Workshop 9 – 2018 Nordic Implementation Conference
Implementing at the Frontline – Practitioners shape Implementation

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Presentation 1: Acceptability of Malaria Rapid Diagnostic Test among Health Workers in Kintampo North Municipality (Michael Anaba)

Background

WHO recommends malaria rapid diagnostic test (mRDT) for implementing the policy of test-based management of malaria to avoid misuse of antimalarials. However, Health Workers (HWs) still treat half of febrile patients with negamalaria results suggesting limited or lack o of acceptability of the intervention.

Project aim

This study sought to measure the level of mRDT acceptability and examine its associated determinants among HWs in Kintampo North Municipality(KNM) of Ghana.

Project methods

Data on mRDT acceptability, its determinants and user characteristics were collected from 110 HWs in KNM involved in malaria management from February to April, 2017. The survey tool was based on two frameworks – the Technology Acceptance Model (TAM) and Normalization Process Theory (NPT). The latter proposed coherence, collective action, cognitive participation and reflexive monitoring as determinants that affect the implementation of health intervention. A composite acceptability score was computed from a 21-item questionnaire for each respondent.

Project results

The median acceptability score was 84 with interquartile range of 68-103. About 34% of HWs were in the low acceptability tertile while 37% and 29% were in the moderate and high acceptability tertiles, respectively. In the adjusted model, coherence, cognitive participation, reflexive monitoring, working in rural facilities and more than three years' experience were associated with high acceptability.

Preliminary or final conclusions/discussion

To successfully implement the test based management with mRDT into real world practice requires considerable attention to both developing and supporting the HWs and also the work needed to embed this new intervention into existing care system. In addition, a key requirement for HW is to exert a low threshold in embedding mRDT in clinical practice as well as supervision to facilitate transition to test based management with mRDT.

Presentation 2: Mobility during an acute medical hospitalization: Who are responsible for this? (Jeanette W. Kirk)

Background

Studies have shown that older medical patients are inactive during hospitalization. Low mobility and bed rest are independent risk factors for physical dependency and mortality. Therefore, interventions that can reduce low mobility during hospitalization are needed. Exploring barriers and facilitators can maybe ensure that a given intervention is adapted to the local context.

Project aim

The aim of the study was to provide a perspective on the relationship between older medical patients' objectively measured level of mobility during hospitalization and observations aimed at health professionals' focus on mobility. Hereby, which barriers and facilitators the health professionals, patients and relatives experience in relation to increased activity.

Project methods

In six medical departments in three hospitals in the Capital Region, mobility was measured in a 24-hour period during hospitalization in 49 elderly medical patients using ActivPal accelerometers. Also, ethnographic field studies were conducted in each department, which have not been used in connection with studies focusing on low mobility of older medical patients. Physio – and occupational therapists, nurses, nursing assistants and physicians were followed for up to 14 days in each department. Fields notes were recorded continuously. Subsequently, a thematic analysis was conducted.

Project results

The patients were lying/sitting a median of 22.25 hours (IQR 21.3-23.2), they were walking 0.2 hours (IQR 0.1-0.4) and standing 1.4 hours (IQR 0.7-0.21) during the assessed 24-hours. One main theme was:" Differences between professional identities and their understandings (cultural models)". Different health professionals acted based on different cultural models that directed how they acted and reacted in relation to mobility of patients. These cultural models also created professional boundaries and caused a blurred distribution of responsibility for ensuring increased mobility.

Preliminary or final conclusions/discussion

The health professionals' act based on different cultural models that create strong professional identities and dictate which actions are valid in the profession. On the other hand, the cultural models create professional boundaries that make it unclear who are responsible for ensuring increased mobility in the older medical patients. Hereby, the patients are not mobilized which is supported by the quantitative data showing that patients spend 22 hours per day either sitting or lying.

Presentation 3: From expected to actual barriers and facilitators: A study applying Theoretical Domains Framework (Ditte M. Sivertsen)

Background

A screening was developed to predict readmission and functional decline in older medical patients acutely admitted to the Emergency Department. If patients were scored to be in risk, primary care nurses were contacted and supporting interventions were initiated. Perceived barriers and facilitators were explored prior to project start. A geriatric team was chosen to perform the screening.

Project aim

The aim of this study was to identify changes in perceived barriers and facilitators during the implementation of a new screening tool in the Emergency Department from the perspective of the geriatric team and its cross-sectoral collaborators.

Project methods

This study is part 2 of an implementation project, and was conducted after 9 months of screening. Data consist of 6 semi-structured interviews; 2 focus groups and 4 individual. The interview guide was developed based on the domains in Theoretical Domains Framework (2), and related to interview questions and answers from study 1 to get reflections on early barriers and facilitators. Monitoring barriers and facilitators over time made it possible to make a comparison, in order to identify areas that will have implications in an implementation process.

Project results

Preliminary results show that the most predominant domain (still) is "Social/Professional role and identity". The main barriers for implementing the screening are conflicting with the geriatric team´s role as experts and is found to lower the quality of their work throughout the entire process, since the screening does not comply with their professional standards. The screening does not contribute to either professional competencies or cross-sectoral collaboration. However, there is a mutual opinion that a "common language", as established in this project, is needed in future collaboration.

Preliminary or final conclusions/discussion
The screening seems to provide benefits for the patients identified by it, however those who perform the screening perceive it as superficial. Sociological theories of (de)professionalization form a discussion of knowledge, competencies and authenticity, or the loss of those, in relation to the screening. In order for the screening to make sense for participants, implementation strategies must be considered continuously or else parallel interpretations and rationales are formed.

Presentation 4: Clinicians' views on implementation of a new model of care for low back pain patients (Inge Ris Hansen)

Background

Back pain is one of the main causes of disability and visits to primary care. Clinical guidelines recommend interventions that support patient self-management, but do not provide directions on implementation. Clinicians' behaviour and perception of an implementation process is multifactorial and their input essential for successful implementation in primary care. More knowledge of this is needed.

Project aim

The overall project aim is to investigate the implementation of new models of care in primary care settings in Denmark and Sweden. Two similar programmes (GLA:D®Back / Better Back) consisting of patient education and supervised exercises were developed to help implement national and international guideline recommendations. The specific objectives of this study were to quantify individual clinician factors that may influence the implementation process using the Determinants of Implementation Behaviour questionnaire (DIBQ), and to analyse possible differences between the countries.

Project methods

The study is a non-controlled experimental design. Participants are primary care physiotherapists and chiropractors from Denmark (n=31) and Sweden (n=45) who participated in a 2-day GLA:D®Back / Better Back course. Clinicians' expectations and views associated with implementation of the GLA:D®Back / Better Back models of care were assessed using DIBQ domains. The DIBQ was completed immediately after the GLA:D®Back / Better Back courses and again after 3-4 months, when it was anticipated that implementation of the programs had been initiated.

Project results

Participating clinicians in both Denmark and Sweden generally had positive expectations regarding the implementation of GLA:D®Back / Better Back program directly after the course. The results of the DIBQ after the implementation period (3-4 months) will reveal actual and perceived factors influencing the implementation process in the two countries and will be presented at the congress, separately for each country and combined.

Preliminary or final conclusions/discussion

Clinicians in both countries indicated a positive attitude towards implementation of a new guideline-based program in primary care. Results at follow-up will show whether initial positive views remain after the implementation process has ended, guiding optimizing the program. Results may inform on the usefulness of DIBQ to determine potential barriers for implementation and may guide selection of relevant domains to plan and analyze future comparable implementation projects.