CARDs (Comfort Ask Relax Distract) Vaccination Intervention: Learnings from Implementing New Practices into Long Term Care Homes

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Introduction

CARD (Comfort Ask Relax Distract) is a person-centred vaccination framework that integrates evidence-based strategies to reduce pain, fear and fainting.[1] This study employed the Consolidated Framework for Implementation Research (CFIR) to examine barriers of CARD implementation for COVID-19 vaccinations in Long Term Care homes (LTCHs).[2]

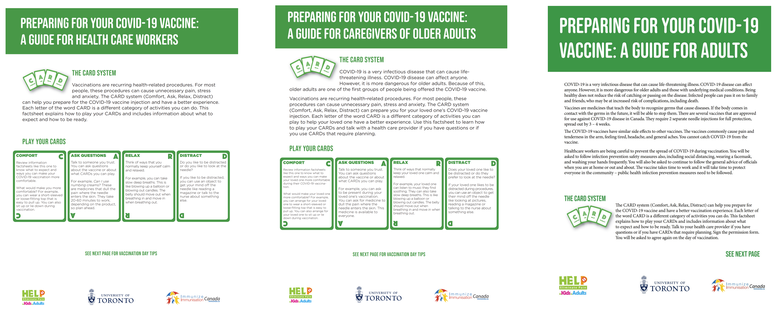

Figure 1: Examples of pamphlets from the CARDs implementation.[1]

Objectives

To identify and examine barriers to implementing new practices or changes in LTCHs to improve future implementation processes.

Methods

A post implementation interpretive evaluation was conducted with 8 participants (2 managers, 4 staff, and 2 residents) in one LTCH in northern Ontario, Canada. We compared valence and strength of CFIR constructs to explain barriers to the implementation of CARDs. From the identified barriers, we determined recommendations for improving implementation of new interventions in LTCHs.

Constructs	Operational Definition	Rating
Complexity	Perceived complexity of the CARDs program as reflected by the degree of disruptiveness to existing workflows and number of steps involved in using the intervention as intended.	-2
Availability of Resources	The level of resources dedicated for implementation and on-going operations, including money, training, education, physical space, and time.	-2
Communication	The quality of the communication networks that support the implementation of the CARDs program.	-2

Table 1: Valence ratings assigned to Consolidated Framework for Implementation Research constructs. [2]

Results

Three constructs emerged from participants' responses as negatively influencing the CARD implementation: **complexity, available resources,** and **communication**. In **complexity**, staff perceived an added number of steps in executing CARDs, and a lack of **communication** between management and staff. Additionally, **lack of available resources,** such as inadequate staffing, negatively influenced the implementation process. To improve implementing new evidence into practice, we suggest: 1) Providing an implementation facilitator; 2) Comprehensive training to communicate and teach the intervention; and 3) Including a resident-centred approach, such as involving the LTCHs' Residents Council, in the intervention development and feedback.

Discussion

We identified barriers to the implementation process and have suggested recommendations to address them. For future studies, strategies should include resident engagement in the implementation process. Further research is required to determine appropriate staffing levels to successfully implement new changes into practice. The study provides insights in adapting future interventions into LTCHs.

References

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