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Before implementing a change in practice, nurses require a systematic, evidence-based approach to identifying gaps in services and the need for change

CHANGING PRACTICE: PART 1 OF 2

Assessing the need for service improvement

In this article...

- How to identify the need for a change in practice
- Sourcing evidence to support a change in practice
- Strengths, weaknesses, opportunities and threats analysis

5 key points

1. Nurses are required to have up-to-date skills
2. Evidence-based practice is a cornerstone of all healthcare
3. As part of revalidation, nurses will need to provide evidence to support practice
4. Regular audits of service provision will measure standards
5. Audit/review cycle ensures high standards

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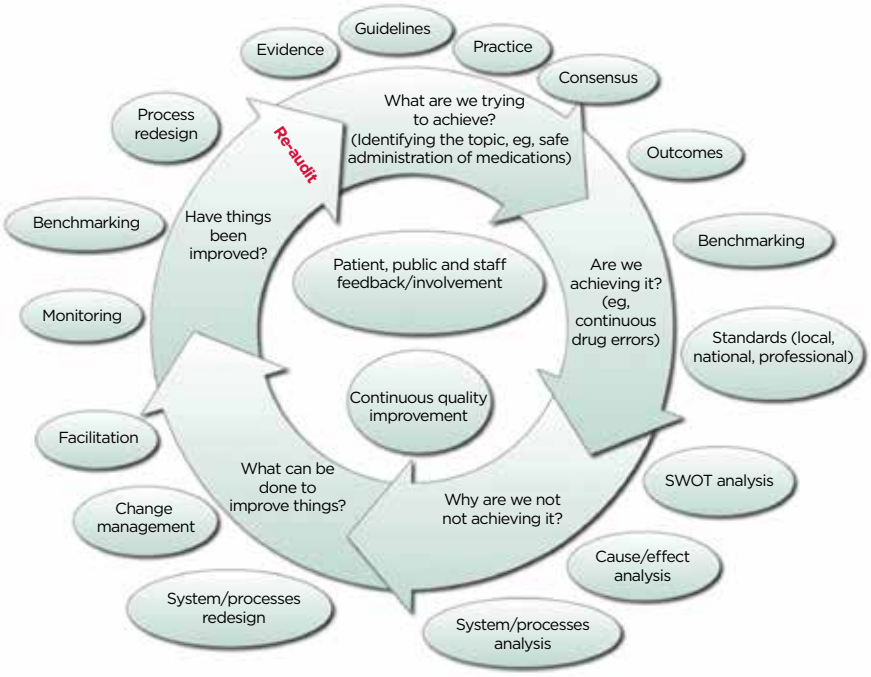
Abstract Carter H, Price L (2016) Changing practice 1: Assessing the need for service improvement. *Nursing Times*; 112: 8, 15-17. In order to ensure the service they offer is of an appropriate standard, nurses need to know how to assess its quality, identify the need for change, and implement and evaluate that change. This two-part series offers practical guidance on how to bring about an evidence-based change in practice, and how to demonstrate the success, or otherwise, of that change. It uses the example of an initiative undertaken to improve medicines management in a hospice to illustrate the process. The article also illustrates how work undertaken in changing practice can form part of the evidence submitted in the nurse revalidation process. Part 1 considers how to determine when a change in practice is needed, how to assess and measure current practice, and identify gaps or weaknesses. Part 2 will discuss how to find out why the current practice is falling short of the desired level, and how to go about implementing improvements and measuring the effect of changes.

Nurses have a responsibility to preserve safety; this is made clear in the revised code of conduct for nurses (Nursing and Midwifery Council, 2015a). The Code states that nurses must "take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures".

Preserving safety involves protecting vulnerable people and ensuring patient safety by reducing errors, rectifying mistakes and reporting concerns immediately. This requires nurses to identify problems and their causes, and put in place changes that will improve safety and the quality of care; it can involve participating in clinical audits and reviews, and any other activity that results in changing practice. This two-part series provides practical advice for

FIG 1. **THE CYCLE OF AUDIT AND RE-EVALUATION**



nurses wishing to make changes to practice, as well as suggestions for documenting and evaluating the resulting changes.

When nurse revalidation begins in April 2016, the NMC will expect nurses to provide evidence of how they practise effectively. This will involve written information, including personal reflections and feedback from colleagues and patients, and evidence of having undertaken continuing professional development (CPD). Bringing together the expectations from The Code (Nursing and Midwifery Council, 2015a) and *How to revalidate with the NMC* (NMC, 2015b), the article also aims to help nurses consider ways to use the evidence collated in service-improvement projects as part of the material submitted in their revalidation evidence.

Importance of reflective practice

The Royal College of Nursing (2010) has developed a set of eight principles to enable nurses to reflect on their own practice. Principle F highlights the need for evidence-based practice, where "nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care" (Gordon and Watts, 2011). More recently, in the *Shape of Caring* review, Lord Willis stated that: "Registered nurses and care assistants are required at all levels to adapt, support and lead research and innovation to deliver high-quality care" (Willis, 2015). His recommendations were influenced by the need to celebrate good care and build on the expertise and evidence base of existing clinical practice.

Evidence-based practice has been defined as: "the integration of best research evidence with clinical expertise and patient values" (Sackett et al, 2000). Implementing a change in practice involves collating a variety of information and analysing the findings against national guidance, service provision and patients' views of their care.

Identifying the need for change

Nursing practice is continually changing and it is important to identify improvements and deterioration in practice, particularly if they affect patient safety. Identifying issues in practice relies on nurses using their clinical judgement and knowledge to collate relevant information, thoroughly analyse appropriate data and provide robust evidence for the success, or otherwise, of change (Benner, 2000).

Once the need for change has been noticed, the process of bringing about change can be thought of as a series of steps:

1. What are we trying to achieve? A review of the relevant evidence-based practice for the particular area of healthcare.
2. Are we achieving it? How does current practice measure up to local and national standards?
3. Why are we not achieving it? A review of current systems and processes to discover why current practice is falling short.
4. What can be done to improve things? Recommendations, timescales and strategies to bring about a change in practice.
5. Have things been improved? Re-audit of current practice and ongoing review to see whether change has been successful.

This article explains steps 1 and 2. Steps 3 to 5 will be discussed in part 2.

What are we trying to achieve?

It is essential to assess current practice within national and local guidance, standards and expectations; this will help to reveal potential gaps in practice and give an indication of what needs to be the main focus of an audit. A range of tools, advice and standards is available that can be used as a baseline or framework for measuring practice. While it is not within the scope of this article to address these in depth, they may include:

- National Institute for Health and Care Excellence (NICE) guidelines;
- Scottish Intercollegiate Guidelines Network;
- National social care standards;
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3);
- NHS Commissioning Board Special Health Authority (responsible for patient safety);
- Professional-body standards and guidelines.

Measuring gaps in practice

Regular audits of the structure, processes and outcomes of service provision are key in measuring whether or not established criteria and standards are being met (Chambers et al, 2006). Even in the best services there is likely to be a gap between what is happening in clinical practice and what has been identified as good practice in national and local guidance.

Carey et al (2009) suggested that closing the gap between best evidence and current clinical practice has the potential to improve health outcomes. If a nurse identifies a gap in practice, evidence such as incident forms, complaints, observations made by staff, patients or the public may show whether it is more than an isolated case. Nurses should therefore explore all available evidence, and discussions with colleagues will help to confirm any gap or poor practice

Once clinical issues needing to be addressed have been identified, it is

BOX 1. CASE STUDY: INVESTIGATING MEDICATION ERRORS IN A HOSPICE

A nurse working in a hospice was studying for an infection prevention and control qualification. The assignment for a module on quality and clinical governance was to identify an area of practice in which the standards of care could be improved. This involved using clinical governance tools and techniques, such as clinical audit, risk management, change management and evidence-based practice.

Within the organisation was a steady flow of incident reports concerning medication errors. The nurse decided to look into the issue to see if she could find any patterns, causes or contributing factors that might reveal why the errors were occurring. With this information the nurse would be able to recommend a change in practice that would improve the quality of care patients received.

The nurse began by auditing incident forms from the previous 12 months. These were benchmarked against criteria in the National Patient Safety Agency (NPSA) patient safety incident reports. Using this information, the nurse analysed the current position of the organisation to identify any underlying causes for the errors.

The nurse felt supported by senior staff and undertook the audit with the full backing of the hospice, which viewed medication errors as valuable opportunities for learning on an organisational and personal level. The World Health Organization (2004) suggested that this response to reporting incidents is more likely to improve patient care than the reporting process.

With information gathered about the causes of errors, and collated evidence of best practice, the nurse would be able to make recommendations to reduce the risk or prevent further errors.

TABLE 1. SWOT ANALYSIS OF THE HOSPICE

Strengths	Weaknesses
● Open, honest and transparent culture ● Staff encouraged and supported to learn from reported errors ● Training and development opportunities available ● Strong leadership and positive role models among management team ● Financial resources available to implement changes	● New organisation just developing – no clear standards or processes in place ● Standards and processes put in place to address gaps as they are identified ● Staff deskilled in respite-focused care
Opportunities	**Threats**
● Continuing professional development available ● Increasing level of skills mix (acute nurses with learning disability nurses) will raise standards ● Organisation is developing and implementing systems that reflect best practice ● Enthusiasm to achieve excellence in the clinical area ● Shift of focus from respite to palliative care, which will result in access to services from wider client group	● Staff shortages ● Difficulty in recruiting ● Lack of promotion opportunities for registered nurses

important to select the most appropriate method to measure the quality and standard that should be available to patients; each will have its advantages and disadvantages. The method used to gather information will depend on the aim of the project. Depending on the time, resources and level of support available, clinical leads may choose to use some or all of the following methods:

- Clinical audit;
- Service review;
- Seeking patient and staff feedback;
- Observation of practice;
- Literature review;
- Complaints review;
- Patterns of incident reporting;
- Primary and/or secondary research.

This series uses a case study of some of the processes used by a nurse who undertook a medicines-management audit in a hospice, outlined in Box 1. Clinical audit is "a quality improvement process that seeks to improve patient care and outcomes through a systematic review of care against explicit criteria and the implementation of change" (NICE, 2002). Based on the audit cycle, Fig 1 outlines the processes that can be followed to maintain a robust approach to any project. Since the process is a cycle, once an audit has been undertaken and the relevant changes made, a re-audit should be carried out to close the loop and evaluate how the service is performing after making changes.

Are we achieving it?

Having identified the issue(s) to be audited, the next step in the process (Fig 1) is to assess whether or not the organisation or an identified clinical area is achieving its aims, in this case, the safe administration of medication. It is imperative to analyse the existing situation; a number of tools such as those mentioned above can be used to determine whether the organisation is achieving a high standard of care and, if not, the reasons for this.

A strengths, weaknesses, opportunities and threats (SWOT) analysis can be undertaken to identify barriers and opportunities for change. This is an integral part of the planning stage, and can save time and frustration at later stages of the project. A SWOT analysis is easy to do, and provides an assessment of internal and external factors that can influence changes in practice. It can be used to support short-term clinical or organisational goals (NICE, 2007).

Table 1 illustrates a SWOT analysis reviewing potential organisational influences on the prevalence of medication errors in the hospice. In this case, the analysis demonstrated that the organisation was open, trusting, willing to learn from mistakes and share good practice. This attitude is reflected in nursing practice and the willingness of staff to report incidents.

Defining the scope

After the need for change has been identified, the project's scope and aim need to be described. The scope highlights the area to be included and excluded from the review or audit, while the aim can be an overarching statement to determine the areas of interest. Examples of reflective questions to ask when defining the scope include:

- What is being measured?
- Is this an audit or review?
- What are the risks to patients, staff and the organisation?
- What is the benchmark?
- Are there any standards to indicate what should be achieved?
- Is a baseline audit required?

The rationale for the project needs to be clearly articulated. The hospice nurse identified the aim as being to reduce the risk of preventable medication errors, thus improving the quality and safety of care.

Documenting change

Records are a vital component throughout the process of change, in order to provide evidence of how issues were identified and why service aims were not being achieved; recommendations to improve practice; and to show that the service has improved. The nature of this cyclical process means that monitoring and ongoing reviews determine whether the change has had an impact on practice or not.

Having identified where practice is not meeting the required national and local standards, the next step it to find out why this is happening and what could be done to improve practice. This will be discussed in part 2 in the next issue. **NT**

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