Barriers to Implementing EBP

**Unit-Based**

- **Financial Constraints**
- **Nurses’ Perceptions**
- **Lack of managerial support**
- **Workplace Culture**

**Institutional**

- **Financial Constraints**
- **Limited access to resources**

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**Methods**

Project implementation was requested by the Director of Critical Care Medicine and an initial needs assessment was performed in June 2013. 8% of the nursing staff were familiar with the CAM-ICU assessment tool.

General ICU: Delirium assessments were given concurrently with CAM-ICU. A bassessment tool teaching. A tool of 50 assessments were given on all shifts over a 4-week period. September 15, 2013 was set as the official “launch date.”

Audits were conducted on a weekly to monthly basis to record CAM-ICU: Bassessment tool frequency of documentation. Overall patient population was also assessed. Bedside training & demonstrations provided as needed.

**Needs Assessment**

- **June 2013**
  - **Week 1**
    - 8% frequency of documentation
    - **Week 2**
      - 10% increase in CAM-ICU assessment of sedated patients
      - Knowledge gap & perceived physician-orientated tool
      - **Week 3**
        - Teaching sessions
        - Audit results were shared with staff
        - Modiﬁcation of documentation encouraged
      - **Week 4**
        - Staff survey with 24 participant response rate
        - Knowledge gap significantly decreased
        - Physician involvement remains a challenge

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**Results**

- **20%** increase in CAM-ICU assessment of sedated patients
- **40%** increase in RASS assessment of sedated patients
- **60%** increase in RASS assessment of sedated patients
- **80%** increase in RASS assessment of sedated patients

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**Conclusion**

Implementation of the Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) is a multi-faceted process as engendered by the Society of Critical Care Medicine in their 2002 guidelines. Our project pilot period showed promising results. As consistently reported in the literature, physician involvement, financial constraints; and workplace culture resistance were the biggest barriers to implementing evidence-based practices on this unit. These barriers were further complicated by the upcoming expansion and move of the patient care centre into one in late 2013. As a result, implementation of the project was halted.

Although initial implementation objectives were not met within the target timeframe, a significant improvement with RASS assessment tool compliance was noted. As project implementation over 70% of bedside staff showed an improvement in compliance over 20% met the recommended reporting frequency of 60% of patients. This result demonstrated a 38% and 60% results respectively. This indicates an increase in awareness and implementation of evidence-based practices while more previously uncharted.

The CAM-ICU assessment tool implementation and continued staff feedback and approaches/applying modifications have been key to positive outcomes. While a lack of physician involvement, perceived care prioritisation, and inability to provide documentation changes persist as barriers to implementing changes, consistent and repeated RASS, delirium & CAM-ICU teaching, identification of key resource people, and visible encouragement have yielded desired but steady results.

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**References**


Forget To Do

- **Feb 6**
  - 10% Cardiothoracic Surgery beds
  - 10 Critical Care Teams
  - >115 bedside nurses

- **April 14**
  - 10 bedside nurses

- **June 30**
  - 10 bedside nurses

- **August 21**
  - 10 bedside nurses

- **October 15**
  - 10 bedside nurses

- **December 21**
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