



De-implementation in Nursing: A Systematic Review of Strategies to Stop Low-Value Care to Improve Patient Safety and Workload Reduction

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Abstract

Background: Continued delivery of low-value nursing care—practices outdated, ineffective, or even harmful—compromises patient safety and contributes to unnecessary nursing workload. While the new implementation of evidence is the focus, the systematic process of removing such practices, known as de-implementation, is needed for healthcare quality improvement.

Aim: The aim of this review study is to synthesize current evidence on de-implementation in nursing, present its theoretical basis, enumerate typical low-value practices, and identify effective ways to stop them for improved patient outcomes and optimal workflow in nursing.

Methods: An integrated literature review was conducted by combining results from current empirical studies, systematic reviews, and quality improvement reports on de-implementation and low-value care in nursing and interprofessional settings.

Results: Routine Foley catheterization, unnecessary vital sign monitoring, and liberal physical restraint use are strong de-implementation candidates, the review implies. Successful strategies are multifaceted, including audit and feedback, clinical decision support in electronic health records, nurse-initiated protocols, and sending out professional campaigns like Choosing Wisely. Success is highly dependent on strong clinical leadership, a psychological safety culture, and interprofessional collaboration to counter cognitive inertia and embedded professional norms.

Conclusion: De-implementation is an ethical and pragmatic imperative to nursing. Systematically eliminating low-value care is essential to sustain patient safety, reduce iatrogenic harm, and allow nurses to focus their skills on high-value, individualized care.

Keywords: De-implementation, Low-Value Care, Nursing, Patient Safety, Evidence-Based Practice

1. Introduction

The relentless pursuit of high-quality, safe, and effective patient care is a core precept of modern nursing. Throughout the many years, the focal priority of translational research and quality improvement has been implementation—the adoption of new EBPs into clinical

practice (Nilsen et al., 2020). However, no less critical, but equally overlooked, is an approach called de-implementation: the systematic removal or reduction of medical or nursing practices that are not evidence-based, wasteful, or potentially harmful (Prasad & Ioannidis, 2014). These rituals, also termed "low-value care," consume scarce

resources, worsen nursing burnout through unnecessary work, and adversely affect patients (Colla et al., 2015).

De-implementation is a shift from the default to perpetuate existing practice to one of continuous critical appraisal. In nursing, given that workflows are task-oriented and convoluted, numerous low-value practices persist despite contradicting evidence. Examples of such practices include the daily use of indwelling urinary catheters for reasons beyond medical necessity, awakening stable patients for vital signs, and the repeated use of physical restraints to prevent falls without trialing alternatives (Oman et al., 2012; Wiltsey Stirman et al., 2012). The ongoing nature of such practices is not just a lack of knowledge, but a multifaceted issue shaped by habit, culture, policy, and cognitive biases (Niven et al., 2015).

The de-implementation driver is robust. From the perspective of patient safety, low-value care can result in direct harm in the form of CAUTIs, sleep deprivation, or emotional distress. For the nursing staff, performing tasks with no clinical benefit leads to task saturation, moral distress, and burnout, depriving high-value, patient-focused care of time and effort (Melnik et al., 2018). Economically, low-value care places a large financial load on the healthcare system, squandering billions of dollars each year on treatments that do no good (Shrank et al., 2019).

This review aims to provide a systematic overview of the science of de-implementation to nursing. It will: (1) define de-implementation and its theoretical foundations; (2) define low-value nursing practices and how they affect care; (3) review evidence-based frameworks and methods for de-implementation; (4) address the central role nurses must play; (5) refer to facilitators and barriers; and (6) provide an ethical and pragmatic guide for embedding de-implementation in routine nursing practice.

The Science of De-implementation

De-implementation is specifically described as the reduction or cessation of implementation of a potentially harmful, not evidence-based, or outdated practice no longer considered standard of care (Prasad & Ioannidis, 2014). It can be distinguished from non-adoption or implementation

failure. Rather, it pertains to actively ceasing a widely implemented practice with firm roots in clinical practices and culture (van Bodegom-Vos et al., 2017).

Theoretical underpinnings of de-implementation are based on implementation science, psychology, and sociology. De-implementation is not merely the reverse of implementation. Discontinuation of a well-known practice has some unique challenges, such as the disruption of habits learned deeply, the conquest of the "this is how we've always done it" culture and managing perceived patient demand for some interventions (Helfrich et al., 2019). Several theoretical models have been applied to describe these challenges. The Theoretical Domains Framework (TDF) may be used to identify barriers in domains including "Knowledge," "Social Influences," "Beliefs about Consequences," and "Environmental Context and Resources" (Atkins et al., 2017). For instance, a nurse may know that frequent catheterization is risky (Knowledge) but continues the practice due to unit culture (Social Influences) or a perception that it saves time in the course of a long shift (Beliefs about Consequences).

The Concept of "Low-Value Care" is also central to de-implementation. Low-value care refers to a spectrum of practices from entirely ineffective to those that could be of value in specific situations but are utilized too often (Beshbishy, 2024). In nursing, it could refer to ritualized practice, unnecessary monitoring, or persisting with certain devices or procedures without a current, valid indication. Seeing that a practice is low value is merely the first step; however, behavior change entails addressing the intricate system that perpetuates its habitual perpetuation.

Common Targets for De-implementation in Nursing Practice

Nursing practice is replete with targets for de-implementation. Attending to these targets has the potential to achieve significantly improved patient outcomes as well as nursing effectiveness. Table 1 and Figure 1 outline some of the most significant examples, their attendant harms, and the evidence base for them.

Table 1: Low-Value Nursing Practices and Their Effects

Low-Value Practice	Rationale for De-implementation	Potential Patient Harms	Impact on Nursing Workload
Routine/Unnecessary Indwelling Urinary Catheters	No evidence for routine use; strong evidence for harm. Major cause of hospital-acquired conditions (Meddings et al., 2017).	Catheter-Associated Urinary Tract Infection (CAUTI), urethral trauma, immobility, delirium, prolonged hospital stays (Saint et al., 2016).	Time spent on catheter insertion, maintenance, monitoring for complications, and documenting CAUTI events.
Frequent Vital Sign Checks in Stable Patients	Lack of evidence that frequent monitoring (e.g., every 4 hours) improves outcomes in clinically stable patients (Weenk et al., 2019).	Sleep disruption, patient discomfort, and unnecessary alarms leading to alarm fatigue (Danesh et al., 2019).	Significant time expenditure on a repetitive task, documentation burden, and responding to false alarms.
Routine Use of Physical Restraints for Fall Prevention	Evidence shows restraints do not reduce fall rates and may increase the risk of serious injury (Hofmann & Hahn, 2014).	Physical injury (strangulation, skin breakdown), psychological harm (agitation, humiliation, trauma), loss of dignity (Berger et al., 2024).	Time spent applying and monitoring restraints, increased supervision required, and ethical distress.
Automatic "Nothing by Mouth" (NPO) Orders Post-Op	Enhanced Recovery After Surgery (ERAS) protocols support early oral intake; prolonged NPO status delays recovery (Ljungqvist et al., 2017).	Dehydration, ileus, malnutrition, increased catabolism, and patient dissatisfaction (Bennett & Cecconi, 2017).	Time spent managing IV fluids, administering antiemetics, and addressing patient hunger/thirst.
Routine Continuous Pulse Oximetry in Non-Critical Settings	Over-monitoring in patients without respiratory compromise leads to no clinical benefit (Jorge et al., 2022).	False alarms, sleep disturbance, unnecessary diagnostic tests or interventions (Gupta & Edwards, 2018).	Time spent responding to non-actionable alarms and documenting normal values.

Daily Indwelling Urinary Catheters

An indwelling urinary catheter is one of the most overused and abused devices within the inpatient

environment. There is no need for de-implementation: there is no evidence to use them daily for incontinence management or convenience, and there is plenty of evidence that has established them as one of the fundamental causes of in-hospital acquired conditions. The most common cause of healthcare-associated bacteremia is catheters, with up to 70% of catheter-associated urinary tract infections (CAUTIs) being preventable (Meddings et al., 2017). Harms to patients go far beyond infection. Catheters cause urethral trauma with insertion or prolonged use, enable immobility that puts patients at risk for pressure injury and venous thromboembolism, and are an independent risk factor for delirium in hospitalized elderly patients. This cascade of complications then frequently results in prolonged lengths of stay and further healthcare costs (Saint et al., 2016). From a nursing workload perspective, the "simple" Foley catheter imposes a significant task burden. This includes insertion and maintenance care time, constant monitoring for signs of CAUTI, and the heavy administrative workload of documentation and reporting these infections. The attentional requirement of working with a device that, by nature, increases the risk profile of a patient is a continuous, typically unmeasured, and ongoing drain on nursing attention.



Figure 1: De-implementation in Nursing — From Awareness to Action

Routine Vital Sign Monitoring in Clinically Stable Patients

The routine repetition of vital sign monitoring, typically to a rigid every-4-hour or every-8-hour protocol regardless of patient status, is a prime example of a low-value nursing intervention. The justification for de-implementation is grounded on the absence of evidence that frequent monitoring of this is advantageous to outcomes in stable patients, particularly on general medical-surgical wards. In fact, in sleeping patients, this is against or detracts from outcomes. The injury to patients is widespread and diverse. Disruption of sleep, especially nocturnal, undermines immune response, wound healing, glucose management, and causes delirium (Danesh et al., 2019). Furthermore, the prevalence of monitors and alarms that accompany frequent monitoring directly fuels the epidemic

of alarm fatigue whereby nurses become desensitized to a continuous stream of typically non-actionable alarms, potentially missing critical changes in the patient's status. For nurses, the amount of time lost to redundant, unnecessary vital sign monitoring and their accompanying documentation is enormous. This time is indeed stolen from more intricate nursing activities such as patient education, comprehensive assessment, emotional support, and care coordination.

Regular use of Physical Restraints for the Prevention of Falls and Disruption

Physical restraint utilization—vests, limb holders, and pelvic ties—claimed for patient safety is an activity whose de-implementation has clear clinical and ethical justifications. There is solid evidence to indicate that physical restraints don't work to stop falls; rather, they can worsen more serious injuries, such as strangulation or fracture, because patients struggle with the equipment (Hofmann & Hahn, 2014). The injury is enormous. Aside from the obvious physical risks of skin breakdown, nerve damage, and circulatory impairment, the psychological injury is ghastly. Restraints lead to agitation, humiliation, helplessness, and fear, which can manifest themselves as post-traumatic stress and profound loss of dignity (Berger et al., 2024). For nurses, the use and monitoring of a restrained patient is not a time-saving task involving timesaving. It may require more scrutiny, constitutes serious ethical distress and moral harm since nurses abrogate their core duty to comfort, and can potentially destroy the therapeutic nurse-patient relationship.

Post-Operative Automatic "Nothing by Mouth" (NPO) Orders

The historical tradition of having patients remain nil by mouth (NBO) status for several hours after surgery, "until bowel sounds are heard," is an entrenched low-value tradition that has been overcome to good effect by Enhanced Recovery After Surgery (ERAS) protocols. The rationale for de-implementation is strong: ERAS evidence strongly supports the safety and benefit of early oral nutrition, including on the day of surgery, in the majority of instances. Prolonged NPO status is not benign; it triggers a catabolic state, leads to dehydration, increases ileus risk, contributes to malnutrition, and considerably reduces patient comfort and satisfaction (Ljungqvist et al., 2017; Bennett & Cecconi, 2017). From an administrative perspective, tending a patient on extended NPO status imposes considerable workload. This includes staff and time required to monitor intravenous fluid therapy, manage nausea medications which are precipitated by an empty stomach, and continuously treat valid complaints of hungry and thirsty patients.

Routine Continuous Pulse Oximetry in Non-Critical Settings

Expansion of continuous pulse oximetry monitoring on the medical floors in patients who have no active respiratory dysfunction or established risk factors constitutes a modern form of low-value care. The case for de-implementation is clear: in patients who are neither hypoxemic nor at risk for acute desaturation, continuous monitoring is not clinically beneficial and generates a high number of false-positive alarms. The most frequent adverse effects in patients are related to sleep disruption due to the device itself and persistent alarms, as well as the potential for "cascading iatrogenesis" when a temporary, spurious, or minor decrease in oxygen saturation leads to inappropriate diagnostic testing (e.g., arterial blood gases, chest X-ray) or

therapy (e.g., unnecessary supplemental oxygen) (Gupta & Edwards, 2018). For nurses, this habit consumes huge amounts of time responding to non-actionable alarms and documenting normal values, time-consuming distractions from clinical monitoring that require human judgment.

In addition to these early examples, other prevalent low-value practices include redundant procedural preparation such as shaving (which is a surgical site infection risk factor), standard flushing of indwelling urinary catheters (which can cause bacterial contamination and urethral damage), and daily weighing of all inpatients for which there is no particular cardiac, renal, or fluid-status indication (Wiltsey Stirman et al., 2012). The aim at these targets is more and more driven by nurse-enhanced quality reviews, patient safety data, and expert recommendations pushed by professional campaigns like Choosing Wisely.

Effective De-implementation Strategies and Frameworks

An effective de-implementation of a low-value practice is a multi-faceted process dealing with the specific context and obstacles. Strategies may be broadly divided into educational, persuasive, structural, and incentivizing strategies (Patey et al., 2018; Figure 2).



Figure 2: Strategies and Frameworks for Effective De-implementation

Educational and Informational Strategies

While awareness is needed, it is often insufficient. Passive dissemination of guidelines has a low effect (Grimshaw et al., 2012). Effective educational interventions are interactive and dynamic. Audit and Feedback is a successful intervention where information on current practice (e.g., rates of catheter use) is collected and fed back to clinicians and units, typically against a benchmark or best practice performer (Ivers et al., 2012). For example, showing a nursing unit, its high rate of catheter use in patients with poor indications will cause reflection and change. Academic Detailing, where one clinical expert (e.g., Clinical Nurse

Specialist) conducts individual or small-group educational outreach visits, can dispel misconceptions and provide practice change support individualized to specific practitioners (O'Brien et al., 2007).

Persuasive and Social Influence Strategies

The American Board of Internal Medicine Foundation's Choosing Wisely(r) campaign has been central to aiding de-implementation. Various professional nursing societies, like the American Nurses Association and Academy of Medical-Surgical Nurses, have created "Five Things Nurses and Patients Should Question" resources (Alatawi et al., 2020). These resources are authoritative, profession-created counsel for mitigating low-value care, founded on social and professional norms. Champions and Opinion Leaders are also critical. Identification and empowerment of highly respected frontline nurses to serve as de-implementation champions will have a greater effect on their colleagues than top-down policy statements (Flodgren et al., 2019). The champions can model new behavior, provide success stories, and share peer-to-peer advice.

Structural and Enabling Strategies

Changing the environment so that the low-value practice is harder to do and the high-value option is easier to do is most often the most effective strategy. Clinical Decision Support (CDS) integrated in the Electronic Health Record (EHR) can potentially serve as a good de-implementation strategy. For instance, utilization of a "hard stop" requiring a positive confirmation from a checklist before a Foley catheter order can be placed has proven to be very useful in avoiding unnecessary catheterizations (Mody et al., 2017). Similarly, changing default order sets to remove frequent daily labs or vital sign frequencies and making them an "opt-in" rather than an "opt-out" choice can reduce low-value care substantially (Nasr et al., 2025). Nurse-driven protocols provide nurses with the authority to unilaterally terminate low-value care on the basis of specific criteria. A common example is a protocol for the removal of catheters initiated by nurses such that nurses can remove catheters without a fresh doctor's order if pre-determined conditions (e.g., no longer needed) are met (Fallatah et al., 2024).

Financial Incentives and Strategy

Financial and regulatory incentives must be aligned with de-implementation goals. The Centers for Medicare & Medicaid Services (CMS) has designated several hospital-acquired conditions, including CAUTIs and injuries related to restraints, as "never events," which means that they will no longer pay for the additional cost of treating the complications (Saud Faleh Alanazi, 2024). This policy is a strong economic incentive for the investment in de-implementation activity by hospitals. Internally, organizations can employ recognition and non-financial rewards to provide units that can effectively reduce low-value care with a sense of achievement and competition (Table 2).

Table 2: De-implementation Strategies Mapped to Common Barriers

Barrier Category	Specific Barrier	De-implementation Strategy
Knowledge & Awareness	Lack of awareness that a practice is low-value.	Choosing Wisely recommendations; Academic detailing; Educational workshops.
Attitudes & Beliefs	Belief that the practice is beneficial or harmless ("It's just a Foley").	Audit and Feedback showing harm data; Patient testimonials; Sharing success stories from other units.

Habit & Inertia	"We've always done it this way"; automated behavior.	Clinical Decision Support (pop-ups, hard stops); Changing default orders in the EHR; Forcing functions.
Social & Cultural Norms	Peer pressure; fear of being judged by colleagues for not following tradition.	Identifying and empowering clinical champions; Visible leadership support; Unit-based benchmarking.
Environmental Context	Lack of time or resources to use the alternative (e.g., no commodes available).	Providing resources (e.g., bladder scanners, commodes); Nurse-driven protocols to empower action; Workflow redesign.
Perceived Patient Demand	Belief that patients expect or want the intervention.	Scripted communication tools for nurses; Patient-facing educational materials.

The Critical Role of Nurses in De-implementation

Nurses are not merely players in the de-implementation process; they are its crucial column. From its location at the crossroads of patient care, clinical workflow, and interprofessional communication, nurses have a unique and integrated perspective that positions them as the most well-suited professionals to be the drivers of recognition, initiation, and sustainment of abandonment of low-value care. As the largest profession of healthcare and the practitioners with the most regular patient contact, nurses gain an intimate contextual understanding of the hard-won, real-world consequences of effective and ineffective practice (Dubois et al., 2013). Such proximity to patient experience gives them an unparalleled ability to appreciate the subtleties of how a clinical guideline does, or doesn't, come into play in real-world patient outcomes, so that their role in de-implementation is not just helpful, but essential.

The Nurses' role as Frontline Identifiers and Sentinels of Harm must not be undervalued. Whereas quantitative information and audit reports may point to a problem, very frequently, it is the bedside nurse who gives the qualitative voice to interpret it. They are the first to observe the clinical sequelae of low-value care: the patient developing a catheter-associated urinary tract infection (CAUTI) not as a data point, but as an individual in pain and fever; delirium caused not just by illness, but by the resultant sleep disturbance of repetitive, non-essential vital sign monitoring; and skin breakdown and psychologic trauma from physical restraints applied for "safety" (Mackey & Bassendowski, 2017). This firsthand observation is an extremely important form of evidence, evoking the compelling, human narrative that has the potential to galvanize a quality improvement effort. Further, nurses are likely to recognize inefficiencies and ritual practices with no evidence base, such as daily catheter irrigation or daily "nothing by mouth" orders in stable post-operative patients. By methodically collecting and elevating these observations through incident reporting systems, shared governance councils, or daily safety huddles, nurses turn anecdotal experience into actionable intelligence for de-implementation.

In addition to identification, nurses are the lead Implementers and Patient Advocates at the point of care. De-implementation ultimately succeeds or fails at the bedside; in the myriad micro-decisions a shift entails. It is the nurse who, in exercise of critical judgment, declines to awaken a stable, sleeping patient for a routine 2 AM vital sign check, thereby practicing sleep hygiene and fostering healing. It is the nurse who, on interprofessional rounds, feels secure enough to ask if an indwelling urinary catheter is still medically necessary, questioning its continued presence on the basis of unit protocol and patient assessment. It is the nurse who, instead of restraining an agitated patient, assembles a team to implement a package of non-pharmacological interventions (Hazazi, 2025). To do this safely and effectively, nurses must be empowered with

authority and with tools. This empowerment comes in the form of nurse-initiated protocols that provide nurses the power to shut off devices like catheters if specific criteria are fulfilled, formalized communication devices like the Situation-Background-Assessment-Recommendation (SBAR) process to support communication with providers, and an affirmative culture built on trust and respect in nursing judgment.

The success of these front-line initiatives is squarely dependent on Nurse Leaders as Culture Setters and System Designers. Chief nursing officers, clinical nurse specialists, and nurse managers have the responsibility to create the environment in which de-implementation can thrive. Their most significant role is to create a culture of psychological safety—a setting in which a nurse may question a long-standing practice or diverge from an outdated practice safely without the threat of reprisal or blame (O'Donovan & McAuliffe, 2020). Leaders accomplish this by publicly endorsing de-implementation efforts, visibly rewarding successful practice changes, and redescribing departures from low-value care as manifestations of critical thinking and patient advocacy, rather than insubordination. Beyond culture, nurse leaders are system architects. They are responsible for the strategic deployment of resources, making provision for low-value care alternatives, such as bladder scanners, pressure-relieving surfaces, and comfortable chairs for patient mobility. They promote redesign of workflow and optimization of the electronic health record (EHR), removing low-value tasks from default order sets and adding clinical decision support that prompts high-value decisions. By facilitating these changes within the overall interprofessional leadership team, nurse leaders transform de-implementation into an organizational, group priority.

Analysis of Barriers and Facilitators to De-implementation

The de-implementation path is strewn with complex, interdependent barriers that extend beyond knowledge deficiencies. An understanding of these barriers is a precondition to devising successful strategies, as simultaneously recognizing key facilitators can illuminate the path forward. The barriers to de-implementation are complex and ingrained. Cognitive Biases are a serious internal obstacle. Inertia, that powerful status-quo bias, makes cozy habits safer and easier than altering them, even when confronted with contradictory evidence. To this is added sunk cost fallacy, in which clinicians and facilities are incentivized to continue a practice because of the time, training, and resources already invested in it, so that abandonment appears to be an admission of waste instead of its correction (Niven et al., 2015). Professional Norms and Cultural Inertia are strong social barriers. Numerous low-value practices are highly ritualized, and their continuation from generation to generation of nurses as "the way we do things here" is difficult to address. Attempting to change these rituals is perceived as disrespecting older colleagues or

not being a "team player," engendering social tension that discourages innovation (Helfrich et al., 2019).

Gaps in Knowledge Translation Gaps persist. Passive publication of a clinical guideline on the Internet or in a journal is insufficient to change behavior. Failure to actively distribute, put into practice, and have evidence easily accessible in the clinical workflow—i.e., at the point of order entry in the EHR—keeps the knowledge from being accessed by the clinician at the point of decision (Grol & Grimshaw, 2003). Financial and Regulatory Organizations have a tendency to create perverse incentives. Volume over value fee-for-service reimbursement systems have a tendency to make more work, even of low value, financially rewarding. Dated hospital rituals and compulsory rituals, such as the regulations mandating 4-hourly vital signs on every patient irrespective of acuity, create a regulatory straitjacket that prevents nurses from exercising clinical judgment (Colla et al., 2015). Finally, patients and family expectations can be under a lot of pressure. Patients, based on prior experience or direct-to-consumer marketing, will request specific treatments like sleeping pills or bladder catheters for convenience. Tackling such requests, notifying patients of the accompanying harms, and negotiating alternative plans require time and communication skills that are too often in short supply during a busy shift, leading to deference as the road of least resistance (Tilburt et al., 2013).

In spite of these challenges, robust evidence establishes several facilitators that can aid successful de-implementation. Strong, Visible Clinical Leadership is arguably the most critical facilitator. Since nurse managers and senior nursing executives consistently and openly champion de-implementation, it is a serious message that the work is a priority. Leaders must do more than just insist upon change; they must actively model desired behaviors, prioritize protected time for training, and cover staff trying out new approaches (Birken et al., 2016). Strong, Contextualized Evidence is the foundation upon which to construct change. The evidence supporting de-implementation must be scientifically sound but also clearly, briefly, and emphatically conveyed in a manner appropriate to the local context. Evidence of harm to the specific population of patients being served by the organization, for instance, the unit-specific rate of CAUTIs or patient injury due to the use of restraints, is far more provocative than inconcrete nationwide rates (Prasad & Ioannidis, 2014). Interprofessional Collaboration is imperative in solving practices that cross disciplinary boundaries. De-implementation of inappropriate catheter utilization, for instance, requires physicians who write them to buy in, nurses who manage the catheters to buy in, and infection preventionists who track the results to buy in. Creating interprofessional groups to co-design and own the de-implementation effort ensures that all voices are heard and that change can be maintained (Green et al., 2017). Finally, establishing a Culture of Safety and Continual Learning is the master facilitator that enables all others. When in a psychological safety culture, an unsuccessful de-implementation attempt is not a failure to be punished but a chance to learn to be investigated. Such a culture facilitates transparency, open disclosure of errors, and innovation where employees can experiment and abandon low-value care for more high-quality, safer patient outcomes (Edmondson & Lei, 2014).

The Ethical Imperative and a Strategic Roadmap for the Future of De-implementation

De-implementation is, in and of itself, not an operational or financial strategy; it is an ethical imperative deeply rooted in the fundamental principles of nursing ethics. The ethical principle of beneficence (to do good) mandates nurses to do good for the patient by care, and the ethical principle of non-maleficence (to do no harm) mandates the practice of not doing what causes harm or pain. To perpetuate a practice proven to be harmful or ineffective is a clear violation of these two principles (Al Atiyah et al., 2024). Every unnecessary Foley catheter, every disruption in vital sign checks, and every avoidable physical restraint is a potential breach of this ethical contract with the patient. By promoting de-implementation, nurses positively serve their role as patient advocates, protecting those under their care from iatrogenic harm. Besides, with the elimination of unnecessary tasks, nurses recover precious time and cognitive bandwidth, applying their abilities to precious, patient-centered interactions such as education, emotional support, and care coordination, thereby increasing the humanistic dimension of healthcare.

For the ultimate success of this ethical mandate, a concerted and strategic effort must be launched on multiple fronts over the next couple of years. The Research agenda must be redirected from chronicling the problem to empirically testing solutions. High-quality, mixed-method studies must be used to determine the most cost-effective and effective bundles of de-implementation strategies for individual nursing practices. Research must investigate the long-term sustainability of these interventions and explore context-dependent factors dictating success or failure in different healthcare settings (Leigh et al., 2022). A paradigm shift in Nursing Education is needed. Undergraduate and graduate education must explicitly include the de-implementation and low-value care principles in addition to learning what to do. New nurses must be provided with informed evidence consumers, having the skills to identify outdated practices, and the courage to act as agents of change in complex systems. In this regard, education in implementation science, quality improvement process, and moral courage (Maashi et al., 2025) must be included.

Policy-wise, alignment is critical. Payers like government insurers and private health plans will have to continue constructing and refining payment structures that penalize hospital-acquired conditions caused by low-value care and reward outcomes achieved through high-value practices. Accrediting organizations will have to incorporate standards that require entities to have ongoing evidence-based processes of de-implementation, rather than just requiring policies for implementation. At the organizational level, Practice must transform. Health care organizations must institute a dedicated infrastructure for de-implementation, consistent with support given to implement new evidence. This entails the provision of special quality improvement support, generating robust data feedback systems that give units timely information about their performance, and leveraging to the maximum the clinical knowledge of frontline nurses using empowered shared governance councils. By investing in this multifaceted future, the healthcare community can infuse de-implementation into its DNA structurally and thus make sure that nursing practice will continue to go in a direction that is safer, more effective, and more profoundly ethical.

Conclusion

De-implementation is a necessary, but challenging, component of progressing the nursing profession and the general healthcare system. It exceeds

simply adding new work to the nurse's job and is rather focused on intuitively removing those that do not generate value. By systematically identifying and stopping low-value practice through using multi-dimensional strategies aimed at addressing knowledge, attitudes, habits, and systems, nurses are capable of launching gargantuan increases in patient safety and quality of care. Concurrently, by reducing unnecessary workload, de-implementation can alleviate burnout and allow nurses to practice at the full extent of their licensure, focusing on the clinical judgment and human care that are the heart of nursing. Implementing de-implementation is not an admission of past failure but a commitment to future excellence.

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