency readiness to engage in EBP is critical to its success[18]. As the current study identified, hospice professionals have multiple factors to consider when determining if their organizations are ready for implementing EBP, including the culture of the community, the agency, and staff. Prior to EBP initiatives starting, strategies for addressing these factors need to be considered and a plan developed. As seen in this study, the community culture involved the beliefs and values of patients and families about pain medications and the dying process, as well as the perspectives of referring physicians about the different types of pain practices. Because of these values and beliefs, some of the hospices found that it was difficult to move the new pain practices forward. Community culture may be best addressed through education. As seen in this study, many of the factors associated with community culture that were barriers to implementing EBP were the result of misperceptions about pain management and treatment. Through educational initiatives, hospice professionals have the opportunity to provide counter facts to some of the misperceptions of the dying process and the types of treatments provided to dying patients that could adversely impact an EBP initiative.

As seen in the present study, the infrastructure of the agency must also be ready for the implementation of EBPs. Administrators must spearhead EBP initiatives. They need to not only be involved during the beginning of the initiative but throughout the change process. Administrators need to lend support to the staff who have been identified as the motivators and cheerleaders of the EBP initiative, as they work to encourage buy-in by other staff. Administrators need to help staff manage competing priorities, changes and additions in roles and responsibilities, and should provide a solid and supportive rationale for why EBP initiatives are needed and will be an asset to their current practice and patient and facility outcomes. Additionally, administrators must allocate agency resources, particularly staff time, to the EBP initiative. This may involve the redistribution of staff responsibilities to support the work of the EBP implementation. Administrators should also consider forming a committee of staff who will dedicate time to the EBP initiative. While the EBP initiative reported in this study was specifically targeting the practices of the medical staff at hospices, other members of the interdisciplinary team, such as chaplains, social workers and volunteers, added support to the process. Some of the hospices formed interdisciplinary committees to help in the implementation process. This helped to promote unity and allowed for greater collaboration among staff. Administrators can also consider using a quality improvement measure, such as the one developed by the researcher in the larger TRIP-CA study, the Cancer Pain Practice Index (CPPI)[16] to help document the improvements made through the EBP initiative. While the CPPI was designed to specifically identify pain practices, tools such as this can be modified and used for other initiatives. Details about the CPPI development and its use are reported elsewhere. [16]

Finally, it is important to consider the staff culture. Staff should be brought onboard the EBP initiative, recognizing that not all nurses value EBP. Because EBP creates culture change, one can assume that the way in which staff have worked and provided care will also change. Hospice staff should be prepared for the changes that will come with the initiative. Research

has already identified that hospice nurses feel a great deal of pressure to meet the physical and emotional demands of hospice patients and their families[20] within work hours. Preparing staff for the changes that come with EBP involves an assessment of their attitudes and openness to change[18]. Additionally, staff may need to be educated about the importance of the EBP initiative over the long-term, because in the short-term, these initiatives may be perceived as more time consuming and adversely impacting the care patients and families are receiving. By helping staff see the long-term benefit of the initiative and how it will enhance patient care and the reputation of the organization can create enthusiasm and generate support for the EBP implementation.

Summary

The implementation of EBPs in hospice programs is a critical step in improving the care of the dying and demonstrating the expertise of hospice professionals in end-of-life care. With the new Medicare Conditions of Participation, momentum to support an environment and culture for EBP must be established. With hospice being one of the last areas of healthcare to implement EBPs, organizations need to begin the process of preparing staff and their communities for these types of initiatives. The consideration of the three factors presented in this study, community culture, agency culture, and staff culture, should aide hospice boards and administration as they initiative this important cultural shift in hospice practices.

Strengths and Limitations

This study is one of the first to examine the use of EBPs in the hospice setting. The findings from this study were based on comprehensive interviews with hospice directors and focus group sessions with hospice professionals who had participated in a 12 month multifaceted TRIP intervention to facilitate pain EBPs. The participants in the focus groups had been involved in the implementation process at their agencies and were knowledgeable about the barriers and facilitators impacting the success of their EBP program. Data were analyzed by a team of researchers which increased the trustworthiness of the findings.

The results of this study should be interpreted with caution. First, not all of the individuals who were in leadership roles, such as the Pain Facilitator, Nurse Champion, and Physician Champion were able to participate in the focus groups. Additionally, not all of the hospice directors had been in their positions since the start of the EBP process. Furthermore, because of the nature of focus groups, some participants may not have felt comfortable voicing their perspective on the process of implementing EBP pain practices at their organization amidst their peers. Others may have felt threatened by having superiors or those with more experience at the focus groups and thus did not share their views on the EBP initiative. Similarly, the hospice directors may have wanted to present their programs in the best light and thus were not completely forthright with their own impressions of the EBP process. Finally, the results from this study represented the factors that impacted the implementation of pain EBPs among hospice patients as perceived by hospice providers. Thus, the findings cannot be generalized to all hospices and EBP initiatives and do not reflect measures of actual adoption of EBPs. Although these findings could be relevant for other EBP programs, other EBP initiatives may involve other factors that agencies should consider that were not identified in this study.

Acknowledgments

This study supported by:

NIH/National Cancer Institute R01CA115363

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Table 1

Considerations for Implementing EBP's in the hospice setting

Theme	Example	Considerations
Community Culture Patient Values/Perceptions	• Pain reporting limited due to culture and values of patient population • Misconceptions related to opioid use	• Assess patient perception of pain & provide education about all available pain management options • Provide education about opioid use, including myths • Provide new guidelines and research on pain practices • Provide pain education at the community level to disease support groups, church groups, service clubs, for HCBS providers, etc.
Community Culture Physician Values/Perceptions	• Knowledge of new medication regimes	• Provide CME courses for physicians • Identify physicians who can be supporters of new practices
Agency Culture	• Agency administration not emphasizing importance of EBP initiative • Staff turnover • Agency involved with multiple initiatives at same time • Lack of resources to support initiatives	• Agency administration spearheading initiative and expressing support and dedication to new EBPs • Administration work to examine turnover patterns • Administration prioritize initiatives so that each receives ample attention • Engage in comprehensive assessment of agency ability to implement EBPs
Staff Culture	• Maintaining needed staff composition for implementation process • Staff resistant to changing current practice protocol • Other workload responsibilities and lack of time	• Identifying strengths and weakness in staffing that could impact EBP initiative • Providing comprehensive education to staff about EBPs • Identify ways to balance workloads with learning EBPs

Am J Hosp Palliat Care. Author manuscript; available in PMC 2015 March 26.