TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practices for Guideline Development, Implementation Science, and Evaluation

DORIS GRINSPUN, PhD, MSN, BScN, RN, LLD(hon), Dr(hc), O.ONT
IRMAJEAN BAJNOK, PhD, MScN, BScN, RN

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

UNIT

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SETTING THE STAGE

CHAPTER

1

TRANSFORMING NURSING THROUGH KNOWLEDGE: THE CONCEPTUAL AND PROGRAMMATIC UNDERPINNINGS OF RNAO'S BPG PROGRAM

Doris Grinspun, PhD, MSN, BScN, RN, LLD(hon), Dr(hc), O.ONT

LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Understand the conceptual and programmatic underpinnings of the Registered Nurses' Association of Ontario's (RNAO) Best Practice Guidelines (BPG) Program
- Define the term *Best Practice Guideline* and outline the benefits of BPGs
- Describe two artificial dichotomies in nursing and how they have influenced the nursing profession and the BPG Program
- Identify the three pillars of the BPG Program and how they inter-relate
- Learn the concepts of *scaling up, scaling out, and scaling deep*
- Discuss the factors that have secured the success of RNAO's BPG Program
- Explain the concept of *collective identity* and the role it plays in shaping and sustaining evidence-based practice cultures and BPG uptake

INTRODUCTION

"Unless we are making progress in our nursing every year, every month, every week, take my word for it we are going back."

–Florence Nightingale

This chapter shares the conceptual and programmatic underpinnings of the Best Practice Guidelines (BPG) Program led by the Registered Nurses' Association of Ontario (RNAO), the professional association of nurses in Canada's largest province. BPGs are "systematically developed statements to assist practitioner and client decisions about appropriate healthcare for specific circumstances" (Field & Lohr, 1990, p. 8). RNAO's BPGs are based on the best evidence and include recommendations for nurses, other health professionals, administrators, educators, and policymakers to improve clinical and work-environment outcomes. BPGs offer an evaluation of the quality of the relevant scientific literature and an assessment of the likely benefits and harms of a particular intervention. This information enables healthcare providers to select the best care for patients based on their preferences. RNAO's BPG Program is comprehensive and multifaceted, including guideline development, active support for implementation, and an international data system for outcome evaluation.

The chapter is organized in four main sections. The first section highlights the conceptual underpinnings for the BPG Program. It underscores a paradigmatic change in nursing to diminish unnecessary dichotomies artificially created by our profession, such as those between caring versus competence, caring versus curing, and emotional versus cognitive work. Instead, it embraces a broad conceptualization that encompasses the cognitive, physical, and relational dimensions of nursing practice, all equally important and all requiring competence and expertise. It explains why the focus on nursing knowledge, broadly defined in this way, is so important for patient, organizational, and health system outcomes, as well as the value added from a program specifically designed to develop, disseminate, and support nurses in using evidence-based knowledge in their day-to-day practice. This section also highlights the dual responsibility of individual nurses and their work environments for delivering safe, quality care.

The second section shifts the discussion from theory and concepts to the programmatic and institutional background. It recounts the 2-decade history of RNAO's BPG Program and focuses on its origins, goals, design, and evolution. It draws attention to the uniqueness of the BPG Program that focuses on: 1) guideline development; 2) dissemination, implementation, and sustainability; and 3) monitoring and evaluation. It highlights the nursing and broader context in Ontario, Canada that makes this Program possible and its extraordinary local, national, and international expansion from its inception in 1998 to date.

The third section of this chapter explores the factors that have made this Program the success it is today, drawing out lessons for others. The seven factors of focus are: location, comprehensiveness, robustness, proven results, accessibility, leading edge, and collective identity.

Finally, in the last section we explore what the next steps for RNAO's BPG Program might be, connected as they are to the local and global needs of the nursing community and the people we serve.

THE VISION: A PARADIGMATIC CHANGE IN NURSING

This book and the BPG Program it describes focus on nursing knowledge. In particular, we answer the questions: Why is evidence-based practice not commonplace in healthcare today? Why is evidence-based practice central to advance nursing care? And how does it affect patient, organizational, and health-system outcomes? Readers may think it is a given that all health professionals' practice is based on the best available evidence and question why we should focus an entire programmatic effort and this book on nursing knowledge. The simple answer is that this is not the case, and, in fact, practicing according to the latest research and evidence requires a dedicated academic, professional, and organizational effort to make it happen. It does not happen by default. The sole purpose of the BPG Program is to assist nurses, other health professionals, and the organizations and health systems in which they work to advance in this direction. To grasp the full vision of the BPG Program and why it is needed, let's first engage in an analytical discussion on what "caring" in nursing is.

"Caring" is a critical concept in the practice of nursing. Although at first glance it would appear that its meaning is obvious and shared by everyone, on closer look that simplicity disappears and a number of questions arise. Is caring a human trait or a competence? Is caring intuition or learned knowledge? Is it emotional and relational work, or is it also cognitive and physical work? Is caring the moral responsibility of each individual nurse, or a collective responsibility? As we will see, clarifying these questions, and sharpening our understanding of what nursing caring is, stands at the core of this RNAO program focused on advancing nursing knowledge.

REFLECTION

How pervasive is evidence-based practice in healthcare? In nursing? In your workplace, is your practice—and others' practices—based on evidence? If yes, what tools do you use? If not, why?

This chapter addresses these and other critical issues in nursing that explain why RNAO—a professional association for registered nurses, nurse practitioners, and nursing students in Ontario, Canada—decided to embark on a large-scale program focused on evidence-based practice (EBP).

WHAT IS CARING?

Nursing is firmly rooted in an ethos of caring and care. Considered vital to nursing, it is not a surprise that care and caring are foundational to many nursing theories and to nursing education (Benner, 1994; Bishop & Scudder, 1991; Boykin & Schoenhofer, 1993; Gadow, 1985; Leininger, 1980; Watson, 1985, 2005). The perception of nursing as a "caring profession" is also consistently expressed by members of the public (Young-Mason, 1997), by the media (Picard, 2000), and by policy analysts and policymakers (Decter, 2000).

Definitions of care and caring are diverse. The terms have been variously defined as: moral ideals (Gadow, 1985; Watson, 1999), nurturing activities (Leininger, 1978; Swanson, 1991), essential to nursing practice (Weiss, 1988), a way of practicing (Swanson, 1999), a human trait (Griffin, 1983; Ray, 1989; Roach, 1987), an effect (Forest, 1989), and an experience (Boykin & Schoenhofer, 1993).

Caring, a foundational concept for nursing, has at times been criticized as a "soft script" that has not served nurses or patients well (Buresh & Gordon, 2003; Gordon, 1997). Some argue that nurses have traditionally been socialized to follow a "virtue script" emphasizing acts of compassion over

knowledge and skill, which has served neither the profession nor the patients well (Gordon, 2005; Nelson & Gordon, 2006). Grinspun's (2010) ethnographic study on the social construction of nursing caring found that the virtue script reinforces behaviour patterns to the detriment of nurses and patients, resulting in a discourse that emphasizes emotional support and minimizes cognitive effort, competence, and expertise.

What follows are two conceptual dichotomies that help explain why RNAO embarked on an evidence-based practice program.

THE CARING-COMPETENCE DICHOTOMY

Halldórsdóttir (1997) points out that the "artificial dichotomy between caring and competence that has emerged in some of the existing scholarly work is most unfortunate, given that nursing is a practical science in which competence is primary, especially from a patient's perspective" (p. 105). She argues that promoting nursing as both an art and a science requires competence and caring as essential ingredients. The patients she interviewed consistently emphasized competence as an essential professional caring component and stated that caring without competence is of little value. At the same time, professional competence does not mean becoming less human. Halldórsdóttir's interviewees explicitly emphasize the human aspects of nursing care: showing genuine concern and respect for individual patients, accepting patients as they are, and acknowledging pain and suffering. Her central message is that "patients do not see caring and competence as dichotomous; rather, they perceive them as two elements that have to go hand in hand to be of any value to professional caring" (Halldórsdóttir, 1997, p. 110). Calman's (2006) conclusions are similar, with patients viewing knowledge and technical skills as threshold competencies that are necessary but not completely sufficient. In a like manner, Liu, Mok, and Wong (2006) report that nursing caring as perceived by Chinese cancer patients includes qualified professional knowledge; attitudes and skills in oncology; and useful informational, emotional, and practical support. This view is reinforced by Grinspun's (2010) doctoral dissertation in which a central finding is that "caring is not only a relational or emotional process, but also one involving intellectual and physical effort" (p. 12).

Knowledge as a foundational concept in nursing is an implicit expectation for patients and at times for nurses themselves. Indeed, research shows that the public and patients assume nurses are always competent, and even if some were to question it, their ability to assess such competence is often nonexistent—especially in terms of clinical knowledge and technical skills. Calman (2006) suggests that most patients take technical and clinical competence for granted, assuming that hospitals are concerned about hiring competent nurses. If true, this addresses the conflicting evidence concerning what patients value. Calman (2006) writes that the literature on the subject has advocated either interpersonal or technical skill. His study indicates that both interpersonal and technical skill are important as the foundation of competent practice, but that patients may not highlight this because it is seen as in the domain of nurses and not patients, and it is assumed to be always present (Calman, 2006: p. 722).

Rejecting a caring-competence dichotomy is a step in the right direction, but one that requires conceptual distinctions between caring (defined in the narrow sense of affect and love) and competence (defined in the narrow sense of physical and cognitive work). Such distinctions are problematic in several ways. First it implies inborn capabilities for relational caring. Second, it implies that the physical and cognitive work of nurses are not ways of caring. To avoid this artificial dichotomy, it is necessary to conceptualize two dimensions of caring work: 1) caring broadly encompasses all practice domains, and 2) competence in all practice domains is required for effective caring encounters to take place.

REFLECTION

How have you experienced the caring-competence dichotomy in your nursing education and/or practice?

In our BPG Program, we envision that all domains of nursing practice—whether emotional or clinical—require competence, and that facilitating access to evidence serves to advance competence and expertise.

THE CARING-CURING DICHOTOMY

Another problematic and, again, artificially created dichotomy is that of the caring-curing paradigm. Moland (2006) argues that a narrow definition of caring puts nurses in a lower position to physicians, who are charged with curing—a role based on scientific knowledge and technical expertise. This reflects poorly on nurses' moral integrity, contributes to their self-deprecation as knowledge workers, and reduces opportunities for physicians to see them as such (Moland, 2006).

A caring-curing dichotomy poses significant challenges for nurses wanting workplace equality since it assumes that one health professional uses the heart to provide comfort, while the other uses the brain to address clinical problems. Consistent with this image, one profession commands love from patients and the other respect. It is unfortunate to encounter interactions where nurses are discussing clinical situations with physician counterparts and observe them present their expertise in the form of suggestions rather than assertions of knowledge (Grinspun, 2010).

RNAO's BPG Program is envisioned as facilitating access to rigorous evidence for all domains of nursing practice including health promotion (e.g., prevention of child obesity), disease prevention (e.g., smoking cessation), and curative aspects of clinical care where nurses play a leading role (e.g., wound care for persons with diabetes).

REFLECTION

What roles do nurses themselves play in perpetuating or dispelling views associated with the caring-curing dichotomy? How can we all help each other be more vigilant in dispelling this dichotomy?

REDEFINING CARING AS COGNITIVE, PHYSICAL, AND RELATIONAL WORK

Partial definitions of nurses' caring work as mainly emotional and relational work, compounded by interprofessional hierarchies and organizational structures that to this date venerate (or fear) physicians over all other health professions, have detrimental consequences for patients and the health system as a whole. The most harmful consequence (and by no means the only one) is the silencing of nurses' knowledge (Grinspun, 2010: p. 193). The human tragedy and suffering that result from silencing nursing knowledge is palpable and devastating (Grinspun, 2010: p. 269); it was, for example, in full display in the court case of a paediatric cardiac surgeon who was held responsible for the deaths of twelve infants in a Canadian hospital in Manitoba. The hearing transcripts indicate that the hospital administrators described staff nurses as "emotional" when they repeatedly expressed concerns about clinical malpractices and the excessive number of deaths associated with the male surgeon. The investigators concluded that the experiences and observations of nursing staff throughout 1994 led them to voice serious and legitimate concerns, but they were ignored (Manitoba Health, 2001; Sinclair, 2001).

Indeed, nurses' knowledge and nurses' ability to contribute their knowledge to advance excellence in clinical care are strongly influenced by status and power (Grinspun, 2007, 2010). The delegitimizing of nursing knowledge as "intuition" is a case in point. One can often hear nurses describe a "gut feeling,"

a "hunch," or "intuition," when what they are actually describing is a sophisticated process of rapid cognition. Rapid cognition is "expert knowledge that allows nurses to grasp patterns across multiple patients and clinical scenarios and correctly apply them to new clinical situations. Rapid cognition requires advanced clinical knowledge, pattern recognition, and patient-specific knowledge gained through relationship continuity" (Grinspun, 2010, p. 178). Labelling such a sophisticated cognitive process as "intuition" belittles nursing knowledge and harms patients who may not get the full benefit of this disempowered knowledge.

REFLECTION

Why is it important for nurses and for patients that we view caring from a perspective of cognitive, physical, and relational work rather than mainly an emotional response?

The BPG Program powers a conceptualization of nursing caring practice that encompasses cognitive caring (e.g., clinical knowledge, care planning), physical caring (e.g., bathing), and relational caring (e.g., communication, touch, presence, compassion). In this way, the Best Practice Guidelines support excellence in nursing care and serve, also, as a megaphone for nurses to speak about their practice.

CARING: AN INDIVIDUAL AND COLLECTIVE RESPONSIBILITY

The work of nurses with patients—in all its domains—takes place within the social organization of a particular workplace—be that a primary care clinic, hospital unit, a patient's home, a long-term care home, a school, or anywhere else that nurses work. Thus, understanding the work environment of nurses and shaping it in a way that advances good nursing care is paramount to good nursing outcomes.

Understanding nurses' caring work as a labour process that, like other human services, is historically and socially constructed under specific conditions, values, and power relations is paramount to enable nurses to deliver safe and quality services (Grinspun, 2010). For example, much has been written about the detrimental impact on patient outcomes that results from reducing the number of registered nurses (RN) in hospital care (Aiken et al., 2001; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Aiken et al., 2016; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002; Needleman, Buerhaus, Stewart, Zelevinsky, & Mattke, 2006; RNAO, 2017a), yet the replacement of RNs with less-qualified personnel continues in Canada and elsewhere. Others have written about the impact of organizational models of care delivery, arguing that models that promote continuity of care and avoid care fragmentation—such as primary nursing—are preferred (Grinspun, 2010; Meyer, Wang, Li, Thomson, & O'Brien-Pallas, 2009; RNAO, 2006). Such models, however, come into sharp contradiction with cost-driven recommendations made by business consultants, who often promote organizational models that move away from an all-RN staff and emphasize a skill mix with larger proportions of less-educated personnel using RNs in mainly a coordinating capacity (Cummings, 2006; Urden & Walston, 2001).

This perspective, which emphasizes the importance of workplace social relations, assumes that enacting caring practices for patients—whether emotional, physical, or cognitive—is a collective responsibility involving important labour processes that can advance or hinder optimal care. Understanding the labour processes of nurses' work helps us address the systemic and structural enablers and blockages that affect their care. Indeed, "nurses' caring work is socially constructed in the context of their day-to-day private and working lives and impacted by cultural, socio-political and economic realities" (Grinspun, 2010, p. 11).

Such is the reason behind the three main areas of best-practice recommendations provided in each guideline: 1) practice recommendations, or what nurses need to do to optimize patient outcomes; 2) education recommendations, or what nurses need to know to deliver optimal nursing care; and 3) organization and policy recommendations, or what organizations need to do to optimize the uptake of knowledge and the ability to enact that knowledge in daily practice. RNAO has further acknowledged the centrality of work environments by augmenting the clinical BPGs with work environment BPGs. Chapter 2 focuses on clinical guidelines, and Chapter 3 focuses on work environment BPGs.

REFLECTION

How do organizational contexts and power relations impact the practice of nurses? Have you experienced such impacts in your work and/or school?

Shifting from the conceptual underpinnings of the BPG Program, we will now move to the context that made this Program possible and facilitated its evolution.

ORIGINS AND EVOLUTION OF RNAO'S BEST PRACTICE GUIDELINES PROGRAM

During 1996 and 1997, there was widespread disruption in Ontario's hospital system as a result of restructuring and layoffs of nurses. RNAO took on a leading role during this difficult period, which led to a positive engagement with government. In 1997, the Ontario government passed the *Expanded Nursing Services for Patients Act*. In March 1998, following RNAO's *Putting Out the Healthcare Fire* report (RNAO, 1998) and meetings with Ontario's Premier and Minister of Health, the government announced at RNAO's Annual General Meeting in April of 1998 the establishment of the Ontario Nursing Task Force to enhance the quality of patient care through the effective use of nursing resources (RNAO, 2013). Its 1999 report, *Good Nursing, Good Health: An Investment for the 21st Century*, recommended several strategies designed to help Ontario retain and attract nurses, improve working conditions for nurses, and ensure nurses have the knowledge and skills they need to provide care in an increasingly complex environment (Ontario Ministry of Health and Long-Term Care—Nursing Task Force, 1999). One of the report's recommendations was to establish clinical models in practice environments to allow nurses to gain expertise in clinical areas and be recognized for these additional skills. RNAO leveraged this recommendation to submit a proposal for funding a program on evidence-based guidelines.

REGISTERED NURSES' ASSOCIATION OF ONTARIO (CANADA)

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses, nurse practitioners, and nursing students in Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contribution to shaping the healthcare system, and influenced decisions that affect nurses and the public they serve.

RNAO's strategic directions are:

- Engaging with registered nurses, nurse practitioners, and nursing students to stimulate membership
- Influencing public policy that strengthens Medicare (Canada's universal publicly funded and administered healthcare system) and impacts on the determinants of health
- Advancing the role and image of nurses as members of a vital, knowledge-driven, caring profession, and as significant contributors to health
- Speaking out on emerging issues that impact nurses and the nursing profession, health, and health services (RNAO, n.d.-a)

RNAO had the capability and experience to lead this initiative on behalf of the nursing community. We had already gained experience creating nursing guidelines based on the best available evidence (Grinspun, Librado, & Góngora, 2005). RNAO also had the social and professional networks required to disseminate the guidelines across Ontario and Canada. RNAO's initial proposal recommended that the guidelines be developed in areas where nursing has an impact on health and clinical outcomes so they could benefit a significant number of people. We reminded government that poll after poll shows the Canadian public considers nursing the most trustworthy of all occupations and that BPGs are a critical tool to support nurses in their day-to-day practice. Indeed, BPGs serve to augment the public's deep trust for nurses by strengthening nurses' clinical and organizational knowledge. In 1998, Ontario's Minister of Health Elizabeth Witmer saw the potential of BPGs, and in 1999 she allocated multi-year funding to RNAO to create a dedicated program for BPG development and implementation.

PURPOSE, GOALS, AND OBJECTIVES OF THE BPG PROGRAM

The BPG Program was officially launched in 1999 by RNAO in partnership with the Ontario Ministry of Health and Long-Term Care (MOHLTC). The purpose of the Program from its inception has been to support Ontario nurses—registered nurses (RN), nurse practitioners (NP), and registered practical nurses (RPN/LPN)—by providing them with Best Practice Guidelines (BPG) for client care. We envisioned this would advance nurses' opportunities to assert their clinical and relational competence and expertise based on the most relevant evidence. This emboldened capacity would inspire action at the individual level of each nurse and nursing student, and, by extension, to the collective levels of service and academic organizations, and influence the broad spectrum of health policy. In doing so, nurses would optimize their contribution to patients, organizations, and health system outcomes.

The goals of the Program are to:

- Improve the consistency and quality of nursing care across the province of Ontario
- Increase access to quality nursing services
- Disseminate resources as broadly as possible so that maximum benefits are achieved for clients, nurses, and the health system

The Program objectives are to:

- Develop, implement, and evaluate three nursing BPGs per year
- Review and revise the BPGs every 5 years
- Develop and implement effective dissemination and implementation mechanisms to secure uptake and sustainability of BPGs
- Evaluate the development, dissemination, and implementation processes, as well as the outcomes associated with the BPGs

BPG PROGRAM: DESIGN AND PURPOSEFUL EVOLUTION

We recognized early on that the traditional tightly planned, and often top-down, approach used by health managers would not produce the type of social engagement needed to deliver substantive and sustained clinical, organizational, and health system change through the BPG Program. Our approach needed to be multifaceted and include magnetic processes that would attract nurses to mobilize their internal commitment and energy to become the drivers for change. In a manner consistent with RNAO's overall approach to working with our members, the BPG Program emulates a grassroots movement—one that both creates and delivers the changes proposed by the clinical guidelines. The end goal of this movement has been, by design, consistent and clear: to advance evidence-based practice and improve patient, organization, and health system outcomes. A secondary goal, one we have not shied away from, is to position nursing and nurses as knowledge professionals and robust contributors to health outcomes.

An important feature of the BPG Program has been its purposeful evolution, both as a comprehensive Program and in each of its components. *Purposeful evolution* means that we make conscious and intentional decisions about slowing down or accelerating growth and expansion; thus, we decided early on that needs from the field and readiness at RNAO would drive the growth and evolution of the Program. This purposeful evolution enables us to ensure a dynamic, evergreen Program that is responsive to the needs of Ontario's health system, patients, and nurses. This has also enabled us to evolve the Program and move beyond the borders of the province of Ontario, embracing both the Canadian and global community—something we did not envision in 1999. At this time, we are fully cognizant of the opportunities with the international expansion of the Program, as well as the potential challenges such growth entails. The positive outcomes of this purposefully (by design) evolutionary approach, discussed in detail in Chapter 12, are evident as well in each of the other chapters of this book. Figure 1.1 shows the BPG Program model with its three pillars.

REFLECTION

What advantages are there to having the guideline development, implementation, and evaluation pillars all part of the same program? Do you see any disadvantages? If yes, how could they be overcome?

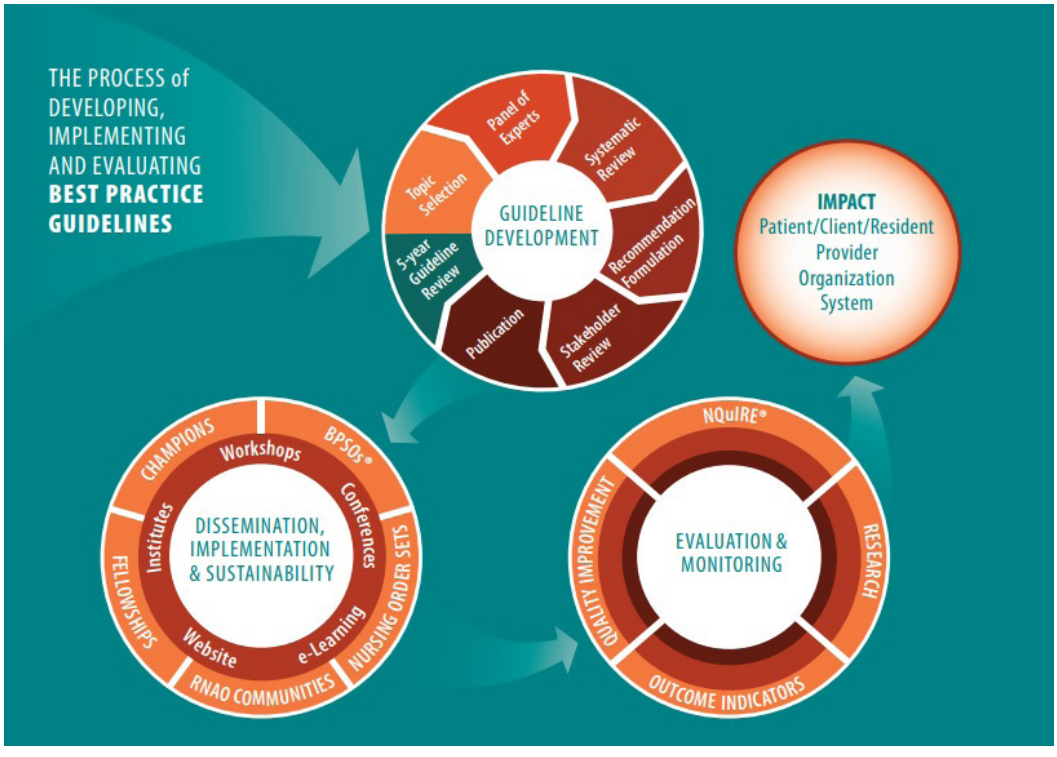

FIGURE 1.1 BPG Program model.

KEY FEATURES OF RNAO'S BPG PROGRAM

The key features of the Program are highlighted in this section, and a detailed account of each main component follows in later chapters of this book.

BPG DEVELOPMENT

The first four BPGs were developed by the end of 2000, pilot tested in 2001, and publicly launched and published in 2002 (Scarrow, 2008). In 2003, we decided that in addition to evidence-based guidelines that advance the clinical practice of nurses, there was an urgent need for evidence-based guidelines to enrich work environments. By 2003, RNAO had issued 17 clinical guidelines and an evidence-based "toolkit" for organizations to implement guidelines (JPNC Implementation Monitoring Subcommittee, 2003). The speed of progress continued sharply in response to demands from the field. By 2008, there were 31 clinical guidelines and six healthy workplace BPGs produced and in use all over Ontario and across Canada (Scarrow, 2008).

To ensure currency of the evidence, we began slowing down new guidelines' production to produce the next generation of the existing guidelines. In 2017, the BPG Program counted 41 clinical guidelines, as well as 12 Healthy Work Environment Best Practice Guidelines (e.g., prevention of violence in the workplace) and/or health system guidelines (e.g., transitions of care). RNAO's unwavering commitment to maintaining a rigorous guideline revision cycle has resulted in a trusted and dependable relationship between RNAO and its guidelines users and funders. The focus of Chapter 2 is the development of our clinical practice BPGs.

BEST PRACTICE GUIDELINE DISSEMINATION, IMPLEMENTATION, AND SUSTAINABILITY

RNAO's plans from the outset included broad dissemination of the evidence-based guidelines and active support for their implementation. The implementation works at three levels singularly and/or collectively: the micro level of individual nurses, meso level of service and academic organizations, and macro level of health systems. The goal is to ensure effective, sustained, and scalable implementation of BPGs in both clinical and management practices. Today, RNAO leads what is likely the most robust and expansive implementation program for evidence-based practice for nurses anywhere in the world, and is amongst the strongest in any healthcare field. This is the result of a zealous approach dedicated to implementation science combined with constant attention to learning from and responding to in-the-field needs. The BPG Program has purposefully evolved over time, both in its depth and breadth of understanding, as well as its ability to mobilize evidence-based knowledge.

The work of Moore, Riddell, and Vocisano (2015) discusses social entrepreneurship program expansion in three ways: 1) *scaling up*, or expanding coverage; 2) *scaling out*, or altering the policies, laws, and standards; and 3) *scaling deep*, or changing the norms. They argue that to maximize the benefits from implementation efforts, all three aspects of scaling are important. Adapting these concepts to RNAO's Program, we engage in scaling up when BPGs are disseminated widely within an organization; scaling out, when they are disseminated to other organizations or to the health system; and scaling deep, when uptake and sustainability have occurred and an evidence-based culture has been achieved. Scaling deep can occur within an organization or across the health system, especially through policy impact. We use these concepts to briefly describe the evolution of RNAO's BPG implementation.

REFLECTION

How has RNAO's status as a professional association influenced scaling of the BPGs?

SCALING UP: DISSEMINATION AND UPTAKE

The focus of scaling up is on wide dissemination and uptake of BPGs within an organization. Our first broad dissemination initiative was the development of *Champions*. We began to train individual nurses as BPG Champions in 2002 to facilitate BPG uptake in their workplaces. By 2003 we had 278 champions in all sectors of Ontario's healthcare system (JPNC Implementation Monitoring Subcommittee, 2003). At first, all the Champions were direct care RNs; over the years the role has evolved to include all nurses and other health professionals in all roles. From the outset and to this day, these are individuals selected by their organizations (and in many organizations, selected by their peers) and/or who volunteer for this role. Such a bottom-up approach helps ensure role sustainability. Champions are passionate about evidence-based practice and improving people's care and health. They raise awareness of BPGs, support understanding, and influence their uptake amongst workplace peers. In 2002, with already hundreds of Champions trained, we launched the *Champions Network* to foster active engagement and knowledge exchange amongst Champions and between them and RNAO.

Now, through this program, over 50,000 volunteer champions access tools and strategies such as in-person workshops, teleconferences, webinars, and online modules. Details of this program are discussed in Chapter 4. The program has expanded to include Certified BPSO Orientation Trainers and Certified BPSO Auditors. These new roles are discussed in Chapter 12.

The next evolution of the BPG Program was the creation of *Best Practice Spotlight Organizations* (or BPSOs) to support healthcare organizations in systematically implementing guidelines. BPSOs were first launched in 2003 in Ontario. We worked with the first seven healthcare organizations to jointly co-create a structured approach for organizations to use BPGs and evaluate their impact (RNAO, 2004). Designation as a BPSO involves a competitive application process and is reserved for healthcare and academic organizations that are selected to sign a formal 3-year agreement to implement multiple BPGs. The criteria here have also purposefully evolved. For example, the request for proposals (RFP) requirement for the first three BPSO cohorts in Ontario was to implement a minimum of three clinical BPGs of their choice. The RFP requirement for cohorts four and five was to implement a minimum of five BPGs of their choice. Starting with cohort six (the current one at time of writing), the RFP stipulates two BPGs of their choice and three common to their healthcare sector (public health, primary care, hospital, home care, nursing home, etc.). Currently with 550 BPSOs worldwide, as illustrated in Figure 1.2, the global BPSO network, such an approach allows for robust data to fuel evaluation and comparison of outcomes in like organizations. BPSOs have a choice to renew their agreement following successful completion of their first 3-year agreement. Each renewal is for 2 additional years during which they commit to ongoing spread of existing guidelines, uptake of two new guidelines, and evaluation of their impact on outcomes.

FIGURE 1.2 Map of global BPSO network.

BPSO MODELS

The Best Practice Spotlight Organization (BPSO) Designation is an opportunity for health service and academic organizations to formally partner with RNAO over a 3-year period. Following this period, the partnership is renewed biennially. The goal of the partnership is to create evidence-based practice cultures through systematic implementation and outcomes evaluation of multiple RNAO BPGs.

There are two BPSO models for service and academic organizations considering applying to achieve their BPSO Designation:

- The *BPSO Direct Model*—Best suited for single organizations wishing to apply to RNAO to engage in the 3-year partnership. These organizations work directly with RNAO to meet the BPSO requirements designation. In Ontario, health organizations that are part of this program are BPSO Direct.
- The *BPSO Host Model*—Best suited for organizations that have the capacity to run, on behalf of RNAO, the full BPSO Designation program for a group of health and/or academic institutions within a country, region, or community. In this model, the BPSO Host enters into a formal agreement with RNAO to deliver and oversee the RNAO BPSO Designation in the country or region where it is located. The BPSO Host is responsible for selecting the BPSO Direct organizations; providing orientation, education, and support; monitoring progress; and evaluating outcomes. The BPSO Host submits regular reports to RNAO. The BPSO Host acts as the liaison between RNAO and the BPSOs in the specific country, region, or community—ensuring full consistency and systematic deployment of all aspects of the RNAO BPG Program, including: guideline implementation, evaluation, sustainability, spread, scaling-up, and scaling-out.

RNAO supports BPSO Hosts and BPSO Direct Organizations outside of Ontario with materials, methodology, and ongoing mentorship—free of charge. In turn, BPSOs do not receive funding from RNAO and must secure the resources to fully manage the BPSO.

In 2010, the BPG Program opened its doors internationally when the government of Spain approached RNAO—first to collaborate in translating the guidelines into Spanish and subsequently to support the creation of a network of BPSOs in that country. This was an important opportunity; Spain is a country with over 46 million people and 164,385 nurses (in 2015). The translation of RNAO's BPGs into Spanish has been critical to opening access to RNAO's BPGs to the world's millions of Spanish-speaking nurses and other health professionals. It also led to envisioning a model that would enable expansion and sustainability of the BPSO Designation at home and abroad; with this the BPSO Host—which coordinates a network of BPSOs—was born. These important developments and their outcomes to date are highlighted in Chapters 12 and 13.

Expanding nationally and internationally was an important leap in RNAO's BPG Program, and the results are impressive. In 2014 RNAO had 370 BPSO sites across Ontario, Quebec, Nova Scotia, and outside Canada; today we have 550. Chapter 6 details the work of BPSOs. We envisioned BPSOs as living labs that would enable us to demonstrate how nursing care, based on evidence contained in RNAO's

BPGs, improves patients' health as well as organizational and health system outcomes. Chapters 7, 8, 9, 11, 13, 14, 15, and 17 discuss the experiences of BPSOs in their own voices and show a vision that is now a lived reality.

BPSOs have proven to be a powerful mechanism to spread and sustain the use of RNAO's BPGs and very effective in enabling a sense of collective identity amongst the participants, a concept I will return to later on in this chapter. They have also nurtured a culture of evidence-based practice in healthcare organizations (Bajnok, Grinspun, Lloyd, & McConnell, 2015; Grinspun, 2011). Its success has been acknowledged both in Canada (Health Council of Canada, 2012) and internationally (WHO, 2015).

REFLECTION

How does a common language in nursing, derived from use of RNAO's BPGs, shape the profession and its impact worldwide?

SCALING OUT NATIONALLY AND INTERNATIONALLY

The Program has also evolved in its breadth, and many Ontario-born programs have been scaled out to the national and international levels. For example, recognizing the expertise of RNAO, the Canadian Patient Safety Institute (CPSI) approached RNAO to act as a national lead agency on falls prevention and to develop a resource on *Falls Prevention/Injury Reduction Getting Started Kit*. Over the past 10 years, based on the highly popular BPG on falls widely used in all sectors, RNAO has partnered with CPSI on a number of falls-related *Safer Healthcare Now!* programs—National Collaborative for the Prevention of Falls in Long-Term Care (2008–2009), Falls Virtual Collaborative (2010–2011), and Falls Facilitated Learning Series (2011–2012)—and it has developed a highly beneficial resource on sustainability of falls-prevention programs. RNAO co-hosted all these national activities with CPSI, drawing on lessons obtained from the Long-Term Care (LTC) Best Practices Program initiated in Ontario in 2005, which has led to improved quality of care for residents and the facilitation of an evidence-based practice culture amongst direct care staff through the implementation of BPGs in LTC homes. Chapter 10 provides details on the scaling initiatives, including RNAO's work with CPSI as their falls lead, leveraging RNAO's BPG on falls. In Chapter 11, the Long-Term Care Best Practices Program is outlined in full, describing both its key success and effective scaling components.

APPLYING TECHNOLOGY-ENABLED TOOLS

The BPG Program recognized from the outset the value of technology-enabled tools to support nursing practice. A first of its kind, it created evidence-based practice "nursing order sets" derived from the practice recommendations of RNAO's BPGs. It also developed an *eHealth Toolkit* (RNAO, 2009). More recently, it launched the *Adopting eHealth Solutions: Implementation Strategies BPG* (RNAO, 2017b) with funding from Canada Health Infoway, an independent, federally funded, not-for-profit organization tasked with accelerating the adoption of digital health solutions across Canada (Punch, 2017). These tools, detailed in Chapter 5, are designed to facilitate the translation of evidence into nursing practice, using technology.

Through such eHealth innovations, and in particular the nursing order sets, RNAO has earned the accreditation—one of only 15 centers in the world, and the first in North America—as a Research & Development Centre working under the International Classification for Nursing Practice (ICNP) (International Council of Nurses, 2013). The accreditation recognizes RNAO's ongoing contribution to the International Council of Nurses' (ICN) eHealth Program through the development of ICNP codes derived from RNAO's nursing order sets and BPG outcome measures.

RNAO's nursing order sets are evidence-based interventions and clinical decision support resources derived from RNAO's clinical BPGs (RNAO, n.d.-b). They enable the integration of the best available evidence into daily clinical practice using technology to facilitate access at the point-of-care. Nursing order sets support the evaluation of BPG implementation by providing a mechanism to link specific interventions to corresponding evidence-based indicators. Each intervention statement is aligned with the ICNP terminology language to support the standardized collection and exchange of nursing information globally.

Another BPG spawning example is the Pan-Canadian *Prevention of Abuse and Neglect of Older Adults* Best Practice Guideline Initiative, which is focused on recognizing, managing, and preventing the abuse and neglect of older adults throughout various healthcare institutions and community settings in Canada. Funded by the Government of Canada's New Horizons for Seniors Program, this initiative includes development of an evidence-based BPG by RNAO; a strategy for dissemination, implementation, and evaluation; practice tools; an e-learning program; and plain-language resources for the public. The initiative builds on the success of a collaborative project between RNAO and the Canadian Nurses Association (CNA), also funded by the federal government, which launched the Prevention of Elder Abuse Centres of Excellence (PEACE) in 2010 in 10 long-term care homes across the country.

REFLECTION

What impact has the integration of evidence-based practice and technology in RNAO's implementation resources had on the uptake of both?

Similarly, the Nursing Best Practice Smoking Cessation Initiative started in Ontario and then expanded across the country in partnership with CNA with funding from Health Canada. It tackles the leading preventable cause of premature death, disease, and disability, based on evidence suggesting that even minimal intervention by healthcare professionals can dramatically reduce rates of smoking. With a focus on knowledge transfer, mobilization of networks, and increased use of existing services and programs, the goal of this national initiative is to strengthen nurses' capacity to help their clients by implementing smoking cessation strategies and techniques in their daily practice. By 2013, the Initiative had formally reached 350 organizations and established over 2,600 Smoking Cessation Best Practice Champions across Canada. This program is detailed in Chapter 10.

REFLECTION

What factors have been pivotal to the success of several provincial and national initiatives that have been based on the BPGs?

Although the BPG Program is based in Ontario, it is deeply significant across Canada and internationally. As evidence of this, BPGs have been translated into French, Spanish, Chinese, Japanese, German, and Italian. Moreover, some 30 of RNAO's clinical BPGs are available on the National Guideline Clearinghouse (NGC), a website established by the Agency for Healthcare Research and Quality (AHRQ), part of the U.S. Department of Health and Human Services. Chapters 13, 14, 15, and 17 share some experiences of BPSO international partners.

SCALING DEEP: TRANSFORMING VALUES AT THE INDIVIDUAL, ORGANIZATIONAL, AND HEALTH SYSTEM LEVELS

Its location within a professional nursing association enriches the BPG Program because it provides a large voluntary membership of RNs, NPs, and nursing students ready to adopt and test the BPGs. Thus, identifying an initial base of early adopters and a testing ground for BPGs was never an issue for RNAO. RNAO's network of professional links to other nursing and non-nursing associations has also benefited the Program. As you will read in Chapter 18, non-nursing partners see the benefits of RNAO's expertise in guideline development and implementation, as well as its powerful impact in health, healthcare, and nursing policy. Being part of a large professional association also means having expert staff. RNAO is organized in seven departments, each with extensive expertise in their fields: Executive Office; Membership and Services; International Affairs and Best Practice Guidelines (IABPG—the department responsible for the BPG Program); Nursing and Health Policy; Communications; Information Management and Technology; and Finance and Administration.

RNAO's work is always strategic, analytical, and actionable. Thus, while one often hears about the need to leverage nurses' expertise into the policy arena (Cohen et al., 1996; Ellenbecker et al., 2017), RNAO acts on this mandate and brings about deep individual, institutional, and broad health system changes in both practice and policy. The BPG Program has been central to RNAO's policy work in areas of nursing practice and work environment. In turn, RNAO policy work has influenced the development of specific BPGs. An example of the latter is a BPG being developed at the time of writing related to nursing care in supervised injection services; more on this in Chapter 18.

Various chapters in this book reflect on deep practice and policy changes that are taking place within BPSOs. For example, Chapter 14 describes changes in scope of practice at a large BPSO hospital in China resulting from nurses' added expertise in wound care using RNAO's guideline. These nurses in China have internalized guideline knowledge and speak with pride about being BPSO Champions, assuming the role with seriousness and sophistication. Chapter 15 describes improvements in human and material resources when nurses give proof that mattresses modified based on BPG descriptions were bringing positive results, causing the hospital administration to approve funding to change all mattresses. In Chapter 17, the Australian Nursing and Midwifery Federation (SA Branch) influences policy by showing the value added of expert clinical nurses using BPGs.

Chapter 18 displays RNAO's capacity to leverage BPGs into policy gains and vice versa. It focuses on the important augmentation of the BPG Program and the richness that ensues when evidence-based clinical knowledge meets evidence-based policy and advocacy knowledge. If pursued vigorously, the outcome is the collective good of our health systems and the people we serve. Scaling deep often leads to the formation of collective identity, which is one of the most impactful outcomes of the BPG Program.

MONITORING, EVALUATION, AND RESEARCH

The next step in the purposeful evolution of the BPG Program was devising a system to monitor and evaluate the impacts of RNAO's BPGs in organizations that implemented them. The impacts can span the whole spectrum of outcomes, from provider and patient to organizational to health system performance. For this purpose, RNAO partnered with BPSOs in Canada and abroad to understand their needs and capacity, leading to the launch of another first-of-its-kind—a comprehensive and free of

charge international data system available to all BPSOs. The *Nursing Quality Indicators for Reporting and Evaluation* (NQuIRE) project consists of a database, an online data-entry system, a data dictionary—including a set of organization-level structural indicators and a set of process and outcome indicators for each BPG—as well as data collection and reporting processes (RNAO, n.d.-c).

Through NQuIRE, RNAO collects, analyzes, and reports quality-indicator data submitted by healthcare service and academic BPSOs. NQuIRE supports BPSOs in making effective practice improvements by providing organizational and comparative data on BPG-directed nursing care processes and resulting clinical outcomes. With NQuIRE data, BPSOs are able to track their progress, identify areas for improvement, highlight areas for further investment, and advance quality improvement to optimize clinical, organizational, and health system outcomes. By monitoring, evaluating, and reporting quality improvements in nursing care across the globe, NQuIRE is producing BPSO-validated and endorsed quality indicators that will contribute to sustainability and enhance our understanding of the full impact of evidence-based nursing practice on healthcare quality and health outcomes. Chapter 16 details the progress and outcomes available through NQuIRE, and its utility for particular BPSOs is described in various chapters.

REFLECTION

How do you think such a robust and comprehensive system for evaluation of BPG use will impact the Program and those who adopt the BPGs?

THE BPG PROGRAM: FROM LOCAL IMPACT TO SEISMIC TRANSFORMATION OF NURSING PRACTICE GLOBALLY

Funded by Ontario's Ministry of Health and Long-Term Care, and independently run, the BPG Program attracted from its inception broad provincial interest in the then-emerging field of clinical guideline development. In the early 1990s, McMaster University had launched its evidence-based curriculum for medicine in Ontario (Guyatt, 1991), and RNAO took the lead in nursing's movement into evidence-based practice. The delivery of the first four guidelines quickly demonstrated RNAO's capacity to develop quality products. Guidelines, however, could have remained on library shelves if it had not been for the parallel and rich program RNAO developed to advance the uptake and utilization of the guidelines in day-to-day clinical practice. This groundbreaking pillar of the BPG Program cemented its place as a leader in implementation science. Already in 2005, RNAO was featured internationally as a robust clinical guideline program (Jordan, 2005) and sought after for its expertise in both guideline development and knowledge translation. While evaluation was a component of the Program from the outset, the systematic evaluation of BPG impacts on patient outcomes evolved through the years from independent evaluations by its implementers to co-creation of the NQuIRE quality indicators system described above and in Chapter 16.

The BPG Program has achieved remarkable accomplishments and demonstrated vast capacity for rapid expansion and innovation since its start in 1999. Developing RNAO's vision and evolving it purposefully throughout the years has greatly contributed to its success. RNAO has guided the Program from inception to maturity in an organic way, informed at the macro level by theories about diffusion of innovation and large-scale system change (Edwards, Rowan, Marck, & Grinspun, 2011; Moore et al., 2015; Rogers, 1962, 2003) and social movements literature (Melucci, 1980, 1989, 1996); at the meso

level by knowledge-transfer scholarly work (Curran, Grimshaw, Hayden, & Campbell, 2011; Grimshaw, Eccles, Lavis, Hill, & Squires, 2012; Sales, Smith, Curran, & Kochevar, 2006; Shekelle, Woolf, Eccles, & Grimshaw, 1999; Straus, Tetroe, & Graham, 2013), and field experience from nurses and organizations—especially our BPSO partners.

At the core of these perspectives is a deep respect, understanding, and accounting for local context and both top-down and bottom-up dynamics. Instead of delivering on a vision fully set by RNAO for others to follow, we chose a beginning path for a program that would advance evidence-based practice in nursing. This path has subsequently been shaped, modified, and adapted, based on new evidence and the evolving socio-political context, to remain responsive to the needs of Ontario, Canada and the world. For example, while other clinical guidelines programs have plans for guideline development decided years in advance, RNAO's flexible approach allows it to respond to evolving provincial and national priorities such as it did when moving ahead with the development of a guideline for Supervised Injection Services (discussed in Chapter 18), or partnering for the eHealth BPG mentioned earlier. Similarly, our implementation plans evolved to embrace national and international nursing organizations in response to their interest in participation. Undoubtedly, central characteristics of this winning vision have been to be good listeners, responsive to context, and committed to shared ownership. Although RNAO has led the effort, the reality of the BPG Program today has been collectively shaped by multiple actors engaged at all levels of the Program.

LARGE-SCALE BPG PROGRAM SPREAD: SUCCESS FACTORS

Multiple factors have contributed to the large-scale spread of the BPG Program and advancing it from producing localized systemic change to leading a seismic transformation of nursing care worldwide. Each chapter that follows highlights various contributing factors that are important. Stepping back and reflecting on the 20 years that have passed since launching the Program, seven broad features of the Program appear central to its success:

1. **Location**—The BPG Program is enriched by being located within a professional nursing association. At the structural level, RNAO's membership-driven association means that there are already thousands of nurses on board, eager to uptake the knowledge contained in the BPGs, apply it to their work, and bring it to patients and to their organizations. It also means that a large group of nurses in all roles and sectors have knowledge needs for which they would like evidence-based answers. The fact that RNAO is composed of a large staff of experts in policy, communications, and information technology means a constant attentiveness to support the BPG Program in succeeding.
2. **Comprehensiveness**—The Program offers nurses, healthcare organizations, academic institutions, and health systems—anywhere in the world—a "full package" inclusive of guidelines, implementation, and evaluation mechanisms to advance evidence-based practice. These are rigorous guidelines that meet international standards. Users can also rely on a solid and well-supported approach to implementation. The last component of the package is a system to evaluate impacts on patients, healthcare organizations, and health systems. As such, it is the only program of its kind for nurses and other health professionals that includes guideline development, implementation, and evaluation.
3. **Robustness**—There is a commitment to outstanding quality for each component of the Program. As a result, in the development pillar, RNAO's BPGs are included in major databases for meeting international standards. In the implementation pillar, BPGs are integrated locally, nationally, and internationally in nursing program curriculum and in day-to-day practice in all

academic and service BPSOs, as well as in many non-BPSOs. The evaluation pillar, while still young, is already delivering with a high degree of maturity, as evidenced through numerous published articles from RNAO and most importantly from BPSOs locally and globally.

4. **Proven results**—The Program in its distinct components produces results. This is why Canada's Council of the Federation selected several BPGs from RNAO for national implementation. Most importantly, as you read through this book, you too will marvel at the results experienced using the Program in various healthcare sectors in Ontario and Canada, as well as in Australia, Belgium, Chile, China, Colombia, Italy, Jamaica, Peru, Portugal, Qatar, and Spain.
5. **Accessibility**—The Program is open-access and free of charge, starting from the BPGs that are freely accessible for download from the RNAO website. This is in keeping with a philosophy that knowledge is to be shared for the collective good, not for private enrichment.
6. **Leading-edge**—The Program is not static; it is always informed by the evidence and in touch with the experience in the field. Indeed, the desire to be responsive to the field inspires us to explore different solutions and bring crucial innovations to the Program (e.g., BPSO Hosts).
7. **Collective identity**—This last point, collective identity, warrants added attention because it is a concept not often discussed in the evidence-based practice or diffusion of innovations literature. It is a concept we borrow from the social sciences and in particular from theoretical perspectives and research about social movements. This is the result of a purposeful and effective methodology of authentic engagement led by RNAO.

REFLECTION

In thinking about the factors attributed to the success of the BPG Program, do you agree? What others would you add?

THE BPG PROGRAM AS A COLLECTIVE IDENTITY

Collective identity is a concept first developed by Alberto Melucci in 1989. Melucci's *collective identity* is "an interactive and shared definition produced by several interacting individuals who are concerned with the orientation of their action as well as the field of opportunities and constraints in which their action takes place" (1989, p. 34). Unsatisfied with the gap between theories on how collective actions form and how individuals find motivation, Melucci (1989) defines an intermediate process, in which individuals recognize that they share certain orientations in common and on that basis decide to act together. For him, collective identity is a process negotiated over time and characterized by three dimensions: a "cognitive definition," which entails a common framework, goals, means, and environments of action; "active relationship" amongst participants; and "emotional investment" amongst the participants (Melucci, 1989). Melucci's definition of collective identity is highly relevant to understand the success of RNAO's BPG Program.

Using social theory concepts represents a sharp departure from traditional approaches to healthcare transformations. Typically, health system change relies heavily on a set of top-down directives with fully planned phases or steps designed to "manage the change" and strategies aimed at getting rank and file employees to "buy into the change." Bates, Robert, and Bevan (2004) discuss the limitations of traditional approaches and explore the potential of social movement theory to understand large-scale health system transformations in the United Kingdom's National Health System. Their conclusion is that "the components of a social movements and a programmatic approach to large scale

organizational change are not necessarily mutually exclusive and may represent the next phase of healthcare improvement" (Bates, Robert, & Bevan, 2004, p. 65).

Consistent with Melucci's (1989) work, RNAO's BPG Program orientation has been geared toward shared ownership and a nurturing of collective identity amongst participants and stakeholders at all levels. Our work with the BPSOs emphasizes a transparent, engaging, and motivational approach that encourages identification with and active participation in all pillars of the Program, as the reader will experience throughout this book. From its inception, we readily connected with enrolled clinicians, organizational and health system administrators, educators, researchers, and policymakers to make them active participants in the process. As described in Chapter 2, in addition to RNAO's professional perspective, we included (and still include) other equally important voices such as Ontario's professional association for RPNs/LPNs. The message was that the BPG Program is a collective good for nurses and the people we serve.

The media and the public have been critical partners. Cementing nursing as a "knowledge profession" and nurses as knowledge workers has meant that anytime there is a clinical topic of import in a media outlet, we respond and reference RNAO's BPGs. Throughout the years, letters to the editor have focused on a myriad of topics including falls, staffing, and obesity (Bajnok, 2008, 2009; Virani, 2007). Since 2012, we augmented these "just in-time" responses to media with on-the-ground press conferences during Nursing Week, organized by BPSOs in partnership with RNAO. At these and other events, BPSO staff and patients display their evidence-based expertise and its positive impact (Zych, 2012).

A final component in this concerted effort to develop a collective identity around the BPG Program has been the link between evidence-based practice and evidence-based policy, a bidirectional effort that has produced impactful results on institutional policies and macro health system policy. These changes are discussed in Chapter 18 as a wrap-up to this book.

Today, RNAO's BPG Program plays a leading role in clinical and healthy work environment guideline development, implementation science, and outcome evaluation—provincially, nationally, and internationally. The Program enables organizations and health systems to focus on patient care and clinical excellence, using the latest research to inform practice and optimize outcomes. The BPG Program has helped advance government priorities, as well as patient, provider, organizational, and health system outcomes. It is recognized across the globe for its rigorous guideline development, transformational approaches that are contributing to implementation science, and robust evaluation methodology (Di Costanzo, 2013; Scarrow, 2008; WHO, 2015). Indeed, BPGs have become part of the nursing culture and lexicon in Ontario and all over Canada, and BPSOs constitute a galvanizing global movement in nursing, and one that creates a collective identity.

REFLECTION

Have you been involved in a project where you experienced collective identity? Can you describe how you felt? How critical is collective identity for sustained change?

LOOKING FORWARD TO THE FUTURE

RNAO BPGs are revolutionizing nursing through a focus on knowledge that optimizes the delivery of care anywhere in the world. These robust, evidence-based tools have captured the imagination

of nurses in practice, administration, education, research, and policy. They have won the hearts and minds of nurses in all roles and especially of direct care nurses: in the community, hospitals, nursing homes, and just about everywhere nurses work. Nurses understand that BPGs are instrumental in moving the profession to a fully evidence-based practice, and that is where they want to go. The biggest success is that growing segments of the nursing community are joining in as BPSOs, sharing their excitement as they team up with RNAO and one another, taking ownership of the movement.

The future is rich with opportunities as the influence of the BPG Program continues to expand across all dimensions including new guidelines, more Champions, additional BPSOs, and expanded capacity to evaluate impact. At the service level, this means we can partner as regional networks, following on the BPSO consortium model that has already been established in Latin America, a model that nurtures rich learning and strong collective identity. Trained auditors and orientation facilitators from various countries will enable Program fidelity and sustainability, as well as further engender collective identity and build shared ownership. Academically, a new generation of students is already graduating à la BPG/BPSO, as both inquisitive professional nurses and change agents for evidence-based practice. Multiplied by thousands, in a few years they will have experienced and will contribute through their careers to a scaling deep of evidence-based values and culture.

Lastly, three important recent innovations are of vital importance to this ever-growing Program. The first engages BPSOs who continue to lead in the implementation pillar. Together with BPSOs, we have launched an *Implementation Research Collaboratory* that will enable us within a few years to identify *implementation indicators* to fully understand which are the most powerful and effective strategies to ensure uptake, sustainability, and fidelity of BPGs in service and academia. These will then be entered as formal indicators into NQuIRE, allowing us to continuously learn about implementation processes and their degree of success on evidence uptake and sustainability. The second innovation is the Evidence Boosters (EB) produced through the monitoring and evaluation pillar. Discussed and showcased in Chapters 11 and 16, EBs demonstrate the value and impact of BPG implementation in BPSOs. These EBs, which are already being produced, also serve as audit and feedback reports for nurses in all roles to showcase their work within their organizations. EBs will act as a springboard for "trending reports," from BPG launch to implementation to sustainability, which will contribute to an in-depth understanding of the economic impact of evidence-based nursing practice and healthy work environments. The third innovation involves demonstrable economic and business benefits. We are already exploring the creation of a nursing atlas on "the state of nursing care," such as falls for older persons, pressure injuries, and so on, telling the story of what excellence in nursing looks like around the globe and the impact it has on patients, organizations, and health system outcomes—clinically and financially.

REFLECTION

How do the three innovations discussed here help RNAO's BPG Program and continue its profound impact on the profession, healthcare, and population health outcomes?

Going forward, we must always keep front and center the people and communities we as nurses serve. The ultimate goal is for the public—individually and collectively—to receive the best possible care every time they come into contact with a nurse. They must always remain the real winners of this important effort.

KEY MESSAGES

- The main purpose of the BPG Program is to assist nurses, other health professionals, and the organizations and health systems in which they work to embrace practice and education based on the best available evidence.
- Caring, a foundational concept for nursing, has at times been criticized as a "soft script" that has not served nurses or patients well. Advancing nursing as an art and a science requires competence in both.
- A caring-curing dichotomy poses significant challenges for nurses wanting workplace equality, especially with physicians, because it assumes that one health professional uses the heart to provide comfort and care, while the other uses the brain to cure clinical problems.
- The BPG Program powers a conceptualization of nursing caring practice that encompasses cognitive caring (e.g., clinical knowledge, care planning), physical caring (e.g., bathing), and relational caring (e.g., communication, touch, presence, compassion).
- RNAO's BPG Program facilitates access to rigorous evidence for all domains of nursing practice: cognitive, physical, and relational. Evidence also pertain to health promotion, disease prevention, and curative aspects of clinical care where nurses play a leading role.
- The BPG Program is based on scientific and nontraditional multifaceted strategies of social engagement, including magnetic approaches that attract nurses to mobilize knowledge, commitment, and energy, becoming drivers of sustained clinical, organizational, and health system change.
- As a result of a zealous approach dedicated to implementation science combined with constant attention to learning from and responding to in-the-field needs, RNAO leads what is likely the most robust and expansive implementation program for evidence-based practice for nurses anywhere in the world, and is amongst the strongest in the healthcare field.
- The location of the BPG Program within a professional nursing association has advanced its goals because it provides a large voluntary membership of nurses and nursing students ready to adopt and test the BPGs, identifying an initial base of early adopters.
- The BPG Program has been central to RNAO's policy work in areas of nursing practice (i.e., funding for offloading devices) and the work environment. In turn, RNAO policy work has influenced the development of specific BPGs (i.e., implementing supervised injection services).
- NQuIRE supports BPSOs in making effective practice improvements to optimize clinical, organizational, and health system outcomes by providing organizational and comparative data on BPG-directed nursing care processes and clinical/financial outcomes.
- Multiple factors have contributed to the large-scale spread of the BPG Program and advancing it from producing localized systemic change to leading a seismic transformation of nursing care worldwide. Central to it is the sense of collective identity.
- RNAO BPGs are revolutionizing nursing through a focus on knowledge that optimizes the delivery of care anywhere in the world. These robust, evidence-based tools have captured the imagination of nurses in practice, administration, education, research, and policy.

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