Looking in the Rearview Mirror
Is Evidence-Based Practice the Best We Can Do?

Adoption of evidence into practice is now a standard for gerontological nursing, and an ever-growing body of research is available for use in designing practice. When used appropriately, evidence-based practice (EBP) improves care outcomes by suggesting what strategies and/or interventions work and by identifying outcomes to measure when evaluating care. EBP helps elevate the status of gerontological nursing by adding science to “art” and is available to all practicing nurses. Yet, there are several concerns.

First, EBP is retrospective in nature. When considering an intervention with a body of evidence, nurses must go to the literature to determine the number of studies completed, the sites where the studies were conducted, the population studied, and the available resources for implementation and oversight.

When a researcher, student, or clinician selects an intervention or concept to study, it often takes years to formulate an idea for study and then design, pilot, fund, implement, analyze, and disseminate that study. It is not uncommon for the writing, submission, review, and publication of studies to take 2 to 3 years. The more evidence for the practice, the older the practice is. In 2010, the U.S. Administration on Aging announced it would fund its Alzheimer’s disease demonstration grants only to applicants who were using one of four EBP program models, which may squash funding of meaningful innovation.

In addition, studies of implementation document the difficulty of translating research into practice. Unless the exact protocols are replicated and time is taken for planning, the same results found in the research cannot be achieved (Blase & Fixsen, 2008).

Second, new promising ideas may be rejected because there is no “evidence” to support them and may be difficult to research because of:
- Political correctness.
- Human subjects concerns.
- Lack of funding.
- Lack of available support from research-trained professionals to assist with all aspects of the research process and/or the researcher’s lack of clinical experience, which may compromise the intervention.
- Methodological issues (if conducted within a nursing home setting) such as staff turnover, potential contamination, and small samples. Moreover, studies conducted in nursing homes may not generalize to sites with different approaches to care and levels of personnel.

An example area of study is avoiding agitation in people with dementia caused by relocation to long-term care facilities. Using an evidence-based model and standards for use of pain medications, it was postulated that a micro-dose of an atypical antipsychotic agent for up to 15 days (i.e., 5 days prior to admission and up to 10 days after) might prevent agitation and the further need for antipsychotic/anxiolytic medications.
Trying this with patients produced the intended result, yet when this was suggested to colleagues with prescriptive privileges, the practice is rebuffed due to a lack of evidence. In addition, the possibility of studying a protocol that involved use of atypical antipsychotic agents raised issues related to political correctness and human subjects protection.

Finally, the long-term care environment is changing at a stunning pace. Families increasingly select long-term care options that employ fewer health care professionals, such as assisted living facilities and family group homes. Compared with nursing homes, these facilities may have dissimilar staffing characteristics, different regulations regarding care, varying missions, and fewer research partners. Families make these choices based on the desire for less expensive care and homelike environments, as well as because of negative perceptions of nursing homes. Care in these alternative facilities is often determined by marketing strategies, and services change rapidly based on what it is perceived the public wants. This fast-paced environment may not allow the time needed to implement EBP. Thus, studies conducted in nursing homes may have limited generalizability to newer sites of care.

By embracing EBP as the standard, we are assuming that because a practice has evidence, it must be the way to go. Thus, while EBP is a blessing for care of older adults, it may create a rearview mirror effect that could stifle creativity by forcing us to dismiss new ideas because they are unstudied. Would not an equally valuable approach be to examine new ideas rigorously and evaluate them as they are implemented? If we are always looking back, care may meet a certain standard, but newer, truly innovative practices may be ignored.

REFERENCES

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The author discloses that she has no significant financial interests in any product or class of products discussed directly or indirectly in this activity, including research support.

doi:10.3928/00989134-20101206-01