Stetler Evidence Based Practice Model

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Evidence-based practice has brought considerable improvement to healthcare by encouraging nurses to combine the best available evidence with clinical expertise, patient preferences, and the circumstances of the practice setting. Instead of relying only on tradition or habit, practitioners examine whether a current procedure is supported by credible knowledge and whether a change is appropriate for the patients and organization involved. One of the earliest nursing frameworks designed to guide this process is the Stetler Model of Research Utilization. The model was first developed in 1976, refined in 1994, and updated again in 2001 so that it could respond to the broader evidence-based practice movement. Its continuing importance lies in its practitioner-oriented character (Stetler, 2001). It can be used by an individual nurse thinking critically about personal practice, by a small clinical group, or as part of a more formal organizational initiative.

The original essay correctly emphasizes that the Stetler Model allows the use of both internal and external evidence. External evidence may include peer-reviewed studies, systematic reviews, professional standards, and national guidance. Internal evidence may include quality reports, incident data, patient feedback, staff experience, local costs, workflow observations, and outcome trends within the organization. These sources answer different questions. Published research may show whether an intervention can work under defined conditions, while local evidence reveals whether the same problem exists, whether the intervention fits the setting, and what barriers are likely to affect implementation. The Stetler Model helps practitioners make judgments about appropriateness, desirability, feasibility, and the manner in which evidence should be used rather than assuming that every published finding should immediately become policy.

Development and Purpose of the Stetler Model

Research utilization models emerged because producing knowledge and using knowledge are separate activities. A well-designed study can remain unread, be judged irrelevant, or fail to change practice when organizations lack time, authority, skills, or resources. Stetler's model addresses this gap through a sequence of critical-thinking phases. It does not present evidence use as a mechanical transfer from journal to bedside. The practitioner must clarify the purpose, assess the evidence, compare it with the local situation, decide how it should be translated, and evaluate the consequences. The 2001 update retained this judgmental orientation while making the model more compatible with evidence-based practice. Stetler explained that the model was designed around the practical decisions of individuals and groups, including clinical nurse specialists and other practitioners who must determine whether findings are credible and useful.

This focus distinguishes the Stetler Model from frameworks developed mainly for large organizational

change. A bedside nurse can use it informally to reconsider a care decision, while a clinical educator can use it to design staff development and a committee can use it to guide a practice change. The flexibility is valuable, but it can also create inconsistency if users do not document their reasoning. A strong application should therefore identify the question, participants, evidence sources, decision criteria, implementation responsibilities, and evaluation measures even when the project is relatively small.

Phase One: Preparation

The preparation phase defines why the evidence is being examined and what decision must be made. A practitioner begins by identifying the problem, purpose, and relevant context. For example, a unit may observe inconsistent pain reassessment, frequent patient falls, delayed sepsis recognition, or poor retention of newly hired nurses. The team should describe the current practice and establish why improvement is needed rather than beginning with a favored solution. A focused question such as PICO—patient or population, intervention, comparison, and outcome—may help organize clinical searching, although the Stetler Model itself is broader than one question format. Preparation also requires awareness of personal assumptions. A nurse who strongly favors an intervention may unintentionally search only for confirming studies.

External factors should be considered at the same time. The organization’s mission, patient population, leadership priorities, legal obligations, technology, staffing, financial position, and political climate can all affect the project. A change that is clinically promising may be impossible within the proposed timetable or may conflict with another safety initiative. Stakeholders should be identified early because delayed consultation often produces resistance that is misinterpreted as unwillingness to use evidence. Patients, bedside nurses, educators, managers, physicians, pharmacists, information-technology staff, and other groups may understand different aspects of the problem. Preparation is successful when the project has a clear purpose, realistic scope, and plan for obtaining the evidence needed to make a decision.

Phase Two: Validation

Validation examines the quality and credibility of the evidence. The original essay describes this phase as checking relevance and feasibility, but the first task is to determine whether the source is methodologically trustworthy. Different forms of evidence require different appraisal questions. A randomized trial should be examined for allocation, blinding where possible, attrition, outcome measurement, and applicability. A qualitative study should be assessed for sampling, data collection, analysis, reflexivity, and credibility. A guideline should disclose how evidence was searched, graded, and translated into recommendations. Local quality data require accurate definitions and dependable collection. A large number of publications does not create a strong evidence base if the studies are biased or answer a different question.

Validation should be proportionate to the decision. A high-risk intervention affecting medication or invasive care needs rigorous review, while a low-risk educational improvement may justify a more rapid assessment. Practitioners should distinguish statistical significance from clinical significance and consider absolute benefit, harm, uncertainty, and the characteristics of participants. Evidence should not be rejected merely because it is imperfect; healthcare decisions often must be made under uncertainty. The purpose of validation is to understand how much confidence the evidence deserves and which limitations must influence later use.

Phase Three: Comparative Evaluation and Decision Making

After individual sources are appraised, the practitioner compares the evidence as a whole and evaluates it against the local setting. This phase asks whether findings are consistent, whether benefits outweigh risks, and whether the intervention is sufficiently similar to what the organization can deliver. Differences among studies may reflect patient characteristics, dose, staff expertise, setting, outcome definitions, or implementation quality. The team should not average conflicting findings without interpretation. It should identify the conditions under which the intervention appears effective and the circumstances in which it may fail or cause harm.

Decision making is central to this phase. The evidence may support adoption, adaptation, a limited pilot, continued observation, or rejection. A decision not to change can be evidence based when the intervention lacks benefit, presents unacceptable risk, or does not fit patient values. Conversely, feasibility problems should not automatically end the process when they can be addressed through training, equipment, scheduling, or leadership support. The decision should be recorded with its rationale so that later teams can understand why a practice was selected. This transparency also prevents an influential individual from presenting personal preference as the inevitable conclusion of the evidence.

Phase Four: Translation and Application

Translation converts the decision into a practical plan. Research articles describe interventions in scientific language, but staff need clear actions, responsibilities, and resources. The team determines what must change in protocols, education, documentation, equipment, communication, and monitoring. It identifies who will perform each task, how competence will be developed, and how the change will fit normal workflow. Translation may involve creating a clinical pathway, teaching materials, electronic prompts, competency assessment, or patient information. The intervention should retain the active elements responsible for benefit while being adapted thoughtfully to the local setting.

Application can occur at different levels. An individual nurse may integrate findings into personal

decision making, provided the change remains within professional scope and organizational policy. A unit-level change may require approval, training, and coordination. A formal policy may require governance review and broader communication. Pilot testing is often useful because it allows the team to identify practical problems before full implementation. Staff should be able to report confusion and unintended consequences without being labeled resistant. Application is not complete when a presentation has been delivered; it is complete when the new behavior can be performed reliably in practice.

Phase Five: Evaluation

Evaluation determines whether the evidence was used as intended and whether the change produced the expected outcome. Process measures examine implementation: Were eligible patients assessed? Did staff follow the new protocol? Was training completed? Outcome measures examine effects such as symptom control, infection, fall rate, patient experience, cost, or staff retention. Balancing measures detect unintended consequences. A protocol that reduces one risk may increase workload, delay another task, or create disparities among patient groups. Evaluation should therefore be planned during preparation rather than added after implementation.

Feedback supports refinement and sustainability. If outcomes do not improve, the team should not assume that the evidence was wrong. The intervention may have been delivered inconsistently, the patient population may differ, or the selected measure may not capture benefit. Conversely, an apparent improvement may reflect seasonal variation or another simultaneous initiative. Repeated measurement and comparison with baseline strengthen interpretation. Evaluation also asks whether the change should be maintained, modified, expanded, or discontinued. This final phase connects the model back to preparation because evidence-based practice is a cycle of learning rather than a one-time project.

Use of Internal and External Evidence

The Stetler Model’s inclusion of internal and external evidence is one of its strongest features. Consider a hospital seeking to reduce falls. External research may identify multifactorial assessment, medication review, mobility support, environmental modification, and patient education as useful components. Internal evidence may reveal that most local falls occur during toileting on evening shifts or among patients waiting for assistance. The external evidence provides tested strategies, while the internal data identify where and how to apply them. Patient and staff accounts add explanations that numerical reports may miss. The project becomes stronger when no single evidence type is treated as complete.

Internal data must still be appraised. A quality report may undercount events when staff fear blame, and patient feedback may represent only those able to respond. External literature may not include

the organization’s population. Evidence-based practice therefore requires triangulation: different sources are compared to determine where they converge and where uncertainty remains. The model’s judgmental activities are designed for exactly this purpose.

Application in Staff Development

The original essay cites Celeste Romp’s application of the Stetler Model within staff development at a 422-bed community hospital. That example should remain central because it demonstrates how the phases can guide an educational practice change. The project used a focused clinical question during preparation, appraised selected literature during validation, and considered the risks and implications for nurses, preceptors, and patients during comparative evaluation. Translation required a documented plan, communication with staff, and examination of the education and expertise needed for implementation. Teaching materials, including presentation handouts, were developed to support application. Evaluation considered staff-development outcomes and job satisfaction.

The case shows that evidence-based practice is not confined to direct treatment. Orientation, preceptorship, continuing education, leadership, and competency assessment can also be evaluated through evidence. An educational intervention should not be considered successful merely because employees attended. The organization should examine learning, transfer to practice, patient or workforce outcomes, and sustainability. The Stetler Model provides a disciplined way to connect a staff-development activity with the problem it is intended to solve.

Strengths of the Model

The model’s principal strength is flexibility. It recognizes individual practitioners as legitimate users of evidence while also supporting groups and organizations. Its phases make critical thinking visible and encourage consideration of local feasibility rather than promoting automatic adoption. The separation of validation from comparative evaluation helps users distinguish methodological quality from practical relevance. Its inclusion of internal data, professional expertise, and patient considerations fits the broader concept of evidence-based practice. The model is also useful across clinical, managerial, and educational questions, which explains its continued presence in nursing literature.

Another strength is that it allows different forms of research use. Evidence may produce direct change, shape understanding, support a decision, or reveal the need for further inquiry. Not every valid study should become a protocol. Sometimes its most important contribution is conceptual: it helps a nurse see a problem differently or ask a better question. This protects evidence-based practice from becoming a collection of rigid rules.

Limitations and Implementation Challenges

Reviews of evidence-based practice models show that the model also has limitations (Schaffer et al., 2013). Because it depends on practitioner judgment, results can vary according to appraisal skill, time, authority, and organizational support. The phases are conceptually clear but do not provide every operational tool needed for searching, project management, stakeholder engagement, or statistical evaluation. Users may need to combine the model with appraisal checklists, implementation science frameworks, and quality-improvement methods. The model is also less explicit than some organizational frameworks about leadership, culture, and system-wide adoption. An individual nurse may identify strong evidence but lack authority to change policy.

Time is another barrier. Bedside nurses may have limited access to databases, protected time, mentorship, or research education. If an organization expects evidence-based practice without providing these resources, the model can become an additional burden. Leadership must create conditions in which staff can search, appraise, discuss, and test evidence. The practitioner orientation of the model is valuable only when practitioners possess real support and a voice in decisions.

Conclusion

The Stetler Evidence-Based Practice Model provides a structured process for moving from a clinical or organizational question to responsible use of evidence. Its five phases—preparation, validation, comparative evaluation and decision making, translation and application, and evaluation—preserve the central concepts presented in the original essay while clarifying their purpose. The model does not treat research as a command. It asks practitioners to judge credibility, fit, feasibility, benefit, and method of use. Internal evidence such as quality reports and patient feedback is considered alongside external research, allowing the final decision to reflect both scientific knowledge and local reality.

The staff-development example demonstrates that the model can guide educational as well as clinical change. Its flexibility and emphasis on individual practitioners are major strengths, while dependence on appraisal skill and organizational support are important limitations. Used carefully, the Stetler Model helps nurses move beyond tradition without abandoning judgment. Evidence is validated, compared, translated, and evaluated so that practice change becomes a transparent learning process rather than an unexamined response to the latest publication.

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