TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practices for Guideline Development, Implementation Science, and Evaluation

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CHAPTER

11

EVIDENCE-BASED PRACTICE IN LONG-TERM CARE

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LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Describe the multifaceted approach and strategies (awareness raising, engagement, capacity development, implementation, integration, evaluation) utilized in scaling up the BPG Program and BPSO Designation to create evidence-based practice cultures in LTC homes
- Identify the impact of the Long-Term Care Best Practices Program (LTC BPP) on resident, provider, and organizational outcomes
- Discuss the approach taken by RNAO to leverage the BPSO Designation within the LTC BPP
- Describe the impact of the organizational (meso) level LTC-BPSO Designation on successful guideline uptake as illustrated in a case example
- Understand how adaptation of an innovation can support scaling up across the LTC sector

INTRODUCTION

The Registered Nurses' Association of Ontario's (RNAO's) *Long-Term Care Best Practices Program* (LTC BPP) represents an example of scaling up of evidence-based practice to the system level in the long-term care (LTC) sector. Mangham and Hanson (2010) describe *scaling up* as a set of processes used in introducing an innovation, that has been effective elsewhere, to a new setting. In this case, RNAO spread the use of BPGs and the Best Practice Spotlight Organization (BPSO) Designation throughout the long-term care sector using various processes and strategies that considered both the policy and cultural contexts of the sector (Mangham & Hanson, 2010).

This chapter chronicles the development of the LTC BPP and highlights key aspects of implementation science and the evidence-based resources instrumental in scaling up this program, leading to positive outcomes for residents and their families, providers, and the sector itself.

BACKGROUND AND HISTORY

Canada has a large and growing community residential care sector that includes a range of living options for people, primarily older adults, needing nursing, personal care, and other therapeutic and support services. The terminology used to describe these residential care settings varies across the country. In some provinces they include lodges, assisted living, supportive housing, and nursing and personal care homes (Canadian Institute for Health Information [CIHI], 2017). In Ontario, these residential care facilities are called long-term care (LTC) homes, specifically to denote the home-like environment that they are designed to emulate. There are approximately 627 publicly funded, licensed, and inspected LTC homes (including 78,052 resident care beds) that provide care for adults in the province (Ministry of Health and Long-Term Care [MOHLTC] Ontario, 2016).

Registered nursing staff in Ontario LTC homes account for 26% of the total resident care hours provided. Registered nurses provide 9% of those hours and registered practical nurses provide 17% of the total hours. Other professional care staff providing expert family, social, activation, nutritional, and physical care, such as social workers, activation therapists, dieticians, physiotherapists, and occupational therapists, provide another 8% of the total resident care hours. Specialized care staff, such as nurse practitioners, infection control specialists, and clinical nurse specialists, provide a small portion of the direct resident care hours (0.27%). The vast majority of direct-care staff in Ontario LTC homes are unregulated personal support workers, and they provide 65% of the total resident care hours (Ontario Association of Non-Profit Homes and Services for Seniors, 2015).

In the late 1990s and early 2000s, in an effort to increase the quality of care in Ontario's LTC sector, the Ontario Government invested resources to address priority care issues. Given its emerging and already highly successful clinical Best Practice Guideline (BPG) Program, RNAO was approached by the Ministry of Health and Long-Term Care (MOHLTC) to develop and disseminate select nursing BPGs on topics such as pressure ulcer prevention and treatment and falls prevention and management for use by the LTC sector and beyond.

In 2005, the Long-Term Care Best Practice Co-ordinator (LTC BPC) role was introduced in Ontario through a 3-year pilot project, the Long-Term Care Best Practices Initiative (Initiative), managed and funded by the Ontario MOHLTC and led by RNAO. The goal of the newly established Initiative was to promote the dissemination and uptake of nursing BPGs in the LTC sector, advance the awareness

and use of BPGs in LTC homes, and enhance the care of LTC home residents (Nursing Health Services Research Unit [NHSRU], 2007a).

This Initiative was evaluated through the Nursing Health Services Research Unit (NHSRU), a collaborative endeavour of the University of Toronto and McMaster University. Using a two-phase approach, the evaluation examined the processes used in phase 1, and the impact of the Initiative at the organizational (LTC home) level in phase 2. Feedback from stakeholders in phase 1 revealed that the LTC BPC role was viewed as a very positive force in increasing the awareness and uptake of BPGs (NHSRU, 2007a). In phase 2, stakeholders indicated that the implementation of the BPGs in the participating LTC homes was beginning to have a positive impact on resident care and outcomes, particularly in the areas of falls prevention, skin and wound care, and continence (NHSRU, 2007b). This was significant at the time because these care areas included three of the top four areas of risk and concern (as identified by the sector) in the care of LTC home residents.

REFLECTION

From your experience, what are some of the challenges of introducing evidence-based practice in long-term care settings, and what types of supports do you think would be most helpful?

Two key recommendations to the MOHLTC from the evaluation of the pilot Initiative included (NHSRU, 2007b):

- Provide sustainable funding for the Initiative while continuing to evaluate the impact of the implementation of BPGs on LTC resident, health provider, and system outcomes
- Consider increasing the number of LTC BPCs in the province (from the original eight) to enhance the opportunity for better resident outcomes resulting from evidence-based practice in LTC homes across the province

Following the success of the 3-year pilot project, the Initiative was formalized in 2008 as an ongoing government-funded program, with an increase in the number of BPCs to 14 (one for each healthcare region in the province) and additional education and management support. RNAO was asked to lead this program in recognition of its cutting-edge work in BPG development and implementation, expertise in project management, and in-depth knowledge of the sector. In 2009, the program was awarded the *Health Minister's Award of Excellence* at the provincial *Innovations in Health Care Expo*, acknowledging its innovative approach to improving quality and patient safety in LTC homes.

PROGRAM INFRASTRUCTURE

Following the formalization and expansion of the program, its philosophical underpinnings were refined to include a vision, mission, set of values, and a guiding framework. This infrastructure enabled and supported the work of the program team and in particular the BPCs, whose role was further developed based on the early work of the pioneer BPCs.

VISION, MISSION, AND VALUES

The vision, mission, and values gave the program a clear focus and direction and fostered a shared understanding of the program's vision amongst the team and stakeholders across the LTC sector. They

have been updated regularly in keeping with evaluation data and context changes. Table 11.1 delineates these aspects of infrastructure.

TABLE 11.1 MISSION, VISION, VALUES OF THE LTC BEST PRACTICES PROGRAM (RNAO, 2008)

Mission	The mission of the Long-Term Care Best Practices Program is to enhance the quality of care for residents in LTC homes and facilitate a culture of evidence-based practice through the implementation of the Best Practice Guidelines by direct-care staff in LTC homes.
Vision	BPGs will be implemented and successfully sustained throughout the long-term care sector for the benefit of residents and their families, providers, the organization, and the system.
Values	Successful BPG implementation will be achieved through collaboration and partnerships by: involving key stakeholders throughout the process, sharing of resources, learning through dialogue, ongoing evaluation and reflection, and developing plans for sustainability.

THE GUIDING FRAMEWORK

The guiding framework consists of six strategies and was developed to operationalize the mission, vision, and values, and reflect principles of implementation science as embedded in the RNAO *Toolkit: Implementation of Best Practice Guidelines* (2012b). These strategies guide the BPG implementation and knowledge-translation work of the Long-Term Care Best Practice Coordinators and other program team members as they support EBP in the LTC Sector. See Figure 11.1.

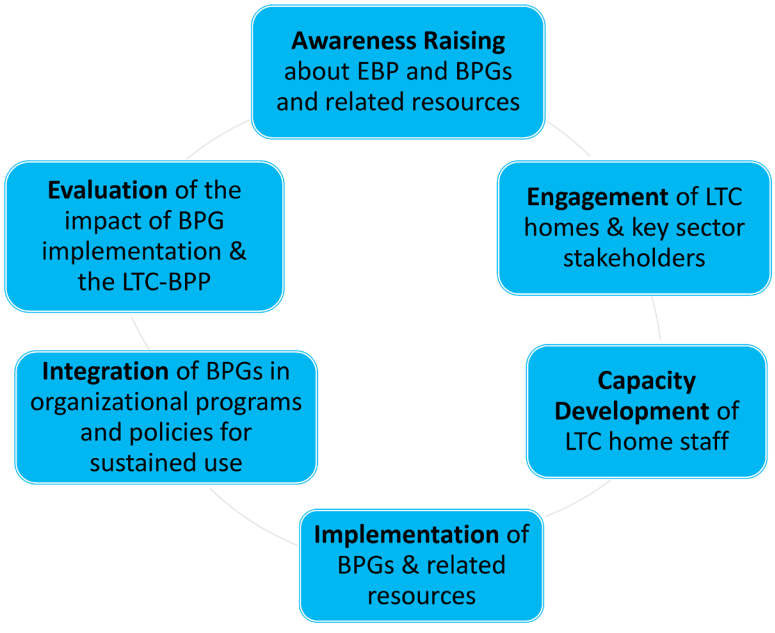


FIGURE 11.1 The six-strategy guiding framework of the LTC Best Practices Program.

REFLECTION

In what ways does the guiding framework for the LTC Best Practice Program reflect the LTC context, and why is this important when introducing evidence-based practice?

THE LTC BEST PRACTICE COORDINATORS

The BPCs are experts in the care of older persons, the LTC sector, and implementation science strategies. They engage with LTC home leaders, nurse practitioners, and direct-care staff to establish and adopt practices based on RNAO clinical BPG recommendations. Thus, the BPCs are catalysts in the provision of evidence-based care to LTC home residents and their families. Their role includes the following activities:

- Seek, create, and coordinate opportunities to promote the use of evidence-based best practices in LTC homes
- Collaborate in the development of a plan for the local implementation of RNAO BPGs in LTC homes, including strategies to facilitate their sustainability and spread
- Promote and support capacity development and knowledge transfer related to evidence-based practice within LTC homes
- Provide support for best practice implementation and integration of best practices in legislated LTC required care and service programs and mandatory quality-improvement plans

The role of the BPCs can be more specifically delineated through a description of each of the six strategies in the guiding framework.

AWARENESS RAISING

Awareness raising is a strategy used by the LTC BPCs to focus the attention of LTC leaders and staff on evidence-based practice (EBP), the RNAO BPGs, related implementation resources applicable to clinical care of LTC home residents, and the RNAO Healthy Work Environment (HWE) BPGs (see Chapter 3, *Creating Healthy Workplaces: Enabling Clinical Excellence*) that support workplace improvements. The LTC BPCs use numerous approaches, such as newsletters, brochures, electronic mailings, meetings with LTC home leaders and staff, and exhibits at various events including workshops and conferences, to raise awareness about the BPGs and program resources. All of the approaches used are designed to encourage LTC home staff to be aware of evidence-based practice, become engaged with the program, and use BPGs in practice.

ENGAGEMENT

Engaging LTC home leaders and their staff with the program through the regional LTC BPCs is a very important strategy to advance homes toward using BPGs in day-to-day practice. LTC BPCs establish and facilitate individual and group meetings in LTC homes and develop networking groups of LTC home staff and other provincial LTC stakeholder groups who are implementing similar BPGs. Communities of practice focusing on a specific clinical practice issue (e.g., falls prevention, oral health) at the local and provincial levels are one example of a purposeful approach to engagement that has been effective in supporting BPG implementation in LTC homes.

CAPACITY DEVELOPMENT

Capacity includes the organizational and technical abilities, knowledge and skills, as well as relationships, attitudes, and values that enable organizations, groups, and individuals to carry out the necessary functions to achieve their development goals over time. Stakeholders are individuals or groups who have an interest in and are affected by, or can effect, a practice change (Baker et al., 1999; Legare, 2009). They play an important role in any change initiative and need to be involved throughout the process. The systematic use of RNAO clinical and HWE BPGs assists LTC homes in developing capacity at the individual staff level and within the sector.

To increase capacity in evidence-based practice and implementation science in LTC, there are varied strategies used including a program to develop LTC Best Practice Champions, a clinical fellowship program, and professional development offerings. In addition, given the importance of leadership at all levels in supporting and sustaining evidence-based practice, RNAO provides education and support to LTC leaders through professional development. For example, the *League of Excellence for LTC* is an interactive educational program developed by the LTC BPP; it is designed to enhance LTC leaders' ability to develop, integrate, evaluate, and sustain evidence-based programs and quality-improvement initiatives in Ontario LTC homes. Two primary resources developed by the LTC BPC Program that are widely used in the sector are presented in the following section.

KEY PROGRAM RESOURCES

Long-Term Care Best Practices Toolkit, 2nd edition

The *LTC Toolkit,* 2nd edition (www.ltctoolkit.rnao.ca) is a free online repository of evidence-based resources that support BPG implementation and LTC program planning and evaluation (RNAO, 2015a). Topics included were based on the expressed needs of the LTC homes and were identified through regular provincial surveys and ongoing contact with the LTC BPCs. All topics are associated with one or more of RNAO's clinical and/or HWE BPGs. Related implementation resources that support evidence-based practice in LTC are sourced for each topic, based on specific criteria. To be included in the *LTC Toolkit,* a resource/tool must reflect applicable legislative and regulatory requirements, be applicable to LTC, be evidence-based, and be available on the web at no cost or very minimal cost to users. To date, thousands of unique users from around the world, including practitioners, faculty, and students, have accessed this resource.

The Nursing Orientation eResource for LTC

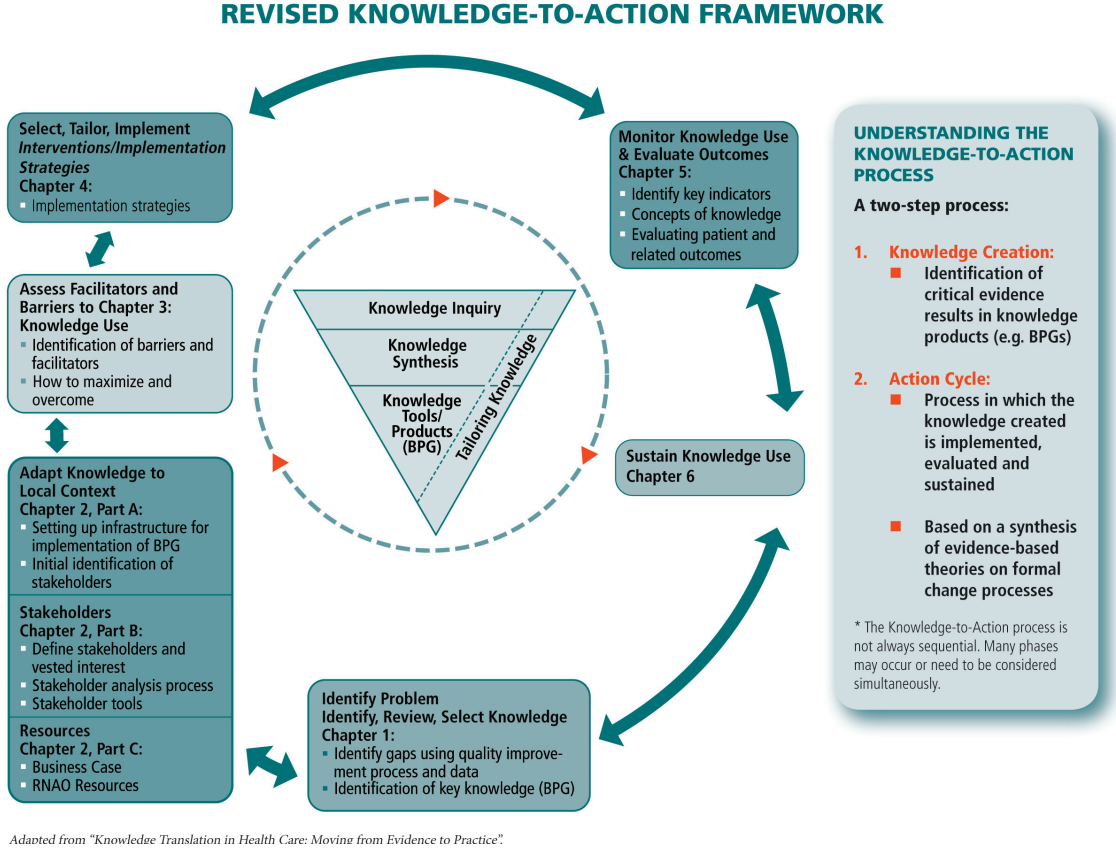
This is a popular, evidence-based eResource (http://ltcorientationeresource.rnao.ca/) that includes comprehensive information to prepare nurses and others to work in and or understand the context of LTC. It includes four knowledge domains—professional, role, clinical, and organizational—and links nurses with the best available online resources and learning activities from reputable provincial and national organizations and select RNAO clinical and HWE BPGs. Each knowledge domain contains several learning modules, each of which includes an introduction to the topic and various "activities to do" and "resources to review" (Holmes & Warner, 2013).

The eResource provides a self-directed approach to learning based on a self-assessment of learning needs using an embedded checklist and planning tool. It is designed to enhance LTC home nursing orientation programs and to introduce users to evidence-based sources of information applicable to LTC that can help answer practice questions as they arise. While the e-Resource was designed for nurses new to LTC, it is also accessed by hundreds of experienced nurses to expand their knowledge and other healthcare professionals, students, and faculty as a source of evidence-based information about the sector (Holmes & Warner, 2013).

IMPLEMENTATION

Although LTC home leaders and direct-care staff strive to provide safe, high-quality, integrated, and evidence-based care, practice change using the best evidence does not happen quickly. Introducing best evidence into day-to-day practice requires a planned change process, with attention to both "hard" (technical) and "soft" (people) areas (Sarayreh, Khudair, & Barakat, 2013). Haines (2007) recognized the importance of garnering internal motivation for change toward a clear vision of the future. His model includes a focus on the experience of the individual, which is predictable as one moves from the current practice to the future desired state, which he depicts through a rollercoaster model. Successful implementation of practice change relates to the culture of the organization, including the leadership capacity, motivation, and resources to pursue clinical excellence.

The LTC BPCs guide implementation of BPGs through use of the Knowledge-to-Action (KTA) framework (Straus, Tetroe, & Graham, 2013), which enables a structured, systematic approach to implementation of best evidence in LTC homes. The KTA framework is described in detail in RNAO's user-friendly *Toolkit: Implementation of Best Practice Guidelines* (2012b). An important aspect of the BPC's role is helping to initiate the structured process to move knowledge (evidence) into practice. They start their work with homes using a gap analysis, linking this approach to the first phase of the KTA Cycle: "*Identify Problem: Identify, Review, and Select Knowledge*" (see Figure 11.2).



Adapted from "Knowledge Translation in Health Care: Moving from Evidence to Practice".

Adapted from "Knowledge Translation in Health Care: Moving From Evidence to Practice." S. Straus, J. Tetroe, and I. Graham. Copyright 2009 by Blackwell Publishing Ltd. Adapted with permission.

FIGURE 11.2 Knowledge-to-Action framework as depicted in *Toolkit: Implementation of Best Practice Guidelines* (RNAO, 2012b).

The gap analysis is led by the LTC BPCs in partnership with the LTC home leaders and is a process for comparing current practice within an LTC home with evidence-based best practice recommendations in the selected BPGs to determine the following:

- Existing practices and processes that are currently implemented and are supported by evidence in the BPG—this information is useful to reinforce practice strengths
- Recommendations that are currently partially implemented in practice or implemented in specific areas of the LTC home—these would be good first targets for change efforts
- Recommendations that are not currently being met
- Recommendations that are not applicable to the practice setting

The team, along with internal and external stakeholders, carries out these comparisons, and at the same time also determines:

- Facilitators to the process and any barriers to implementation, which may include staffing, skill mix, budget, workload issues, and staff knowledge and motivation
- The timeframes related to specific actions and people or departments that can support the change effort
- Links with other practices and programs in the LTC home
- Existing resources and education that the LTC home can access

Table 11.2 illustrates an example of a gap analysis for one recommendation in the RNAO *Prevention of Falls and Fall Injuries in the Older Adult* BPG (2005, 2011) that will help the team determine areas of the recommendation that are met, partially met, and not met, and enable them to focus their actions.

TABLE 11.2 EXAMPLE OF A GAP ANALYSIS FOR ONE RECOMMENDATION

RNAO Best Practice Guideline Recommendations	Met	Partially Met	Unmet	Notes (Examples of what to include: is this a priority, information on current practice, possible overlap with other programs or partners)
Practice Recommendation: Assessment 1.0 Assess fall risk on admission. (Level 1b Evidence)		X		Discussed the risk assessment tool used on admission to determine if the staff is knowledgeable about the risk factors associated with falls and if risk assessments are completed within 24 hours of admission. Staff asked if the past fall history could be available at admission. Staff identified from latest Quality Improvement reports that 40% of admissions have a staff-completed falls risk assessment. Action plan: Select and use a consistent tool for falls risk assessment on all units, and complete 100% of the time within 24 hours of admission.

Benefits of conducting a gap analysis include (RNAO, 2012b):

- Identifying strengths in current practice
- Focusing on needed practice change based on best evidence, with attention to priority areas that may be most easily addressed
- Determining barriers and facilitators, resource requirements, selection of implementation strategies, and evaluation approaches
- Agreeing on next steps, such as development of infrastructure to support BPG implementation, stakeholder engagement
- Increasing likelihood of sustained practice change through involving staff in a candid discussion of current practice and how to plan for practice changes

The LTC Best Practice Program focuses on supporting LTC homes, within the context of their available resources, to develop and carry out their plans to implement BPGs. Support is provided, primarily though the expertise of the LTC BPCs, who use consultative and coaching approaches while working with LTC leaders and Champions to apply change-management principles in adopting clinical and HWE best practices.

REFLECTION

How would you introduce the gap analysis and tool to your colleagues in your setting? In what ways does this process facilitate change management related to uptake of BPGs?

INTEGRATION

Adoption of clinical and HWE BPGs in LTC homes is compatible with the LTC regulations and requirements for service programs, policies, procedures, clinical care, and workplace practices. This, along with the systematic, inclusive approaches used in implementation, helps to sustain BPG uptake across the sector. LTC BPCs provide expert consultation to LTC home leaders and staff in maintaining a focus on EBP through leveraging regulatory requirements, quality-improvement initiatives, orientation, performance appraisal, and ongoing evaluation and follow-up.

EVALUATION

Evaluation is a critical component of the role of the BPC in their BPG implementation work with the LTC homes. Through full integration of BPGs into required care and service programs and mandatory quality-improvement plans (QIP), the impact of BPG implementation can be measured. LTC homes are mandated to monitor and report on Resident Assessment Instrument-Minimum Data Set (RAI-MDS) quality indicators on a quarterly basis. Several of the LTC quality indicators are publicly reported, and they are important sources of information used by the LTC BPP to gauge the BPG uptake and impact on resident care and workplace outcomes. Staff leads are helped to assess the approaches taken, and their results, to inform subsequent work in relation to the next BPG to be implemented.

LTC BEST PRACTICE GUIDELINES PROGRAM EVALUATION

In April 2014, a two-phase program evaluation, focusing on program structures and processes (phase 1) and program outcomes (phase 2), was carried out by an external evaluator. It included an examination of the entire program across Ontario and implementation activities within individual homes where that information was useful in gleaning promising practices related to overall program delivery.

KEY EVALUATION QUESTIONS (SOURCE: MCGUIRE ASSOCIATES, 2014)

The key evaluation questions for phase 1 and phase 2 of the LTC BPP evaluation were:

1. To what extent was the LTC BPP implemented as planned?
2. Were the recommendations from the pilot project evaluation implemented? Why or why not? What changes have occurred?
3. To what extent did the services and resources provided to LTC homes through the program meet their needs and expectations?
4. What effect did the program have on the use of evidence-based practice in LTC homes?
5. Which of the strategies used by the program contributed most toward LTC homes moving forward in the use of evidence-based practices?

The key questions directed the type and focus of data collection and the data analysis. Results from phase 1 of the program evaluation were very positive, indicating a steady increase in awareness about the program amongst long-term care homes, and strong agreement that services and resources were very useful and making a difference in the homes. Recommendations included strengthening data collection and monitoring processes, in particular striving for consistency and reliability in approaches to gathering and analyzing monitoring data and using it for program planning and reporting.

The results from phase 2 showed that the nature of the relationship between the BPCs and the LTC home in the awareness-raising and implementation phases of the guiding framework was critical in moving the LTC home to BPG uptake. This reinforced the need for consistent coaches and the importance of retaining BPCs in the role over time. In addition, it was clear that in early stages of adoption, homes required much more interaction and support, while those in the later stages of BPG uptake could maintain their work with regular but less-intensive coaching sessions (McGuire Associates, 2015).

IMPACT OF THE PROGRAM ON THE LONG-TERM CARE SECTOR

Included here are two examples from the field as to how specific BPGs were implemented and the impact they have had on resident, provider, and organizational outcomes.

CASE STUDY

EXTENDICARE HALIBURTON

Extendicare Haliburton, Ontario, Canada, working with its LTC BPC, successfully implemented the RNAO BPG *Promoting Safety: Alternative Approaches to the Use of Restraints* (2012a) across the entire LTC home. The results were spectacular—the facility reduced restraint use from 15.9% to zero over a 2-year period. Implementation activities were based on the three types of recommendations in the BPG and included:

- Revising and implementing a set of behavioural assessment and organizational policies, based on the organizational recommendations
- Developing and implementing care plans, based on the practice recommendations
- Educating staff by developing them as Best Practice Champions to lead practice change, based on the education recommendations

The home's restraint-free practices were shared with new residents, their families, and staff. Residents and family members appreciated understanding how the home's policies were supported by evidence-based recommendations from the RNAO BPG. The team at Extendicare Haliburton committed to providing quality, person-centered care (RNAO, 2012a), and that meant everyone including residents and families understood the benefits of alternative approaches to the use of restraints without compromising resident safety (Wood, 2017). Figure 11.3 depicts restraint use over time at Extendicare Haliburton after implementation of the *Promoting Safety: Alternative Approaches to the Use of Restraints* BPG (2012a) as compared to restraint use regionally, provincially, and nationally.

REFLECTION

What factors do you feel contributed to the excellent outcomes experienced by this LTC home in relation to the adoption of the Alternative Approaches to Use of Restraints BPG?

Trend Over Time: Restraint Use in Long-Term Care (Percentage)
Website location: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/043/4/O99187/

Comparator	2011–12	2012–13	2013–14	2014–15	2015–16
Canada	13.4	11.2	9.6	8.6	7.4
Ontario	13.9	11.0	8.9	7.4	6.0
Central East LHIN	12.1	9.3	7.9	6.7	5.3
Extendicare — Haliburton	15.9	2.9	0.8	0.0	0.0

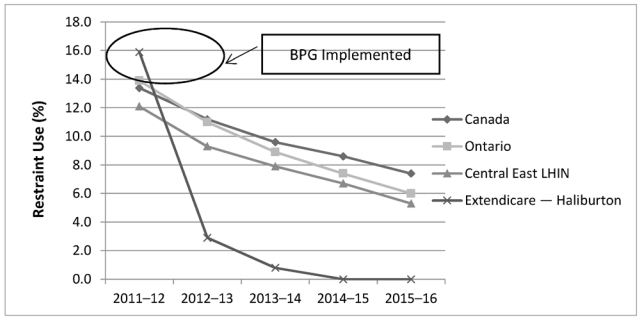


FIGURE 11.3 Organization restraint use over time compared to the region, province, and country.

Source: *Your Health System: Restraint Use in Long-Term Care Details for Extendicare Ontario,* CIHI, 2016. Used with permission of Extendicare Haliburton.

CASE STUDY

TILBURY MANOR

Tilbury Manor is a 75-resident LTC home in Tilbury, Ontario that implemented Best Practice Guidelines to improve resident care and create a healthy work environment. The interprofessional team used several gap-analysis tools to review current practices in relation to the BPG recommendations and created action plans to improve resident outcomes in the required programs (falls prevention and management, skin and wound care, continence care and bowel management, and pain management). Existing policies, resident care practices, and documentation were reviewed to determine the extent to which screening, assessment, and re-assessment tools aligned with RNAO BPGs. From November 2014 to June 2015, Tilbury Manor implemented practice changes based on the recommendations from 12 RNAO BPGs. *Senior Care Canada* magazine featured Tilbury Manor as a cover story for its nomination for the *Ontario Long-Term Care Association's Leadership Excellence Award* in 2015. The article shares their journey in maintaining best practices by "organizing and empowering staff to find solutions" (Patten, 2017).

Program teams, led by nurses and supported by the LTC BPCs, were established to promote practice changes and improve resident outcomes. Each leader was responsible for training and educating staff, implementing practice changes, and evaluating their effectiveness, based on the KTA model as outlined in the RNAO Implementation Toolkit (2012b). Results of chart audits, nursing care reviews, and scores measuring key RAI-MDS indicators of quality in LTC used in many parts of Canada were monitored and regularly reported to the Director of Care to promote continuity and ensure sustainability of practice changes. Within one reporting cycle (fiscal quarter), the RAI-MDS indicators (see Figure 11.4) showed considerable improvements that have been sustained for over 2 years (Le & Faubert, 2016).

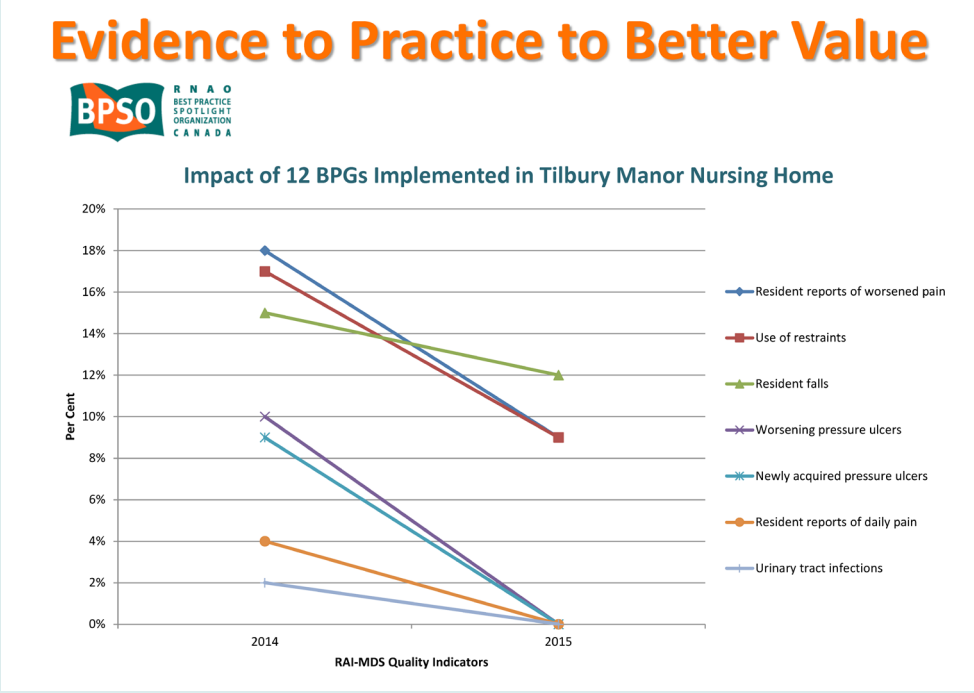


FIGURE 11.4 Impact of 12 BPGs implemented in Tilbury Manor.
Source: Tilbury Manor RAI-MDS quality indicators November 2014 to June 2015.
Implementation of 12 RNAO BPGs improved resident outcomes for seven Resident Assessment Instrument-Minimum Data Set (RAI-MDS) quality indicators. Used with permission.

REFLECTION

What are the benefits of monitoring, measuring, and sharing client health outcomes with staff in achieving and sustaining quality care?

FURTHER SCALING UP THROUGH ADAPTATION OF THE RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION DESIGNATION

Once the LTC BPP was soundly established, and considerable effort was spent in building individual capacity related to evidence-based practice and developing a network of Champions within the sector, RNAO turned to spreading its successful organizational implementation strategy—the Best Practice Spotlight Organization Designation (see Chapter 6, *Best Practice Spotlight Organization: Implementation Science at Its Best*)—across the LTC sector by incorporating it into the LTC BPP as the LTC-BPSO. The BPSO Designation, established in 2003, gives organizations the opportunity to formally implement BPGs in partnership with RNAO and was adapted to be consistent with the LTC context.

PURPOSE AND ADAPTATIONS OF THE BPSO DESIGNATION TO LONG-TERM CARE

Through a formal partnership with RNAO, LTC homes create evidence-based cultures in their organizations through the systematic implementation and evaluation of multiple RNAO BPGs over a 3-year period, after which they are designated as LTC-BPSOs. The objectives of the LTC-BPSO Designation are to (RNAO, 2016):

- Establish dynamic, long-term partnerships with LTC settings that focus on making an impact on resident care through supporting knowledge-based nursing practice
- Demonstrate creative strategies for successfully implementing nursing BPGs at the individual and organizational level
- Establish and adopt effective and consistent approaches to evaluate implementation activities utilizing appropriate structure, process, and outcome indicators
- Integrate effective strategies for system-wide dissemination of guideline implementation and outcomes, particularly targeted to LTC

To adapt the BPSO Designation to the LTC sector, an open consultation was held with LTC home leaders to discuss their contextually related challenges and needs in implementing RNAO's BPGs. The program was tailored to provide committed support to the LTC-BPSO homes while maintaining the integrity of the BPSO Designation. The LTC BPCs serve as formal coaches to the LTC-BPSO leadership teams and provide consultation services up to the equivalent of 1 day a week over the initial 3-year

predesignation period. LTC-BPSOs work collaboratively with RNAO, and both commit human and financial resources to support achievement of program deliverables.

ORGANIZATIONAL COMMITMENT

The request-for-proposal (RFP) process for the LTC-BPSO began in 2014. As opposed to the 3-year intake of the other Ontario BPSOs, the RFP for LTC-BPSOs is issued annually, and intake has been maintained for 4 successive years since 2014. The increased frequency was established in response to the early positive outcomes achieved by LTC-BPSO predesignate homes and the demand expressed by LTC homes across the province to participate in this meso-level BPG implementation program. In 2017, the first LTC-BPSOs achieved designation. To date, there are 29 LTC-BPSOs—providing care to 3,750 residents—with more planned to come each year.

COLLABORATIVE ROLE OF THE LTC-BPSO COACH AND LTC-BPSO LIAISON

The LTC-BPSO Coach is an RNAO LTC BPC, who supports the LTC-BPSO in the systematic implementation, evaluation, and sustainability of the RNAO BPGs identified by the LTC-BPSO. The LTC-BPSO Coach works directly with the LTC-BPSO Liaison, a staff member of the LTC-BPSO who coordinates implementation and evaluation activities. The coach provides consultation, teaching, support, and role-modeling, using the RNAO Implementation Toolkit (2012b) as a guide to implementation science and through holistic facilitation processes of enabling individuals, teams, and organizations to change (Harvey et al., 2002).

DELIVERABLES

The key requirement for participating LTC-BPSOs is to implement and/or expand the implementation of a minimum of three RNAO clinical BPGs from a select list of BPGs that support quality resident care, are highly relevant to the care of LTC home residents, and are included in legislated required programs for which RNAO has a BPG. At minimum, one of the three clinical guidelines must be implemented across the entire LTC home, while the others may be implemented within specific resident care areas. All BPGs selected must be implemented by the end of the second year, and at least one guideline must be fully implemented in the first year. In year three, the focus is on evaluation and sustainability and preparing for LTC-BPSO Designation.

CAPACITY BUILDING

Consistent with the expectations for all BPSOs, LTC-BPSOs are required to engage at least 15% of caregiving and management staff as RNAO Best Practice Champions over the span of the 3-year predesignation period. The intent is to develop capacity amongst a cohort of direct-care staff, including registered nursing staff, to support guideline implementation and evaluation. In addition, there are requirements for other capacity-building activities, such as attendance at RNAO learning institutes and other professional development offerings related to evidence-based practice and implementation science.

DISSEMINATION

As a way of consolidating, reinforcing, and acknowledging their work, organizations are required to share their key lessons learned, resources developed, and achievements with the LTC sector and the wider healthcare community. In keeping with the resources available in the sector, LTC-BPSOs have a number of in-person and web-based options for disseminating their work. In addition, a minimum of one manuscript is to be submitted for publication in a peer-reviewed or non-peer-reviewed journal by the end of the 3-year predesignation period.

MONITORING AND EVALUATION

As is the case for all BPSOs, mandatory participation in the RNAO international indicator data system, Nursing Quality Indicators for Reporting and Evaluation (NQuIRE) (see Chapter 16, *Evaluating BPG Impact: Development and Refinement of NQuIRE*), is a key deliverable for the LTC-BPSO Designation. NQuIRE collects data on human resource structural indicators, and process and resident outcome indicators. This participation is formalized through a signed agreement with RNAO outlining responsibilities related to monitoring and evaluation requirements, data security, and data sharing. LTC-BPSOs work with the NQuIRE team to select quality indicators related to the guidelines identified for implementation and appropriate to the LTC sector, and data are collected on a monthly basis on these indicators and submitted to the NQuIRE data system. The LTC-BPSOs can retrieve their reports and are required to submit them in progress reports to RNAO, along with results of other regular quality-improvement monitoring activities related to the implementation of each BPG.

SUSTAINING AND SPREADING

At the end of the 3-year LTC-BPSO predesignation period, assuming all deliverables are met, the LTC-BPSO attains "LTC-BPSO Designate" status. This is a renewable designation every 2 years, pending achievement of ongoing requirements consistent with an evidence-based LTC organization continuing to enhance, expand, and spread implementation of best practices. BPSO Designates become mentors to other new LTC-BPSOs at the local, national, and international levels.

SUMMARY OF THE BPSO SCALING UP INITIATIVE

The LTC-BPSO has been a resounding success in creating a culture of evidence-based practice in LTC settings and in improving resident outcomes, particularly in those consistently challenging areas of care for older persons such as wound care, chronic pain, falls, and urinary incontinence. The formula of soundly developed evidence-based practice guidelines and related resources, expert coaches, dedicated organizations that have committed resources, a systematic methodology, and a focus on evaluation and sustainability has meant that long-term care settings have embraced evidence-based practice. This has resulted in unprecedented outcomes in many cases for residents, staff, organizations, and the system.

Why is it so important to tailor programs to the local context, in this case the long-term care context? How do you think this tailoring contributed to the BPSO Designation's success in LTC?

CASE STUDY

THE IMPACT OF LTC-BPSO AT ST. PETER'S RESIDENCE

St. Peter's Residence at Chedoke (SPR) is a nonprofit LTC home for 210 residents in Hamilton, Ontario, Canada and is part of the Thrive Group. In 2013, SPR responded to the first LTC-BPSO request for proposals. Many factors led senior leaders to recognize the opportunity in pursuing the LTC-BPSO Designation and its focus on evidence-based practice. Ontario LTC homes are required to meet the regulations of the LTC Homes Act, 2007 (Queen's Printer for Ontario, 2007) and to submit annual QIPs that are publicly reported.

The changing resident population within the LTC sector also challenges homes to meet the needs of the residents with complex health conditions, including mental health issues and psychosocial and behavioural symptoms of dementia. Residents, families, and substitute decision-makers are increasingly better informed and expect excellent care and customer service for which they hold the healthcare team accountable. At SPR, Resident and Family Councils are highly involved in decision-making and hold the team accountable for ensuring care and service meets and/or exceeds legislated standards. As LTC homes struggle with limited resources and funding, finding efficiencies (through the use of best practices, developing staff capacity and knowledge, and empowering staff members) is essential.

Leading innovation and enhancing versatility are two of the values of the Thrive Group organizations. As such, the decision to partner with the RNAO as an LTC-BPSO and support SPR in implementing BPGs and making practice changes to improve resident outcomes was consistent with both the values and the current goals and challenges of the sector.

GETTING STARTED

As part of the application process and based on a participatory approach, the SPR team chose one HWE and five clinical BPGs to implement during the 2014–2017 3-year predesignation period. The BPGs implemented included:

- *Client Centred Care* (RNAO, 2006); *Person- and Family-Centred Care* (RNAO, 2015b)
- *Assessment and Management of Pain* (RNAO, 2002, 2007 Supplement, 2013a)
- *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches* (RNAO, 2014)
- *Prevention of Falls and Fall Injuries in the Older Adult* (RNAO, 2005, 2011 Supplement)
- *Promoting Safety: Alternative Approaches to the Use of Restraints* (RNAO, 2012a)
- *Developing and Sustaining Nursing Leadership* (2nd ed.) (RNAO, 2013b)

SPR is committed to the mission, vision, and values of the Thrive Group, ensuring that clients, employees, and all other stakeholders receive excellent quality services. Organizational values include teamwork, honesty, respect, innovation, versatility, and excellence. The LTC-BPSO Program and its focus on evidence-based practice were seen as a way to promote innovation and practice excellence.

At SPR, staff are consistently encouraged and supported to commit to continuous learning and development, always moving forward and building highly efficient programs and services. The rationale for engaging in the LTC-BPSO included: enhancing required care and service programs, empowering nursing staff, increasing the engagement of all disciplines in decision-making, and enhancing collaboration and teamwork. It was also anticipated that this work would inspire a sense of ownership and pride in all staff, encourage shared responsibility and sustainment of desired changes to improve resident care, and address the common barriers to knowledge translation in LTC.

SPR's goals for the LTC-BPSO were as follows:

- Enhance staff knowledge in implementing BPGs
- Review and revise resident care programs related to falls, restraint use, and pain
- Increase awareness of and prevent abuse and neglect to ensure the safety of residents
- Share knowledge and learn from peers to improve nursing services

- Develop staff capacity to engage in BPG implementation
- Review and identify the quality indicators aligned with BPGs selected for implementation
- Develop quality-improvement plans, and evaluate and enhance programs, policies, and processes to achieve improved outcomes for residents, families, and staff

One of the first steps in the predesignation experience was to appoint an LTC-BPSO Liaison and an internal steering committee accountable to the senior leadership team. Operating in an advisory capacity, the committee was responsible for laying the foundation for change and implementing the strategies outlined in the Knowledge-to-Action framework and the *Toolkit: Implementation of Best Practice Guidelines* (RNAO, 2012b; Straus et al., 2013).

The steering committee was highly involved: participating in regular meetings chaired by the LTC-BPSO Liaison, making sure the BPSO remained a priority, contributing to decision-making, and reporting on (as well as providing recognition and acknowledgement of) milestones met. Staff interest in becoming RNAO Best Practice Champions grew far beyond the initial target group of nurses. Participation levels amongst quality-improvement committee members were also high. Both Champions and committee members were responsible for program development and evaluation; annual review of policies and programs; and ensuring best practices through conducting gap analysis, implementation of practices changes, facilitating education, and conducting audit and feedback.

PRACTICE CHANGES AND RESIDENT OUTCOMES

Through the implementation of the BPGs, significant changes to practice were established. The team achieved this by using organizational policy and education recommendations in the relevant BPGs to revise policies and procedures, improve or develop new structures, provide education, and create new tools and processes. These changes included areas related to the clinical and HWE BPGs and spread to other areas of care and services. Some examples include the implementation of recommendations from HWE BPGs within the home's Joint Health and Safety Committee, Employee Wellness program, and Transportation program.

RAI-MDS quality indicators data demonstrated sustained improvement in resident outcomes in all BPGs implemented. For example, the number of resident falls decreased from 21.2% to 16.7% from June 2015 to April 2017 and continues to drop. In conjunction with a decrease in falls, simultaneously an improvement in the percentage of residents in daily physical restraints fell from 2.1% to 0.6% in the same timeframe.

BENEFITS TO THE ORGANIZATIONS, LTC SECTOR, AND SYSTEM

The most significant change through this process was the culture shift in using evidence in practice and sustaining practice change. SPR is recognized by the community for key achievements associated with the LTC-BPSO Designation, which include but are not limited to the following:

- A national journal published a manuscript called *Transformational Leadership at the Point of Care: Approaches and Outcomes in a Long-Term Care Setting* (Karimi, Mills, Clavert, & Ryckman, 2017).
- As part of the implementation of the nursing leadership BPG, SPR developed an internal mentorship program for staff. A poster on the mentorship program was presented at a national nursing conference.
- SPR continues to be invited to present at multiple conferences and events and to mentor other LTC homes with BPG implementation, Champion development, and leadership at the point of care.
- SPR is a member of an international working group with multiple universities to develop a research agenda to understand how to sustain the culture of EBP.

REFLECTION

Consider how engagement of the SPR LTC Home as a BPSO impacted their uptake of BPGs and contributed to positive outcomes for residents, staff, and the organization as a whole. Do you think that SPR is an evidence-based organization?

CONCLUSION

The LTC Best Practices Initiative was formalized as a program under the management of the RNAO in 2008 following a successful 3-year pilot project. Since that time, it has grown to become an extremely successful example of a scaling up strategy that has served to create evidence-based practice cultures and deliver improved clinical outcomes. Through the LTC Best Practices Program, and in particular with the work of the Best Practice Coordinators focused on building individual and organizational capacity, more LTC homes are now expecting all categories of staff to use evidence in their decision-making and have established this as the "modus operandi" for both regulated and unregulated staff members.

Furthermore, scaling up of the specific meso-level BPG implementation strategy, the BPSO Designation, was made possible through its adaptation to the LTC sector. The LTC-BPSO Designation, now spreading rapidly in this sector, has shown considerable promise in improving outcomes for residents and their families; enhancing the quality of care provided by nursing and other staff; and inspiring staff to embrace evidence-based practice, leading to a cultural shift in the sector.

KEY MESSAGES

- Multifaceted approaches—at the individual (micro), organizational (meso), and systems (macro) levels—are necessary to enable the scaling up of practice change within a sector.
- Implementation of BPGs in the LTC sector can have a significant positive impact on resident, provider, and organizational outcomes.
- Meso-level BPG implementation programs, such as the BPSO Designation, that are based on implementation science principles can be successfully adapted and scaled up to address the context of specific sectors, in this case, LTC.

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