RtKW 5: Piloting implementation

Integrating AI in Nursing with Decubitus Risk Prediction Alerts (DRAAI): A pilot implementation study

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Enablers and challenges to the implementation of a pioneer Social Prescribing program in Portugal: Learning from evidence to improve practice and inform policy

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ENHANCING PERIOPERATIVE LUNG CANCER CARE THROUGH DASHBOARD IMPLEMENTATION: A PILOT STUDY IN THE NETHERLANDS

Pauline Mens[1,2], Nina Zipfel[1], Erik von Meyenfeldt[2], Han Anema[1]

'*The intention was to work bottom-up, and it worked out*' – Local champions transforming antibiotic prescribing practices amongst Belgian general practitioners: a pilot implementation study

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RtKW 292

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Background
This study evaluates the acceptability and feasibility of DRAAI (Decubitus Risk Alert Artificial Intelligence) in clinical practice, the feasibility of the implementation plan, and the timeliness of follow-up on (high)risk predictions with preventive measures.

Methods
From June to September 2023, an explorative process evaluation was conducted on three general wards in a tertiary hospital. Key strategies included re-examining the implementation, providing local technical assistance, and organising clinician team meetings. Nurses' acceptability and feasibility were assessed through questionnaires and field notes, along with timely follow-up of at-risk predictions.

Results
Fifty-five nurses participated in the questionnaire. Implementation strategies reached a cumulative attendance of 270 nurses. Nurses valued DRAAI predictions and believed they could lead to pressure ulcer prevention. Most nurses found it feasible to integrate DRAAI into their workflow. DRAAI provided risk predictions for 428 unique admissions, with 30% receiving at least one (high) risk prediction. Half of these predictions were followed up with preventive measures within 24 hours.

Discussion
Nurses initially struggled with the transition from traditional risk assessment to AI predictions. Key success factors included intensive support, daily reminders, and formal commitment. Ongoing involvement and clear communication are crucial for integrating AI into nursing workflows. Despite concerns about missing at-risk patients, nurses continued identifying patients without relying solely on DRAAI predictions. DRAAI shows promise in improving PU prevention – how would you design future research to assess implementation and effectiveness?

RtKW 322

Enablers and challenges to the implementation of a pioneer Social Prescribing program in Portugal: Learning from evidence to improve practice and inform policy

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Research aim
Social prescribing (SP) is an integrated, person-centred care approach aimed at responding to patients' social and emotional needs affecting health through community resources. Using the CFIR, we identified enablers and barriers to implementing the first SP pilot project in Portugal to support improvement and scale-up.

Setting
The SP pilot project is implemented in two primary healthcare units in Lisbon, which provide general healthcare to approximately 29.000 people of all ages. Users of these units include elderly in isolation, recently arrived migrants, and unemployed people. The project also involves partners from the social and voluntary sectors in the community.

Method(s)
When healthcare providers identify patients with non-clinical needs, they invite them to the SP program. In the SP appointment, a social worker assesses patient needs, preferences, and motivations, and together they design a personalised action plan. Following the agreed-upon plan, the patient is referred to services fostering social interaction, physical activity, and other health-promoting aspects provided by local public/private/non-profit entities. In five years, approximately 1300 patients were referred to the SP program. Semi-structured interviews were conducted with family doctors, social workers, and community partners' representatives to assess the implementation of the SP program, using CFIR for thematic analysis.

Key finding(s)
The main enablers of SP implementation included its recognised potential to address broader determinants of health and well-being beyond traditional medical interventions, the personal characteristics of professionals as being proactive and motivated towards SP, and the dynamic communication strategy used to engage the stakeholders. Perceived challenges were related to raising users' awareness about the SP benefits and increasing adherence. Lack of preparedness for intersectoral working processes (e.g. insufficient communication channels), limited community responses and unsystematic collection of data on activities adherence and progress were also highlighted as barriers to SP implementation.

Discussion
- SP implementation seems simple, but our findings show that, in practice, SP is a complex intervention that involves multiple stakeholders and diverse community responses and is subject to multilevel factors that can highly impact its successful implementation. How can actions be prioritised to move forward and improve the implementation process?
- A strong and comprehensive community sector is vital for a successful SP intervention. Adequate funding and appropriate infrastructure are required while ensuring community resources are fully aligned with patients' needs and accessible. How do we engage managers, funders and policy developers to work together, find common ground, and boost community development?

Challenges

The lack of preparedness for intersectoral work and communication was challenging, yet the SP implementation team used a dynamic communication strategy (e.g., monthly meetings with social partners, regular feedback to healthcare providers, and publication of newsletters), which provided transparency about the project being implemented and greater closer ties with social partners.

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ENHANCING PERIOPERATIVE LUNG CANCER CARE THROUGH DASHBOARD IMPLEMENTATION: A PILOT STUDY IN THE NETHERLANDS

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Research aim
This pilot study evaluates the implementation plan for the Enhanced-Recovery-After-Thoracic-Surgery (ERATS)-dashboard, aimed at monitoring adherence to the ERATS-guideline and improving perioperative care and outcomes for lung cancer patients. It explores participants' experiences as it provides an opportunity to test and refine the plan for broader integration into daily practice.

Setting
The study was conducted in two hospitals in the Netherlands, where perioperative teams implemented the implementation plan over six months. The plan included appointing an ERATS-Champion, conducting training sessions, and holding quarterly feedback meetings to discuss adherence and patient outcomes. This setting evaluates the dashboard's implementation into real-world clinical workflows.

Method(s)
A mixed methods study was conducted, combining quantitative data from usability questionnaire (IQ Healthcare, 2003) and monitoring guideline adherence with qualitative data from focus group discussion. Guideline adherence was evaluated by monitoring core indicators results, obtained from the dashboard; pain management, chest drain duration, and early mobilisation. Focus group discussions were guided by Proctor et al.'s (2011) implementation outcomes, such as feasibility and acceptability. Participants included perioperative teams from two hospitals, where the implementation plan was independently followed. Data collection lasted six months, enabling analysing of engagement with the dashboard, the effectiveness of feedback sessions, and guideline adherence.

Key finding(s)
Preliminary results indicate strong engagement of perioperative teams with the ERATS-dashboard and feedback meetings, supporting successful implementation. However, the absence of a Clinical Lead was identified as a barrier, as participants stressed the need for chairmanship to ensure deeper understanding of the ERATS-guideline's objectives and to guide feedback meetings effectively. The dashboard's usability and ability to track performance, enabling improved perioperative care and patient outcomes through structured audit and feedback, were well-received. Core indicators data is being analysed to assess changes in guideline adherence over six months. Final results will be available at the EIE.

Discussion
- What are your experiences with conducting pilot studies to implement new guidelines or tool? How have pilot studies helped refine implementation strategies, address unexpected challenges, or adapt to the needs of multidisciplinary teams in your context?
- In your experiences, how and which implementation science frameworks, such as Proctor et al.'s implementation outcomes, guide the development of strategies to implement new tools, dashboards, multidisciplinary feedback cycles, or guidelines.

Challenges

A key challenge was the variation in data registration practices, with one hospital entering data in batches and the other one recording it individually. This made timing data processing difficult. To address this, adjustments were made in the electronic patient record system, allowing for more consistent data entry.

RtKW 364

'*The intention was to work bottom-up, and it worked out*' – Local champions transforming antibiotic prescribing practices amongst Belgian general practitioners: a pilot implementation study

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Research aim
Inappropriate antibiotic prescribing remains a persistent challenge, demanding solutions that are both evidence-based and adaptable to real-world clinical practice. This study evaluates a bottom-up implementation approach, leveraging local champions (LCs) to drive changes in antibiotic prescribing behaviour amongst Belgian general practitioners (GPs) from November 2023 to October 2024.

Setting
Forty-two Belgian LCs, trained in antimicrobial resistance stewardship, peer-learning facilitation, and strategies for addressing key behavioural determinants, each engaged up to ten GPs. Using peer-support meetings (intervisions) and a digital toolkit, they helped GPs incorporate best practices into routine clinical care.

Method(s)
Post-implementation, three focus groups (two Dutch, one French) explored the experiences of LCs and their engagement with GPs. Using the Normalisation Process Theory framework, the discussions examined how champions facilitated behaviour change and identified opportunities for improvement. Transcripts were analysed via NVivo 14, employing both deductive and inductive coding.

Key finding(s)
In the Coherence construct, LCs differed in their perceptions of their role, with some acting as moderators and others as teachers. For Cognitive Participation, LCs engaged in the project due to its relevance to their clinical experience, while others valued fostering communication among GPs. Under Collective Action, LCs sought alternative ways to engage GPs when tools like action plans proved too complex. They also found that knowing GPs personally facilitated the intervisions. Lastly, in Reflexive Monitoring, LCs suggested future improvements, including a more user-friendly digital toolkit and the inclusion of other healthcare professionals beyond GPs.

Discussion
- To what extent are local champions a viable implementation strategy to translate knowledge into practice?
- What are the broader implications of engaging local champions as an implementation strategy to motivate behaviour change?

Challenges
An action plan based on behavioural change literature was developed but deemed overly complex by GPs and LCs, leading to disengagement. Despite training, LCs struggled to apply the action plan during intervisions. They adopted alternative engagement methods, and the project team simplified the plan to enhance its accessibility.