

TRANSFORMING NURSING THROUGH KNOWLEDGE

Best Practices for Guideline Development,
Implementation Science, and Evaluation



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INSPIRING AND MANAGING IMPLEMENTATION ON A GLOBAL SCALE

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RNAO'S GLOBAL SPREAD OF BPGS: THE BPSO DESIGNATION SUSTAINABILITY AND FIDELITY

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LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Describe the key factors that have contributed to widespread diffusion of RNAO's evidence-based guidelines
- Identify how the Best Practice Spotlight Organization (BPSO) Designation is critical to RNAO's diffusion of Best Practice Guidelines (BPG) at the meso and macro levels
- Differentiate between a BPSO Direct and BPSO Host, and relate the models to diffusion of innovation theory, sustainability, and fidelity
- Outline key strategies that are used to ensure fidelity of the BPSO Designation as it is operationalized in different contexts worldwide
- Discuss the elements of an effective Training of Trainers (TOT) Model and how these are reflected in RNAO's International BPSO TOT Model

INTRODUCTION

As discussed in previous chapters, RNAO developed a signature program devoted to impacting the practice of nurses through use of best evidence to improve patient outcomes. RNAO's Best Practice Guidelines (BPG) Program, launched in 1999, produces rigorously developed, evidence-based guidelines that translate the latest and best research knowledge into tools for ready use by clinicians. At the same time, RNAO leads a program of diffusion and implementation of these guidelines in practice and academia and helps users evaluate the outcomes. Over the years, various strategies have been utilized to support dissemination and spread of this work, such that RNAO's BPGs are recognized as a global movement in healthcare (Health Council of Canada, 2012; Grinspun, Melnyk, & Fineout-Overholt, 2014; Bajnok, Grinspun, Lloyd, & McConnell, 2015; Gardner, 2010; Grinspun, Lloyd, Xiao, & Bajnok, 2015; Jordan, 2005).

This chapter discusses why RNAO's BPG Program has sustained change and how it has achieved extensive global diffusion. We compare and contrast Rogers' (2003) main elements with key aspects of RNAO's BPG Program that have been central to its success. In doing so, we discuss the program's spread, sustainability, and fidelity—all critical attributes to consider in any large-scale global initiative. We highlight opportunities and challenges and how RNAO is addressing these now and into the future to strengthen the qualities that have propelled the BPG Program into a global movement in evidence-based practice (EBP). This is particularly important to others who seek to influence spread in a program that, like RNAO's BPG Program, has been adopted in different service sectors and academia, geographic locations, contexts, and cultures around the world.



As you read this chapter, consider how involvement of a professional association has influenced the success of the evidence-based practice movement around the world.

ROGERS' DIFFUSION OF INNOVATION AND RNAO'S BPG PROGRAM SUCCESS

Diffusion of innovation is an age-old challenge, first recognized as a sociological concept in the late-18th century and expanded in the area of rural sociology in the mid-19th century (Kinnunen, 1996). Everett Rogers, a professor of rural sociology, advanced the phenomenon through an extensive synthesis of research in this area and published his theory of the adoption of innovation in a groundbreaking publication, *Diffusion of Innovations* (Rogers, 1962). Since then, he has revised the model of diffusion over time (Rogers and Shoemaker, 1971; Rogers, 1983; Rogers, 1995), with the last iteration published in 2003 (Rogers, 2003). It has also been further refined and expanded to fields other than sociology (Berwick, 2003; Greenhalgh, Robert, Bate, Macfarlane, & Kyriakidou, 2005; Meyer, 2004).

Diffusion remains an ongoing quest for those aspiring to advance uptake of new ideas, especially at the systems level (Greenhalgh et al., 2004). In healthcare, diffusion of innovation has been identified as an urgent challenge that is in serious need of attention (Melnyk, 2017). Archie Cochrane first pointed to the negative impact of not integrating evidence into practice in his most influential 1973 publication, *Effectiveness and Efficiency*, where he strongly criticized the lack of reliable evidence behind many of the commonly accepted healthcare interventions at the time. Over 40 years have passed, and it continues to be of grave concern that new knowledge generation at breakneck speed by world-class healthcare researchers is yet to be adopted into daily use by healthcare practitioners (Berwick, Godfrey, & Roessner, 1991, 2002; Grinspun et al., 2014; Melnyk, 2017; Van Achterberg, Schoonhoven, & Grol, 2008).

THE ELEMENTS OF DIFFUSION: FACTORS AND CHARACTERISTICS

Rogers (2003) discusses four factors that influence spread of an innovation:

- The innovation itself
- The means of communication
- Time
- The social system

Rogers (2003) also identifies six characteristics of innovations that determine between 49% and 87% of the variation in their adoption:

- Relative advantage
- Compatibility with existing values and practices
- Degree of complexity and ease of use
- Trialability
- Visible results
- Transferability

Figure 12.1 depicts these factors and characteristics.



FIGURE 12.1 Model of diffusion of innovation theory, adapted by RNAO from Rogers (2003). Used with permission.

RNAO's BPG Program, including its most transformative meso-level implementation strategy—the BPSO Designation—are discussed next, paralleling our success to Rogers' key elements of innovation spread and uptake.

THE INNOVATION ITSELF

According to Rogers (2003) and others (Greenhalgh et al., 2004, 2005), the nature of the innovation is a critical factor in its adoption. Those involved in implementation science need to embed the characteristics of successful innovations—relative advantage, compatibility, complexity, trialability, visible results, and transferability—in their planning and implementation efforts. The BPG Program, as a successful innovation, exemplifies these characteristics (Health Council of Canada, 2012).

Advantage

First, Rogers (1983) indicates innovations that demonstrate perceived efficiencies, or show some *advantage* compared to the current system, are likely to be met with less resistance. In the case of the BPGs, these have been perceived as highly advantageous to healthcare organizations and health professionals in all roles to address needed quality improvements. This has been validated by our early adopters in Chapter 7, as well as by others (Jeffs, Lo, Beswick, & Campbell, 2013). With the BPGs, and the related supports offered by RNAO, adopters have a tangible program, evidence-based tools, and a systematic methodology (RNAO, 2012) to tackle the implementation of best evidence and solve some of the thorniest issues in healthcare—pressure injuries, falls, pain, smoking cessation, and breastfeeding rates (Athwal et al., 2014; Gifford et al., 2016; Jennings, O'Neil, Bossy, Dodman, & Campbell, 2016; Johnson-Bhatti, Case, & Shaikh, 2017; Rempel & McCleary, 2012). The evidence behind the key BPG recommendations clearly demonstrates the desired outcomes (advantages) for patients, health providers, and the system.

Compatibility

Rogers' (2003) second characteristic of *compatibility*, how the innovation relates to the pre-existing system, is evident in the BPGs and how the recommendations are structured for implementation. Given that the guidelines include recommendations addressing practice, education, and organizational policy (Grinspun et al., 2014), it is likely that some of these structures, processes, and practices are already in place. Through a gap analysis, a method of analyzing what is already being carried out as compared to the recommended best practices (RNAO, 2012), BPG implementation teams identify what they are doing that matches best practice and what they need to do (Patten, 2017). Invariably, some recommendations are already being implemented, either fully or partially, creating a “we can do it” attitude. Based on their assessment, a guide for what is to be maintained, strengthened, or newly implemented can be developed (Bajnok et al., 2015; Grinspun et al., 2015). This makes the new knowledge compatible with the current system, “makes sense” to both managers and clinicians, and eases the uptake of BPGs (Rogers, 2003). The three types of recommendations also provide a blueprint for how change in practice can be successful with appropriate policy supports and targeted education.

Moreover, another compatibility factor for direct-care nurses, the real targets for the BPGs, is that this innovation focuses on “what they do”—their work with patients. In many cases, innovations in healthcare sorely lack any relevance to the direct-care nurse. That is never the case with BPGs, and these clinicians love it.

Complexity

Third, innovations theory reinforces that the new product must not be too complex and/or it must be easy to learn about. *Complexity*, especially in the absence of visible learning resources, is a major barrier to change (Heath & Heath, 2010). In keeping with this characteristic, RNAO focuses on making evidence-based practice meaningful, easy, and enjoyable to learn. BPG Champion programs are hosted and facilitated around the province of Ontario and have also been delivered in numerous sites across Canada. RNAO invited nurses to engage in the BPG Champion workshops and attracted the innovators and early adopters (Rogers, 2003). These Champions enthusiastically embrace new knowledge, are ambassadors of the change with their peers, and know how to convey the information in ways that can be easily understood (Ploeg et al., 2010).

In 2002, RNAO published its first Implementation Toolkit, which was revised in 2012; it is a highly popular resource that embodies implementation science principles (RNAO, 2002, 2012) and incorporates a step-by-step process to BPG implementation. In 2003, RNAO inaugurated its world-renowned BPG Learning Institute, a 5-day event packed with knowledge transfer, opportunities for application, and network building. The Institute uses dynamic, engaging teaching methodologies and adult learning principles that make learning about EBP and BPGs very meaningful, effective, and fun.

Trialability

Rogers' (2003) fourth characteristic is *trialability* of the innovation, wherein the target just wants to test it out, have a taste, or take a small step. In this regard, organizations are coached by RNAO to get started with the first BPG and to “try it out” on one unit or with one team, then revise and refine from there. Champions are encouraged to work with one peer at a time, helping them understand what evidence-based practice and BPG implementation could mean for their patients and also to their own sense of satisfaction as a nurse (Ploeg et al., 2010). RNAO has a number of communication channels (newsletters, networks, webinars, knowledge-exchange teleconferences) through which organizations can share the results of their trials and lessons learned, and further diffuse the innovation.

Visible Impact

Fifth, a good innovation should *show results*, which is incredible fuel to continue and sustain the innovation (Rogers, 2003). RNAO requires a focus on evaluation right at the outset in implementation of the BPGs (RNAO, 2012). Organizations are helped to identify baseline data so they can gauge their progress. We also encourage realistic goal setting, recognizing that practice change in healthcare has a history of taking up to 17 years (Morris, Wooding, & Grant, 2011). We help staff focus on small steps of change (Grol, Wensing, Eccles, & Davis, 2013; Heath & Heath, 2010; Kotter, 2012), beginning with provider awareness, knowledge, practice change, and then patient outcomes.

With such a focus on the clinical domain of nursing, nurses are invigorated about their practice, have language from the BPGs with which to explain their work, and feel increasing confidence in understanding the knowledge base of their profession and the evidence behind their interventions. Once these results and more improvements are evident to BPG adopters, including higher rates of retention; less variability in care resulting in cost savings; and better outcomes for patients, such as reduced falls and falls injuries (Davies, Edwards, Ploeg, & Virani, 2008; Ireland, Kirkpatrick, Boblin, & Robertson, 2013), adoption becomes an imperative.

Rogers (2003) also discusses the visibility of the innovation or how tangible it is. In order to make the BPGs more tangible, all education sessions and resources define a BPG, so there is clear understanding about what a BPG is (Jefferis, Beswick, Lo, Campbell, Ferris, & Sidani, 2013). Furthermore, in the initial stages of uptake, although RNAO had developed a state-of-the-art BPG website, we were strongly encouraged by the innovators who first used them to have hard copies of the BPGs. They indicated that it was important for nurses to be able to hold a BPG in their hands and have BPGs available to pick up and use.

Transferability

The sixth characteristic of an effective innovation, *transferability*, or use beyond the initial purpose, is important to mention here because of its impact with the BPG innovation. This last characteristic can also be seen as the degree to which the innovation will spill over into other situations and can be reinvented for other uses (Rogers, 1962, 2003). In the case of the BPGs, there are numerous other impacts that result from engagement in the BPG Program, and three are highlighted in the following discussion.

First, the RNAO Implementation Toolkit (2002) and its second edition (2012), and the many knowledge-translation strategies learned by clinicians as part of implementation science, are useful in other endeavours related to working in the rapidly changing healthcare system. This meant that nurses were more frequently identified to lead other change initiatives in their workplaces. The Implementation Toolkit has also become a teaching resource used by faculty in academic settings. Second, with the advent of BPG Champions, BPG Leaders, and the many opportunities for nurses to be involved with and engaged in BPG development and implementation networks, there has been rapid growth of leadership capacity in the nursing profession. Mid-career nurses in particular have welcomed this for the many career-enhancement opportunities it brings. Third, because many of the BPG recommendations address other members of the interprofessional team, it eases interprofessional relationships and fosters interprofessional care (McKeown, Woodbeck, & Lloyd, 2014).



REFLECTION

How have you experienced the characteristics of an innovation as applied to RNAO's BPGs? How has this contributed to diffusion of BPGs in your workplace?

Summary of Characteristics of the Innovation

RNAO's BPGs meet the characteristics of a successful innovation. Some characteristics are innate to the innovation, such as the magnetic clinical focus of the guidelines. Others are by design, as RNAO creates approaches to guideline development, implementation, and evaluation that make BPGs "diffusion-friendly" resources.

Rogers' (2003) work reinforces the need for innovations to meet the above characteristics; however, the nature of the innovation alone is not sufficient for sustained uptake, as there are still the factors of communication of the innovation, the timeframe, and the social system, which must all be considered. These three factors are addressed next in relation to RNAO's successful diffusion of its BPGs.

COMMUNICATION

Communication is extremely important to move the idea about an innovation into the system through various means of information-sharing and promoting its value. According to diffusion theory, two stages of communication are necessary—one that is more general and widespread through mass media,

and the other that is more targeted and usually person to person. This helps the potential adopter move from awareness to evaluation of the innovation, and eventually to uptake (Ghoshal & Bartlett, 1988; Rogers, 1983, 2003).

RNAO built powerful communication channels to advance its BPG innovation. The BPG development process itself is a communication channel because it involves a broad range of stakeholders, from the Expert Panel to the reviewers of the draft guideline prior to publication, and the wide dissemination of the guideline once published both in hard copy and on the web.

The BPGs are RNAO branded, prominently featuring the names of the Expert Panel members and all stakeholder reviewers and including photographs of direct-care nurses in practice situations. This serves to both acknowledge all that have contributed, adding to our collective identity (a term discussed in Chapter 1 and later in this chapter), as well as to advance program spread. Various forms of mass communication—to all nurses, other healthcare providers, and stakeholders including government leaders and the public—are used, including RNAO's *Registered Nurse Journal* (Punch, 2016); online newsletter; media releases; news stories; publications; presentations at local, national, and international events; and ongoing learning opportunities that always feature the BPGs.

For example, each year during Nursing Week, RNAO co-hosts in partnership with BPSOs a series of media events to showcase nursing leadership in evidence-based practice, featuring the impact of BPG implementation on patients and families (RNAO, 2015b, 2016a, 2017b). RNAO and healthcare organizations implementing BPGs are also very present in the media, through regular submissions of letters to the editor that respond to key healthcare issues such as breastfeeding, dementia, diabetes, pain management, and sudden infant death syndrome. In this way, important information is provided to the public about best practices related to the respective issue and how nurses are using them with demonstrated results (Bajnok, 2008; Brundage, 2008; Virani, 2007).

Furthermore, RNAO uses its commanding media presence to host press events when initiating and/or releasing specific BPGs with high public interest, such as the elder abuse BPG (RNAO, 2014) and the supervised injection services BPG (RNAO, 2016b). Our BPSOs around the world have learned to use the media as an influential communication channel to reinforce nursing as a knowledge profession making strong contributions to positive health outcomes. In Beijing, China, the launch of their BPSOs was publicized on both of their websites in order to showcase this milestone for nursing (China Care Management, 2015; School of Nursing, Beijing University of Chinese Medicine, 2017). In Colombia, a BPSO Audit was profiled in the media (Vanguardia, 2017).

Person-to-person communication channels are also involved including Champions, Expert Panel members, coaches, BPSO leaders, and RNAO partners, all of whom engage in peer-to-peer communication about available guidelines and their use and impact. The professional association status of RNAO provides ready outreach to all members through chapters and regions and to those members of other like organizations. Through these means, RNAO's BPGs have become known as credible tools that are rigorously developed and easy to use, with proven results (Davies et al., 2008).

TIME

In all diffusion activity, time is a critical factor. Rogers (2003) discusses it as the *rate of adoption*, basically how long it takes to move from awareness to uptake and full use, and also from when the product is first marketed until it can be readily available. As identified in the early exploration of the phenomenon

of diffusion, uptake can happen over a long period after introduction of the innovation (Ryan & Gross, 1943). However, RNAO has learned that in most cases with release of a particular BPG, readiness soon follows, and in fact in many cases it is already apparent. RNAO's focus—since the inception of the program—on critical clinical issues in nursing and healthcare as a guide to BPG development priorities greatly influences readiness and therefore uptake (Grinspun, Virani, & Bajnok, 2002).

RNAO is fully aware of the need to be nimble when organizations are ready to adopt BPGs, and we make them highly accessible on the website and in hard copy. Implementation Toolkits are dispatched to sites on request, and BPG Champions trained, with follow-up from RNAO to keep the momentum. Other aspects of time have to do with the BPG development process, which has been reduced sharply from 24 months to 14 months. Once a BPG that reflects a major issue in healthcare is launched in the development phase, there is keen interest in its availability by nurses and other stakeholders. In our case, the shorter the development time the greater the readiness for uptake and successful diffusion.

The passage of time has been most evident in the international uptake of BPGs. Through various networks and communication channels such as the RNAO BPG website, international conferences, and publications, nurses in other countries began to adopt the BPGs in their work and were ready to become Best Practice Spotlight Organizations (BPSO) when that opportunity became available.

THE SOCIAL SYSTEM

The final factor is the social system, or the set of interrelated units that are engaged in joint problem-solving to accomplish a common goal (Rogers, 1983; Strang & Soule, 1998). Rogers maintains that the values and culture of the social system will impact the degree and speed of uptake of an innovation (Rogers, 1983, 2003). Basically, the social system is a gatekeeper and accepts or rejects innovations based on values and norms. RNAO's profile as a professional association of registered nurses, nurse practitioners, and nursing students, and a credible, successful advocate for quality, evidence-based healthcare in the system, means it understands the nursing and healthcare social systems well.

The fact that an organization such as RNAO committed to lead this work for the profession in Ontario is embraced by nursing and health systems. The social system on all levels is addressed by RNAO in the BPG development and implementation work. For example, from the outset, the BPG user targets were broad, with recommendations developed for practitioners, educators, administrators, organizations, and system policy-makers. Therefore, the guidelines encourage full engagement of all elements of the social system. In addition, RNAO actively encourages opinion leaders, Champions, and other BPG leaders in organizations to conduct stakeholder analyses in order to determine the degree of support for and influence in the adoption of the BPG innovation (Baker et al., 1999; Legare, 2009). All of these activities reinforce how the social system is a facilitator in relation to diffusion of the BPGs.

REFLECTION

Can you identify how RNAO successfully used diffusion theory in its plans for BPG development, dissemination, and support for uptake?

The narrative above provided an in-depth analysis of the RNAO BPG Program and its BPGs using Rogers' (2003) key factors that influence the spread of an innovation. Included is a discussion of the specific characteristics of successful innovations as they apply to the program and BPGs, as the innovation. The analysis of the BPG Program using the *factors of diffusion* is presented in summary form for the reader in Table 12.1. In Table 12.2, a summary of how the RNAO BPGs and the BPSO Designation reflect the *characteristics of successful innovations* is presented.

TABLE 12.1 COMPARING RNAO'S BPG PROGRAM TO ROGERS' (2003) FACTORS OF DIFFUSION**ROGERS' DIFFUSION OF INNOVATION THEORY: FACTORS THAT INFLUENCE SPREAD****RNAO BPG PROGRAM AND BPGS**

The innovation is an idea, or entity, or practice perceived as being new by the unit of adoption—individual or organization or other unit (Rogers, 1983).

- The RNAO BPG Program with evidence-based BPGs, as the innovation, was a new entity in the nursing profession in the early 2000s, requiring practice change. See Table 12.2 for an outline of how this innovation reflects the characteristics for successful diffusion or what now is coined as spread.

Adopters are individuals, and/or organizations, or parts or all of a social system (Meyer, 2004). In Rogers' (1983) theory they are categorized, according to the timing and degree of adoption, as innovators, early adopters, early majority, late majority, and laggards.

- Adopters are individuals (micro level) attracted through the BPG Champion Network and our powerful communication channels. Many are innovators and early adopters who champion the BPGs to others in various categories of adoption—early majority, late majority, and laggards (Rogers, 1983).
- Other adopters, attracted through the BPSO Designation, are BPSO organizations at the meso level and BPSO Host organizations at the macro level.

Communication channels are the means by which the adopters learn about the innovation and are a must if diffusion is to occur (Ghoshal & Bartlett, 1988; Rogers, 1983).

- The BPG development process:
 - The BPG launch
 - Expert Panel
 - Stakeholders
 - BPG release once published, and wide dissemination
- Mass communication to all nurses, other stakeholders, and the public through RNAO's *Registered Nurse Journal*; online newsletter; media releases; news stories; scholarly publications; presentations at local, national, and international events; and ongoing learning opportunities featuring BPGs
- Inclusion of all BPG and related resources on the easily accessible RNAO website, available at no cost
- Person-to-person communication channels involving Champions, Expert Panel members, coaches, BPSO leaders, and RNAO partners engaging in peer-to-peer communication
- Professional association status of RNAO and ready outreach to all members through chapters and regions, and to members of other like organizations

Time is an element in diffusion, and usually passage of time is necessary for diffusion.

- Organizations express readiness for the innovation, given key communication channels used.
- RNAO reduced time from initiation to release for guideline development in response to readiness (BPG development time reduced from 24 months to 14 months and less).
- RNAO is responsive—Toolkits are dispatched to sites, on request, and Champions are trained.
- Passage of time has influenced worldwide dissemination of all BPGs across all sectors, including governments and academia.

continues

TABLE 12.1 COMPARING RNAO'S BPG PROGRAM TO ROGERS' (2003) FACTORS OF DIFFUSION (CONTINUED)**ROGERS' DIFFUSION OF INNOVATION THEORY: FACTORS THAT INFLUENCE SPREAD**

The social system is the context of the adopter, including internal and external influences, values, and norms (Rogers, 1983; Strang & Soule, 1998).

RNAO BPG PROGRAM AND BPGS

- The social system is a facilitator in relation to diffusion of the BPGs.
- RNAO's status as a powerful and evidence-based professional association gives it a sound understanding of the nursing and health and healthcare systems, inspiring respect for the BPG Program.
- The social system on all levels is addressed by RNAO BPG development and implementation—BPG user targets are broad, with recommendations developed for practitioners, educators, administrators, organizations, and system policymakers.
- Guidelines encourage full engagement of all elements of the social system.
- RNAO actively encourages opinion leaders, Champions, and other leaders to conduct stakeholder analyses.

BPSO DESIGNATION: SUCCESSFUL DIFFUSION AT THE ORGANIZATIONAL LEVEL

In order to speed up the rate of diffusion of BPGs and ensure sustainability, RNAO began to formally target organizations as adopters and shifted its energies for implementation to the meso (organizational) level with the creation of the Best Practice Spotlight Organization (BPSO) Designation. RNAO's intent with BPSOs is to embed EBP into the culture of an organization, thereby sustaining BPG use in a way not possible with a focus only on individuals. BPG Champions, competent ambassadors of EBP, have provided feedback that their work is not enough to effect sustained change in practice, education, and policy at the meso level in a timely manner.

As outlined in Chapter 6, *Best Practice Spotlight Organization: Implementation Science at Its Best*, BPSOs are organizations that are selected by a request-for-proposal application process to partner directly with RNAO (through a formal signed Agreement) to implement multiple clinical guidelines. These are called BPSO Direct organizations. Some of the guidelines selected by BPSOs must be implemented at the unit/team level and others at the organizational level, truly engaging the entire organization. Very specific deliverables expected of the BPSOs relate to: establishing an infrastructure, building capacity in EBP and implementation science, implementing the guidelines, dissemination of implementation efforts, results and outcomes, evaluation, regular meetings with RNAO and peer BPSOs, and biannual reports to RNAO (Bajnok et al., 2015).

This formalized organizational meso level knowledge-translation strategy commenced in 2003, and every 3 years RNAO accepts a new cohort of BPSOs in Ontario, Canada, with the most recent cohort launched in 2018. The LTC BPSO Designation tailored to this sector has some differences in BPSO intake time and other parameters as discussed fully in Chapter 11, *Evidence-Based Practice in Long-Term Care*. Beginning with nine Canadian spotlights, the BPSO Designation has expanded in Canada and since 2012 opened its doors to the world, encompassing today more than 100 BPSOs representing over 550 healthcare and academic organizations. This indicates the massive growth in 15 years, since each BPSO can represent a number of organizations either as part of a corporation, a recent amalgamation, a Canada-wide health service incorporating several provincial jurisdictions, or a whole country as is the case in Spain (for the latter, see Chapter 13, *BPSO Host: A Model for Scaling Out Globally*). The numbers of healthcare providers and organizations using BPGs and the number of BPSOs worldwide have clearly reached a critical mass (Rogers, 2003).

The first cohort of BPSOs that eagerly stepped forth to partner with RNAO to create and sustain evidence-based cultures (Bajnok et al., 2015; Higuchi, Davies, Edwards, Ploeg, & Virani, 2011; Higuchi, Davies, & Ploeg, 2017) were spurred on by their BPG Champions, who themselves were innovators and early adopters. These organizations represented large acute care settings in Toronto and northern Ontario, and also two large home health settings and one large rehabilitation hospital (see Chapter 7, *The BPSO Pioneers: Creating, Sustaining, and Expanding Evidence-Based Cultures Through the BPSO Designation*). All had substantial numbers of nurses, were looking to create meaningful work for their staff, and were prepared to target resources to knowledge translation for quality improvement to achieve better patient outcomes. These pioneers, most of whom have retained their designation over the past 15 years, demonstrate sustainability above the norm (Davies, Tremblay, & Edwards, 2010; Higuchi, Downey, Davies, Bajnok, & Waggott, 2013). They have also paved the way and have become exceptional mentors to novice BPSOs, a much-needed strategy in EBP implementation (Grinspun et al., 2014; Melnyk, 2007, 2014; Stetler, Richie, Rycroft-Malone, & Charns, 2014).

From acute care teaching hospitals to large home healthcare organizations, the BPSOs have spread throughout the health sectors, including community hospitals, public health, primary care, and long-term care, as well as academic settings (Bajnok et al., 2015). In fact, to support the ever-growing cohort of academic BPSOs, RNAO developed the *Educator's Resource* (2005), much like the Implementation Toolkit initially developed in 2002, to be used as a guide to integrate BPGs throughout the curriculum, address change challenges, align teaching methodology with BPG integration, and evaluate outcomes. Moreover, RNAO has collaborated with faculty to develop resources for undergraduate nursing curricula to support integration of specific BPGs such as the *Nurse Educator Mental Health and Addiction Resource* (RNAO, 2017a) and *Nursing Faculty Education Guide (NFEG): Tobacco Use and Associated Health Risks* (RNAO, 2010).

The approach to diffusion of the BPSO Designation and its rapid uptake around the world reflect Rogers' diffusion theory in ways similar to uptake of the BPGs. Table 12.2 summarizes the discussion of the BPG Program and the BPSO Designation in relation to Rogers' (2003) theory of diffusion and shows how each meet the six characteristics of a successful innovation.



REFLECTION

How do the characteristics of the BPSO Designation link to diffusion theory? How did attention to this theory help overcome potential challenges of organizational adoption of evidence-based practice?

TABLE 12.2 APPLICATION OF ROGERS' (2003) CHARACTERISTICS OF SUCCESSFUL INNOVATIONS TO RNAO BPGS AND THE BPSO DESIGNATION

CHARACTERISTIC OF SUCCESSFUL INNOVATIONS (ROGERS, 2003)	BPGS AS AN INNOVATION	BPSO DESIGNATION AS AN INNOVATION
Advantage	<ul style="list-style-type: none"> ■ Advantageous to healthcare organizations and staff working to address quality improvements ■ Offers a tangible program, evidence-based tools, and a systematic methodology (RNAO, 2012) to use in tackling the implementation of best evidence ■ Tools are now available to solve issues in healthcare—pressure injuries, falls, pain, smoking cessation, and breastfeeding. ■ Evidence in BPGs demonstrates the potential advantages to the users and, ultimately, the patients. 	<ul style="list-style-type: none"> ■ The BPSO Designation provides a tangible program to support organization-wide implementation of EBP, and taking action to resolve some key healthcare issues. ■ Evidence-based BPGs and implementation resources, including systematic methodology for implementation, are perceived as advantageous to the organizations. ■ The BPSOs engage and involve nurses directly in leading evidence-based solutions for clinical issues through BPG implementation.
Compatibility	<ul style="list-style-type: none"> ■ Gap analysis helps determine what is being done right and gives information for development of a plan increasing compatibility with current work. ■ The three types of recommendations provide a blueprint for how change in practice can be successful with appropriate policy supports and focused education. ■ Compatible with direct-care nurses, this innovation is focused on “what they do,” their work with patients, and is welcomed. 	<ul style="list-style-type: none"> ■ Given that the BPSO Designation bundles numerous approaches based on implementation science, it simplifies the knowledge transfer and BPG implementation, influencing the speed of uptake and further aiding diffusion across health sectors and borders. ■ The formal Agreement with RNAO clearly identifies the supports available from RNAO and expectations of the organizations. ■ RNAO hosts webinars in advance of BPSO application due dates to provide information. ■ The BPSO Orientation Program brings clarity to the BPG implementation and evaluation processes.
Complexity	<ul style="list-style-type: none"> ■ Focus on making EBP meaningful, easy, and enjoyable to learn ■ BPG Champion programs are hosted and facilitated. ■ The Champions are also ambassadors of the change with their peers and can simplify information for them. ■ RNAO's Implementation Toolkit was developed, which embodies implementation science and incorporates a step-by-step process to BPG implementation. 	<ul style="list-style-type: none"> ■ BPSO applicants are expected to have had some success already in BPG implementation. ■ Many organizations have a critical mass of BPG Champions. ■ The BPSO activities provide an approach organizations are committed to carrying out for quality patient care according to their vision, mission, and values. ■ BPSOs identify BPGs that align with their priorities and quality-improvement challenges, within the parameters of the BPSO Agreement.

CHARACTERISTIC OF SUCCESSFUL INNOVATIONS (ROGERS, 2003)	BPGS AS AN INNOVATION	BPSO DESIGNATION AS AN INNOVATION
Complexity (continued)	<ul style="list-style-type: none"> ■ RNAO inaugurated the Clinical BPG Learning Institute, which makes learning this innovation very accessible, fun, and effective, through sound content and engaging, participatory, action-oriented methodology. 	<ul style="list-style-type: none"> ■ Opportunities for mentoring from other BPSOs and the peer collaboration and support in each cohort of BPSOs reduces complexity and helps address challenges.
Triability	<ul style="list-style-type: none"> ■ Organizations are coached by RNAO to get started with the first BPG and to “try it out” on one unit or with one team, then revise and refine and take next steps. ■ Champions are encouraged to work with one peer at a time and help them to understand what EBP and BPG implementation could mean. ■ RNAO set up communication channels so organizations can share the results of their trials, and lessons learned, and widen the spread. 	<ul style="list-style-type: none"> ■ Although the BPSO signs a formal Agreement, there is an option to end the Agreement. ■ The 3-year timeframe, along with RNAO supports and peer support throughout the BPSO qualifying period and following qualification as a BPSO Designate, helps organizations to address issues one step at a time. ■ There is opportunity for an extension of the predesignation period should an organization require it.
Tangible innovation and visible impacts	<ul style="list-style-type: none"> ■ To make BPGs more tangible, all education sessions and resources provide a discussion of BPGs, what they are, why they are important, and how to use them. ■ In the initial stages of uptake, RNAO produced hard copies of the BPGs so nurses could hold a BPG in their hands and have them available to pick up and use. ■ RNAO encourages a focus on evaluation at the outset in implementation of the BPGs. ■ Organizations are helped to identify baseline data so they can gauge their progress. ■ Realistic goal setting is encouraged. ■ Small steps of change are a focus, beginning with provider awareness, knowledge, practice change, and then patient outcomes. 	<ul style="list-style-type: none"> ■ The BPSO Model includes a focus on several areas to ensure robust evaluation of the BPG implementation efforts by BPSOs, including: <ul style="list-style-type: none"> ■ Submission of data to NQuIRE (RNAO's data system), as well as through assessment of structures, processes, and patient outcomes ■ Monthly knowledge-exchange sessions with peer BPSOs, regular reporting to RNAO, and requirements for dissemination all contribute to visible outcomes from the innovation. ■ Biannual reporting into RNAO's myBPSO, which is the online reporting system ■ Secondary data analysis of other health system data repositories to complement NQuIRE data analysis ■ This supports triangulation of quantitative and qualitative data within the different analytic approaches in our framework to respond to various research and evaluation questions, methods, and methodologies. (See Chapter 16, <i>Evaluating BPG Impact: Development and Refinement of NQuIRE</i>)

continues

TABLE 12.2 APPLICATION OF ROGERS' (2003) CHARACTERISTICS OF SUCCESSFUL INNOVATIONS TO RNAO BPGS AND THE BPSO DESIGNATION (CONTINUED)

CHARACTERISTIC OF SUCCESSFUL INNOVATIONS (ROGERS, 2003)	BPGS AS AN INNOVATION	BPSO DESIGNATION AS AN INNOVATION
Tangible innovation and visible impacts (continued)	<ul style="list-style-type: none"> ■ Early results are shared widely through communication channels. <ul style="list-style-type: none"> ■ For nurses: They are invigorated about their practice, have language from the BPGs with which to explain their work, and feel increasing confidence in understanding the knowledge base of their profession and evidence-based interventions. ■ For patients: They experience better outcomes such as reduced falls and fall injuries. ■ For organizations: They report increased retention of nurses and less variability in care, resulting in cost savings. 	<ul style="list-style-type: none"> ■ Evaluation is a key component of BPSO deliverables, both through submission of data to NQuIRE (RNAO's data system), as well as through assessment of structures, processes, and patient outcomes.
Usefulness in other situations	<ul style="list-style-type: none"> ■ Numerous other transferable impacts from this innovation: <ul style="list-style-type: none"> ■ Nurses and others learn about change management and practice change. ■ Nurses assume leadership roles in other change initiatives. ■ Faculty use implementation resources in teaching. ■ Broad leadership capacity building for nurses and other clinicians ■ Career boost for mid-career nurses ■ Stronger interprofessional relationships and interprofessional care 	<ul style="list-style-type: none"> ■ The expectations related to the BPSO Program enhance professional practice, interprofessional practice, and the organizational profile as an EBP culture. ■ Increased engagement and morale of nurses and other clinicians ■ There are strong links between BPSO and accreditation success, and BPSOs in LTC incorporate their BPG implementation efforts and outcomes in their required Quality Improvement Plans submitted to the government to support funding. ■ BPSOs in all sectors, and especially in hospitals, home care, and LTC, are achieving top scores in quality improvements and financial efficiencies. ■ BPSO enrollment has assisted several hospitals secure their Magnet status.

BPSO HOST MODEL: SUCCESSFUL DIFFUSION AT THE MACRO GLOBAL LEVEL

The creation of the BPSO Host Model was the next step in RNAO's approach to diffusion, from micro-level diffusion with the BPG Champion Network, to meso-level diffusion with the BPSO Direct Model, to macro-level diffusion with the BPSO Host Model. RNAO was spurred onto the development of the BPSO Host Model by the great enthusiasm shown by nurse leaders in Spain regarding RNAO's work in policy and evidence-based guidelines and our active implementation through the BPSO Designation. The vision of RNAO leadership to extend the BPSO Designation to incorporate satellite sites around the world (BPSO Host Model), with Spain as the first innovator BPSO Host, was the springboard to a rapid global spread. From this beginning in Spain in 2012 (Grinspun, 2011; Albornos-Munoz, González-María, & Moreno-Casbas, 2015), other BPSO Hosts have been established in Australia, Italy, Peru, and Chile. Logos from some of these Hosts are included in Figure 12.2. In addition, RNAO continues using the BPSO Direct Model to establish centers of evidence-based practice in countries like Belgium, China, Colombia, Nova Scotia (Canada), Portugal, and Jamaica, some of which will in time become BPSO Hosts and extend the spread throughout their jurisdictions.

The evidence-based practice movement, led by RNAO and impacting nursing and healthcare on a global level, has affected practice change, policies at organizational and systems levels, the image of nursing, the scope of practice of nurses, governance and decision-making structures, and monitoring and evaluation of outcomes. From Canadian BPSOs in public health, primary care, hospitals, home care, and long-term care, to service organizations and academic institutions in Australia, Belgium, Chile, China, Colombia, Italy, Jamaica, Peru, Portugal, Qatar, and Spain, there has been a sustained shift in how care is delivered and how students are taught. This has bolstered the degree of nursing pride and satisfaction and strengthened the status and place of nursing on the healthcare team (RNAO, 2015a).

REFLECTION

What other examples can you think of where change in practice has influenced the organization or system more broadly? How do you think involvement of a professional association and its partnerships influenced the changes generated by the BPSO global spread?



FIGURE 12.2 Logos from BPSO Hosts in Canada, Chile, and Peru.

MAXIMIZING SPREAD WHILE MAINTAINING BPG PROGRAM AND BPSO FIDELITY

As we enable global spread, RNAO is paying close attention to the systems and processes necessary to ensure BPSO fidelity. Mowbray, Holter, Teague, and Bybee (2003) define *fidelity* as the degree to which program delivery is consistent with the program model as planned by the developers. Carroll et al. (2007), in crafting a conceptual framework for implementation fidelity, purport that attention to fidelity is critical in being able to determine program impacts and prevent inaccurate conclusions about a program's effectiveness. They reinforce the importance of this, stressing that program fidelity affects how well it succeeds.

There is general agreement (Dane & Schneider, 1998; Durlak & DuPre, 2008; Dusenbury, Brannigan, Falco, & Hanson, 2003; Fagan, Hanson, Hawkins, & Arthurs, 2008) that fidelity implementation can be measured through a review of the following components that should be part of all program evaluation. These components are:

- **Adherence**—How well the program meets the requirements
- **Exposure**—The extent of program delivery, how widespread it is
- **Quality of delivery**—Its ability to reflect program standards and values to a high degree
- **Participant responsiveness**—The extent of engagement, level of interest, belief in usefulness of the program, and enthusiasm
- **Program differentiation**—The distinctiveness of each component of the program, including those with most impact

Alternatively, in recognizing the concepts of fidelity and fit and their inherent tensions (Castro, Barrera, & Martinez, 2004), Chambers, Glasgow, and Stange (2013) discuss the importance of dynamic sustainment that acknowledges evolution of EBP interventions over time and contexts, and they assert that dynamic sustainability is necessary in order to respond to contextual realities and keep programs relevant to the users. Chambers et al. (2013) reinforce the need for program targets to be able to contribute to the program and co-create some aspects to ensure relevance and sustainability within the program parameters.

These are all critical considerations in the ongoing expansion and spread of the BPSO Designation and present challenges that RNAO's program of quality assurance and fidelity has kept in focus, including:

- Ensuring the BPSO Designation remains consistent in all aspects: when RNAO acts as the BPSO Host; when an organization outside RNAO acts as a BPSO Host; when BPSOs are overseen by BPSO Hosts in other jurisdictions
- Balancing continued contextual relevance, along with sustainment and fidelity
- Maintaining communication channels to keep BPSO Hosts and RNAO BPSO Direct organizations informed about changes in the BPSO Designation
- Fostering a collective identity amongst all BPSO organizations as part of a global evidence-based practice movement

Each aspect of the fidelity process is designed to meet one or more of the four goals identified above. As discussed at the outset of this book, a key success factor of RNAO's program and especially of its BPSOs is that it has created a sense of *collective identity*, which is a major influencer of sustainability, fidelity, and accelerated diffusion (see Chapter 1, *Transforming Nursing Through Knowledge: The Conceptual and Programmatic Underpinnings of RNAO's BPG Program*). Collective identity of the BPSOs

reflects the values of the BPSO Designation. It is expressed through the intense pride organizations have in being a BPSO and part of the global EBP movement through sustained implementation of RNAO BPGs and ongoing evaluation and dissemination of their impact. Collective identity is evident in:

- The display of the logo on organizational materials
- Open sharing and building of new tools and approaches together across borders
- Dissemination of outcomes in presentations and publications
- Ready agreement to be part of all aspects of the program—whether it be guideline development, implementation, evaluation, teaching, mentoring, or auditing
- The intense work by all BPSOs to make use of best evidence better and better for patients

This section discusses the various ways RNAO has addressed fidelity of the BPSO Designation as it expands and spreads. They encompass approaches that enable dynamic sustainment (Chambers et al., 2013) of a quality EBP initiative that impacts effective guideline uptake across global contexts, and address each of the five components discussed above. The quality assurance and fidelity assessment components incorporate: 1) the BPSO Orientation Program; 2) the Certified BPSO Orientation Trainer process; 3) the audit and feedback requirement; 4) the NQuIRE Data System and MyBPSO Reports; 5) the use of technology to provide education and consultation; 6) approaches to translation; and 7) ongoing program requirements.

These are all apparent when measuring fidelity, in particular the components of quality and participant responsiveness.

THE BPSO ORIENTATION PROGRAM

The 5-day BPSO Orientation Program provides foundational knowledge and skills to the identified group of stakeholders and Champions who will lead the BPSO process in their organization, including specific BPG implementation. This Orientation Program is based on the RNAO Implementation Toolkit (2012), uses several examples of successful BPG implementation and achievements of BPSOs, and consists of curriculum components based on the Knowledge-to-Action framework (Straus, Tetroe, & Graham, 2013). It serves as the training program for BPSO Sponsors, BPSO Leads, and Champion Leaders, who in turn train BPG Leads and Champions in a workshop targeted to their roles in accomplishing BPSO deliverables including BPG implementation.

All BPSOs and BPSO Hosts begin their BPSO Designation work with the Orientation Program, which is delivered in a consistent manner in all settings. Where possible, participants from different BPSOs attend the orientation together, contributing to their collective identity as BPSOs. RNAO leads the orientation for its BPSO Direct organizations as well as new BPSO Host organizations and provides ongoing support according to the BPSO Agreement. Once fully oriented, BPSO Hosts plan and lead the orientation for BPSOs in their own jurisdictions and continue with the follow-up monitoring and support.

Participants receive a workbook prepared by RNAO, complete with objectives, content, handouts, application exercises, and reference material for each session. The teaching methodology (as critical as the content) is built on a model of sustainable capacity building and includes personal goal setting, critical knowledge exchange, engagement, application exercises reflecting their context, network building, individual and group leadership opportunities, and action planning. For many nurses outside of North America, these sessions introduce an entirely new approach to teaching and learning and build knowledge and understanding, and ability to apply theory, as well as confidence and skill in articulating the rationale for evidence-based practice and the value and impact of nursing.

The BPSO Orientation Program is led by RNAO International BPSO Coaches—as *BPSO Master Trainers*. In the case of orientation for BPSO Hosts, the BPSO Orientation Program incorporates a train-the-trainer process at the outset, wherein RNAO trains the BPSO Host Lead as a *Certified BPSO Host Master Trainer* for future delivery of the program to continue capacity development and BPSO spread in their jurisdiction. For new BPSO Direct organizations, the RNAO BPSO Master Trainers, BPSO Host Master Trainers, and/or a *Certified BPSO Orientation Trainer (CBOT)* conduct their orientation. CBOTs are registered nurses who meet set criteria and undergo training with the Master Trainer, be it RNAO or the BPSO Host. More details about the RNAO International BPSO Training of Trainers Model are discussed later in this chapter.

The Training of Trainers Model for BPSO Hosts benefits both the BPSO initiative in that country and the overall BPSO Program. Not only does the country-specific initiative build on a partnership model and extend RNAO resources, it also contributes to capacity development and the collective identity of BPSOs, working collaboratively with each other.

BPSO AUDIT AND FEEDBACK REQUIREMENT

The Cochrane Effective Practice and Organization of Care (EPOC) group defines *audit and feedback* as a synopsis of clinical behaviours of health practitioners related to their care, over a specific time-frame, in order to modify such behaviours according to a standard (Grimshaw, Eccles, Lavis, Hill, & Squires, 2012). The synopsis may result from observed practice, outcomes, and/or written records, and include recommendations and action plans (Grimshaw et al., 2012). In exploring effective interventions to improve health outcomes, Grimshaw et al. (2012) analyzed key Cochrane reviews of professional behaviour change strategies, including audit and feedback. They identified that important elements of effective audit and feedback are: an objective standard, provision of feedback with recommendations, and an action plan. Grimshaw and colleagues (2012) concluded that audit and feedback are useful tools because up to almost a third of the time, professionals rate their performance at levels higher than actual (Adams, Soumerai, Lomas, & Ross-Degnan, 1999). Audit and feedback, by exposing this discrepancy, can stimulate behaviour change. In more in-depth secondary analyses of these systematic reviews, Ivers and colleagues (2014) verified these findings and asserted that audit and feedback indeed works.

Consistent with these views related to motivating professional behaviour change, RNAO's attention to BPSO quality includes an annual audit of the BPSO in years two and three of the prequalifying period. Through the required audit and feedback processes, site visits are made to the BPSO Hosts and BPSO Directs. The BPSOs are informed in advance that the visit will take place within a mutually agreed upon timeframe. They are advised that we expect to observe evidence of the required deliverables as outlined in the BPSO Agreement. These deliverables include infrastructure, capacity building, BPG implementation, dissemination, and evaluation, as well as in-time practice and/or teaching observa-

tions according to the recommendations contained in the selected BPGs. Specific audit tools have been developed for BPSO Hosts, as well as Direct Service and Academic BPSOs, which reflect the BPSO Agreement deliverables and serve as criteria for the audit. The audit tools guide the BPSO audit visit and assist in determining strengths and areas for growth for provision of timely feedback to BPSOs. BPSO Hosts conduct audits with their BPSO Directs; RNAO audits the BPSO Directs for which it is responsible, as well as all the BPSO Hosts.

During the onsite audit, an initial meeting is held and presentations are made by the BPSO or BPSO Host reflecting major aspects of the cultural shift that has taken place over the past year. In service BPSO audits, this meeting is attended by key organizational stakeholders including senior management, the BPSO Lead, specific BPG Champions, and other leaders, all of whom have a role to play in the presentation. Visits are then made to specific units/teams where BPGs are being implemented, and the auditors observe practice situations and speak with nurses, physicians, other members of the team, and patients. If students and faculty are part of the audited unit or team, they participate as well. This type of visit can take from 3 to 4 days depending on the size of the BPSO and number of units and teams involved. When an academic BPSO is audited, the same process is used involving senior academic administration, BPSO Leads, faculty, and students, and observations are made of the curriculum, teaching materials, and teaching-learning situations.

Consistent with the recommendations of Ivers et al. (2014) and Grimshaw et al. (2012), relative to an effective audit and feedback process, the visit concludes with a final opportunity for the organization to review highlights, followed by a presentation from the auditors. The auditors present a summary of the strengths and necessary improvements according to the criteria, and recommendations for follow-up are outlined and discussed. Within a 2-week period, the BPSO receives a written summary with the recommendations that are to be addressed by the BPSO in a plan of action. Coaching and monitoring continues, and progress is measured through regular meetings, biannual reports, and future audits.

NQUIRE DATA SYSTEM AS A FIDELITY AND QUALITY ASSURANCE STRATEGY

RNAO's focus on a consistent means of evaluation of BPG implementation through NQuIRE (see Chapter 16, *Evaluating BPG Impact: Development and Refinement of NQuIRE*) also acts as a quality assurance strategy (Grinspun et al., 2015). All BPSOs are required to submit data on quality indicators defined in data dictionaries for the NQuIRE international data system. Human resource structural indicators are submitted for the BPSO and implementation sites, as are the evidence-based process and outcome indicators specific to each BPG. Regular communication with BPSOs, and review of the NQuIRE results in the biannual report submissions to RNAO, ensure that BPSOs are consistent in their focus on key interventions and in how they measure both practice changes and BPG impacts. NQuIRE is enabling RNAO, BPSO Hosts, and BPSO Direct organizations to review implementation across jurisdictions or units and teams, which helps identify trending of outcomes that can lead to further opportunities for quality-improvement practices.

USE OF TECHNOLOGY TO PROVIDE EDUCATION AND CONSULTATION

In an effort to better prepare local, national, and international BPSOs, RNAO devised a boot camp methodology to exchange knowledge on critical aspects of the BPG Program and BPSO Designation. These include face-to-face interactive sessions attended by Ontario BPSOs in person and virtual boot camps organized for national and international BPSOs. Such sessions have provided information about the NQuIRE data system, guidance for selecting indicators and submitting data, and the opportunity to troubleshoot problems and to have hands-on experience using the NQuIRE demonstration site. This mode of interactive education serves as another means to ensure consistent approaches to data submission that meet the quality standards. It also provides opportunities for BPSOs to meet via interactive web-conferencing platforms. It is important in our focus on global uptake that we offer similar education, coaching, and feedback opportunities to local, national, and international partners, and build collective identity amongst BPSOs.

APPROACHES TO TRANSLATION

Currently, RNAO has a formal translation process that guides the translation of BPGs and various resources and supports into a variety of languages. The process includes a signed Agreement between RNAO and the organization sponsoring the translation, stipulating their responsibilities for funding the initial translation, and our mutual engagement in reverse translation and other validating processes. An ever-critical aspect of quality control is accurate translation of the evidence-based tools that reflects the evidence and the intent of the recommendations and is consistent with language and cultural nuances.

ONGOING BPSO DESIGNATION REQUIREMENTS AND OPPORTUNITIES

The stringent requirements to become a BPSO Designate and to retain the Designation, as outlined in Chapter 6 and highlighted throughout this chapter, are also key factors that impact program fidelity. These requirements ensure program consistency and fidelity.

Opportunities for meetings and interactive reviews of processes and outcomes, including NQuIRE outcomes, contribute to BPSOs' understanding of the program requirements and RNAO's ability to monitor that the BPSOs have met the requirements. BPSOs have a wealth of opportunities to be informed about and engaged in aspects of BPG development, implementation, and evaluation. They may contribute as BPG development Expert Panel members; stakeholder reviewers of guidelines, implementation tools, indicators, and other program proposals; and members of advisory committees.

Table 12.3 summarizes the goals of RNAO's process of measuring implementation fidelity and the key components relevant to each goal.

REFLECTION

How will attention to quality assurance and fidelity of the BPG implementation and the BPSO Designation assist in building nursing as a knowledge profession, and creating evidence-based cultures the world over?

TABLE 12.3 GOALS OF RNAO'S PROCESS OF MEASURING IMPLEMENTATION FIDELITY AND THE KEY COMPONENTS RELEVANT TO EACH GOAL

GOAL OF FIDELITY	KEY FIDELITY PROGRAM COMPONENTS TO ADDRESS GOAL
Ensure the BPSO Designation remains consistent in all aspects when RNAO acts as the BPSO Host; when an organization outside RNAO acts as a BPSO Host; when BPSOs are overseen by BPSO Hosts in other jurisdictions	<ul style="list-style-type: none"> ■ BPSO Orientation Program ■ Certified BPSO Orientation Program Trainer ■ Regular knowledge exchange meetings amongst RNAO and BPSOs organized by country, region, designation status, and/or type or model of BPSO ■ RNAO's annual audit and feedback process with the BPSO when RNAO acts as the Host, and of the BPSO Host with selected visits to BPSOs ■ Annual audit and feedback process conducted by BPSO Host ■ Review of reports including NQUIRE and myBPSO reports ■ Translation process
Balance continued contextual relevance, along with sustainment and fidelity	<ul style="list-style-type: none"> ■ Formal and informal opportunities to provide feedback ■ Sharing of context-related strategies in meetings, reports ■ Opportunities to be stakeholders, reviewers, and/or give input to BPGs, BPG development process, implementation tools, BPG evaluation, NQUIRE, BPSO Agreements ■ Membership on advisory committees related to major program elements, development, implementation, and evaluation ■ Audit site visits to see context and how BPSO is relevant in the context
Maintain communication channels to keep BPSO Hosts informed about changes in the BPSO Designation; and monitor achievements	<ul style="list-style-type: none"> ■ RNAO website ■ Connection with RNAO Coach and regular meetings and knowledge exchange sessions with RNAO and BPSOs ■ BPG Newsletter ■ Regular reports with discussion ■ Similar processes carried out by BPSO Hosts with their BPSOs—website, newsletter, meetings, and reporting ■ Several knowledge tools to assist in understanding specific BPGs and their application, including webinars, eLearning programs, BPG quick reference guides, NQUIRE updates, and overall reporting requirements
Cultivate a collective identity amongst all BPSOs as part of a global evidence-based practice movement	<ul style="list-style-type: none"> ■ BPSO is a partnership. ■ Collective meetings with all BPSOs ■ Annual international BPSO symposium ■ Regional BPSO events ■ CBOT and Network ■ Certified BPSO auditor (CBA) and Network ■ Use of BPSO logo ■ BPSO Communities of Practice ■ Mentorship opportunities ■ Technology-supported learning opportunities

THE FUTURE

The future for the RNAO BPGs and BPSO Designation holds much promise. With the BPSO Designation currently in 12 countries and several others in the application phase, the RNAO BPGs are well recognized as quality knowledge products that are positively transforming the nursing profession and its clinical, educational, and managerial practices. The program's impact in service and academic organizations consistently demonstrates improvements in education, patient, organizational, and health system outcomes. The enthusiastic BPG use by nurses in all roles and sectors, other health professionals, faculty and students, as well as policymakers has cemented the strong credibility of RNAO's BPGs and its BPSO Program. Added to this is the ongoing media attention that has served to spread the success of this program. The rapid growth of the BPSO Designation as a successful knowledge transfer strategy across various contexts has brought new strengths and important challenges to the BPSO Designation. Within this perspective, some of the future considerations are discussed next.

BPSO DESIGNATION AS A PARTNERSHIP INSPIRING COLLECTIVE IDENTITY

As the BPSO Models expand and mature, RNAO's role will be to continue to partner with BPSOs, to examine what is working well, what needs to be strengthened, and what needs to evolve to ensure effective evidence-based care around the world, through a high-quality BPG Program and BPSO Designation. The BPSO Model presents an opportunity for capacity development in the nursing profession from the perspective of evidence-based practice. Furthermore, in the process, countries around the world have learned many strategies related to policy development, political advocacy, and honing collaborative partnerships with other professional and healthcare bodies, and governments.

There are a number of emerging supports that will need to be tested and contextualized to fit the variety of systems and cultures that are part of the burgeoning BPSO Designation worldwide. Mentoring has been identified in the literature as a significant support (Melnik, 2007, 2014), and based on RNAO's experience, it enhances quality in both the mentor and mentee organizations. More international mentors will be identified and supported into the future, as technology is harnessed to expand and create new knowledge-sharing links, which connect individuals and organizations for mutual learning.

Collective identity is a term discussed in detail in Chapter 1, *Transforming Nursing Through Knowledge: The Conceptual and Programmatic Underpinnings of RNAO's BPG Program*. RNAO will continue to set the standard to inspire and nurture the program's collective identity in all forms of knowledge exchange, wherein BPSOs build on their relationships and expertise to learn from each other and together with RNAO build the BPSO movement. For example, academic BPSOs in Belgium, Canada, Chile, China, Colombia, Italy, Jamaica, Peru, Portugal, and Spain are teaching us how to best integrate BPGs throughout the curriculum. The Academic BPSOs around the world are helping us build better evaluation strategies of BPG impact on faculty, student, and patient outcomes, which will soon be part of the NQuIRE data system. The onsite visits, including RNAO's in-person audit and feedback processes, were first introduced in our international BPSOs and in 2016 became part of the requirements for Ontario's BPSOs.

The more our international BPSOs have a voice in the processes of developing evidence-based cultures, the more the co-created structures and processes will contribute to a collective identity and dynamic sustainment, yielding better outcomes for our patients at home and abroad. Real and sustained growth of the nursing profession globally will only happen when all nurses have equal voices in shaping the destiny of our profession as evidence-based, client-centred, and equal partners on the interprofessional team. This is being realized through the BPSO Designation that is experiencing continued spread, dynamic sustainment, and robust fidelity.

BPG TRANSLATION

As the development of BPSOs around the world accelerates, so too must the systems of translation to see that BPGs are accurately translated into different languages. Spread in regions and countries will facilitate this, as the presence of several BPSOs in an area that communicate in a similar language will mean additional skills and resources to engage in the process. Translation teams—including RNAO staff and members of the BPSO organizations who can work to synchronize language, healthcare, and cultural differences—will be more and more important as expansion occurs.

BPSO SPREAD, SUSTAINABILITY, AND QUALITY MONITORING THROUGH TRAINING TRAINERS

Critical to the spread of the BPGs and BPSOs is RNAO's philosophy and capacity to extend its knowledge, skills, and resources widely beyond its own milieu. As described in Chapter 1 and Chapter 18, *Scaling Deep to Improve People's Health: From Evidence-Based Practice to Evidence-Based Policy*, such capacity has been fuelled by RNAO's strong standing as a professional association with a network of members in chapters and interest groups, an activist membership, and strong relations with like organizations. RNAO's formal dissemination channels and extensive use of technology provide a robust springboard for the BPG Program to build upon, with a roster of educational opportunities that serve audiences across the globe. Chapter 4, *Forging the Way With Implementation Science*, details a few of these capacity-building opportunities.

Consistent with the concept of purposeful evolution discussed in Chapter 1, RNAO has honed additional spread, sustainability, and quality-monitoring approaches: the *Certified BPSO Host Master Trainer*, *Certified BPSO Orientation Trainer*, and the *Certified Auditor* that are part of the emerging RNAO Training of Trainers Model. These approaches are integral to global scaling within a context of promoting a dynamic BPSO Designation that spreads, sustains, ensures fidelity, and serves to manage finite resources. What follows is an overview of the *Certified BPSO Host Master Trainer*, *Certified BPSO Orientation Trainer*, and the *Certified Auditor*.

CERTIFIED BPSO HOST MASTER TRAINER

Certified BPSO Host Master Trainers (CBHMT) are registered nurses from BPSO Hosts who have worked closely with an RNAO Master Trainer in the Certified BPSO Orientation Trainer role, training BPSO Sponsors, BPSO Leads, and Champion Leaders in their BPSO Directs. CBHMTs are familiar with the BPSO Orientation materials and teaching methodologies. They work independently in their jurisdictions with their BPSO Directs. Monitoring of this role by RNAO occurs through the reporting, knowledge transfer, and audit requirements of the BPSO Host, which includes ongoing assessment of the CBHMT role.

CERTIFIED BPSO ORIENTATION TRAINER

As briefly discussed earlier, Certified BPSO Orientation Trainers (CBOT) are registered nurses who meet set criteria including: Champion experience in a BPSO, skill in training, and experience in working with international populations. They are nominated from BPSO Designate organizations and once selected, receive the BPSO Orientation Program for review and discussion. They then partner

with an RNAO BPSO Master Trainer or a BPSO Host Master Trainer to co-lead orientation sessions until they demonstrate proficiency to be certified. After the Orientation Program, CBOTs commit to working with BPSOs as they achieve the required deliverables and work with Master Trainers in delivering the BPSO Orientation Program to new BPSOs.

The involvement of more CBOTs from each of the BPSO countries and creation of a Certified BPSO Trainer Network will enhance this approach to quality assurance for budding BPSOs all over the world, and also sharpen the work in the trainers' BPSOs. Moreover, this cross-pollination of best evidence will enhance healthcare globally. The impacts of a Certified BPSO Trainer Network merit investigation, and the best practices in selecting and training trainers, and maintaining trainer skill levels, need to be developed over time. The involvement of BPSO Hosts in developing CBOTs and expanding the Certified Trainer Network will be increasingly necessary.

CERTIFIED BPSO AUDITOR

Certified BPSO Auditors (CBA) are registered nurses from BPSOs who have worked with an RNAO International BPSO Coach in conducting service and academic audits using RNAO's audit tools with specific feedback and follow-up processes. Previous discussion in this chapter outlined the BPSO audit process and its effectiveness internationally as means of providing feedback, a critical component of guideline implementation and sustainment. The future will bring more requirements for RNAO and BPSO Hosts to conduct audits around the world and increase the need for Certified BPSO Auditors (CBA) from across jurisdictions and the creation of a CBA Network, much like the Certified BPSO Trainers Network. The TOT Model, explained next, will be central to this process.

TRAINING OF TRAINERS MODEL (TOT)

To establish a clear process for training of trainers such as CBOTs and CBAs, as well as the additional knowledge leaders to ensure BPSO quality and fidelity, RNAO has developed the International BPSO Training of Trainers (TOT) Model. The literature supports some of the obvious benefits of the TOT Model for individuals, organizations, trainers, and trainees alike, including: more rapid diffusion, direct access to local communities, understanding of contextual issues, local collaboration, and cost benefits (Assemi, Mutha, & Hudmon, 2007; Hiner et al., 2009; Rajapakse, Neeman, & Dawson, 2013; Yarber et al., 2015).

TRAINING PROGRAMS KEY COMPONENTS

Key components of the most effective approaches to training programs have been identified in the literature based on research of local and global programs, as detailed:

- Careful selection of candidates (Hiner et al., 2009)
- Provision of a workbook and/or specific tools (Assemi et al., 2007; Baron, 2006; Rajapakse et al., 2013)
- Supervised hands-on experience and group work (Hiner et al., 2009; Yarber et al., 2015)
- Teach-back opportunities (Hiner et al., 2009; Yarber et al., 2015)

- Focus on content as well as methodology of instruction (Assemi et al., 2007; Baron, 2006; Hiner et al., 2009; Rajapakse et al., 2013)
- Connection with local structures (Hiner et al., 2009; Rajapakse et al., 2013)
- Evaluation and feedback (Assemi et al., 2007; Baron, 2006; Hines et al., 2009)
- Creation of a TOT network (Baron, 2006; Yarber et al., 2015)

RNAO's TOT Model meets all the above criteria, and given its clear link to the specific set of deliverables required in the BPSO Designation, unlike many TOT programs, where most trainees never replicate the program (Hahn, Noland, Rayens, & Christie, 2002), in our case those trained actually deliver. RNAO's aim is to multiply its effects the world over through a TOT Model that cascades through several tiers of trainers and trainees, including RNAO BPSO Master Trainers, BPSO Host Master Trainers, Certified BPSO Orientation Trainers, BPSO Sponsors, BPSO Coaches, Champion Leaders, BPSO Leads, Champions, and BPG Leads.

Figure 12.3 shows the tiered approach to the TOT Model, whereas Figure 12.4 defines each of the tiers in the model and explains their linkages, evident in the BPSO Designation activities. Both are explained in the narrative after the figures.

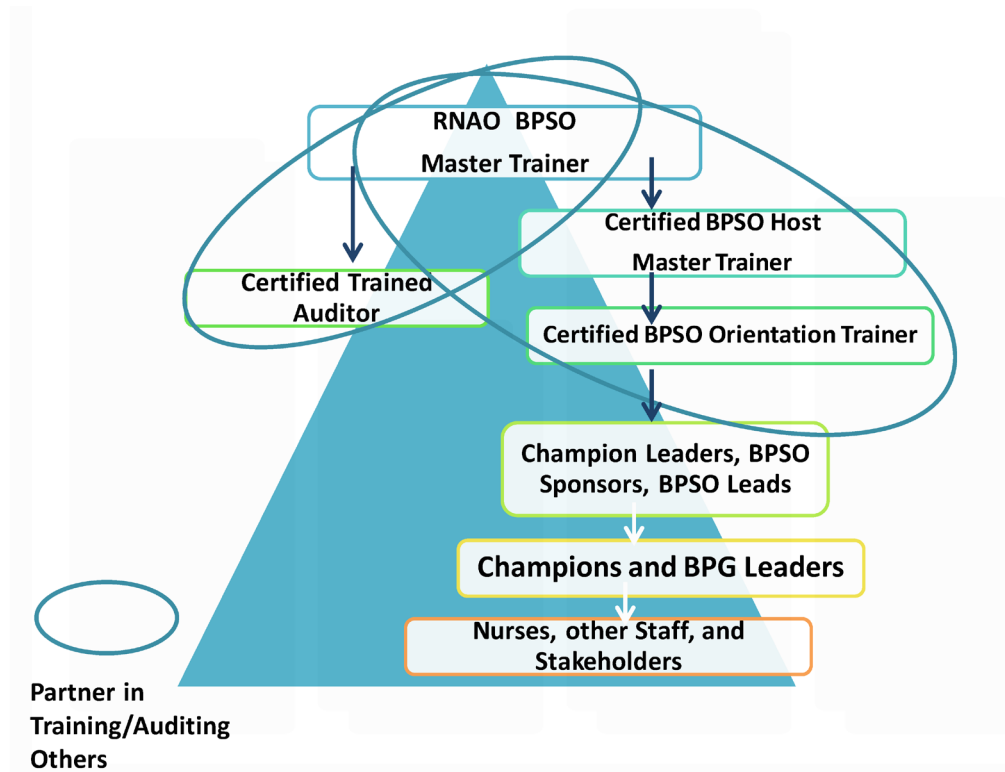


FIGURE 12.3 RNAO BPSO TOT Model showing tiers of training.
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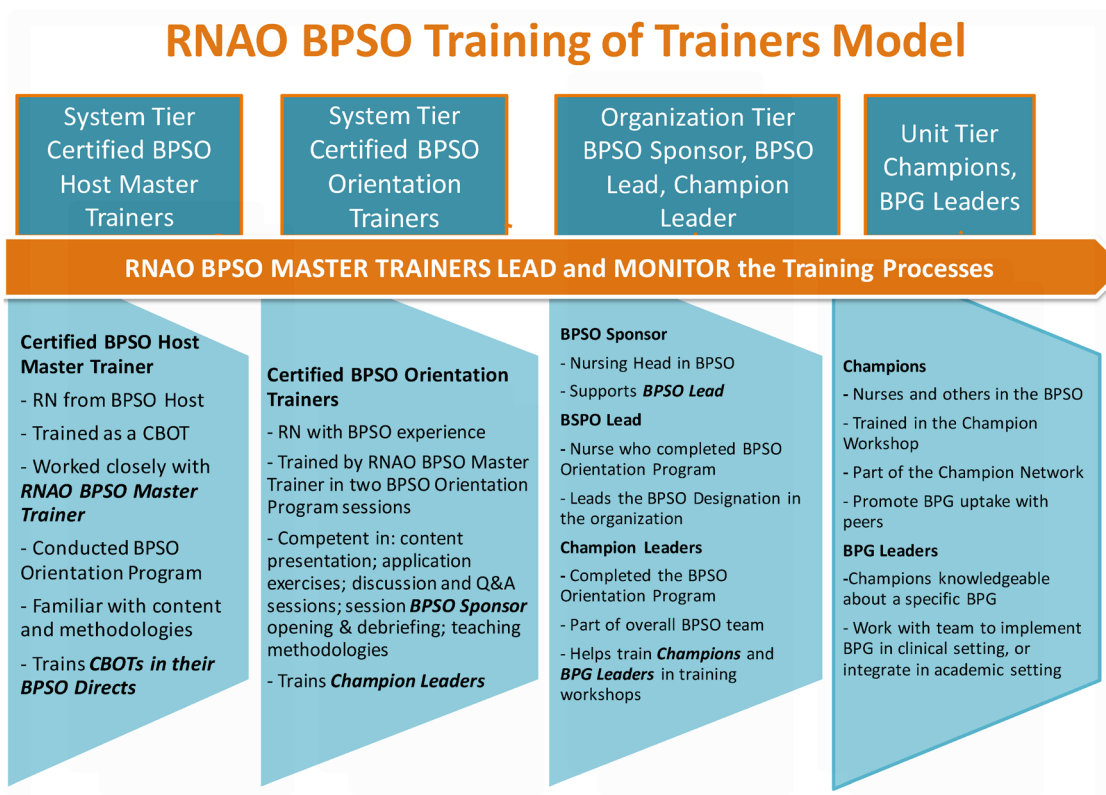


FIGURE 12.4 RNAO BPSO TOT Model with an explanation of each tier of the model.
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As can be seen in Figures 12.3 and 12.4, the TOT Model begins with the training of BPSO Sponsors, BPSO Leads, and Champion Leaders by RNAO International BPSO Coaches who are the BPSO Master Trainers. The RNAO BPSO Master Trainers select the candidates for certification based on specific criteria and work with them side by side to prepare them to fulfill the role of the Certified BPSO Trainer or Certified BPSO Auditor.

As mentioned earlier, the BPSO Host Model presents another opportunity for training the trainer. In these situations, the RNAO BPSO Master Trainer will train a BPSO Host Master Trainer, who in turn can train Certified BPSO Trainers as well as organization-tier leaders.

These Champion Leaders in turn train Champions and BPG leaders at the unit tier, using a similar methodology in a shortened course. The Champions and BPG Leaders have clear roles in working with nurses, other staff, and stakeholders. Nurses and others who have received training wear their titles of Champion Leader, BPSO Lead, Champion, and BPG Leader with pride.

REFLECTION

How does RNAO's International BPSO TOT Model influence engagement of staff in all roles in the BPSOs?

CONCLUSION

This chapter provides an overview of how RNAO has used diffusion theory in its approaches to the spread of BPGs and the adoption of the BPSO Designation around the globe. The RNAO BPG Program, including the BPSO Designation juxtaposed against diffusion theory (Rogers, 2003), demonstrates how and why the innovations and the processes used by RNAO are effective. Such processes include BPG development through to dissemination and creation of robust, systematic, evidence-based implementation processes, and establishment of the NQuIRE data system and BPSO-NQuIRE Evaluation Model.

The creation of the BPSO Designation through both the Direct and Host Models has greatly enhanced BPG dissemination and added a robust global component to RNAO's work in evidence-based practice. Undoubtedly, it has been a strong factor in the speed of uptake and sustainment of evidence-based practice. The system-wide impacts of BPG implementation and creation of evidence-based cultures have resulted in changes in practice and education in Canadian healthcare settings and the international BPSOs. These results, augmented by an effective Training of Trainers Model developed by RNAO and used around the world, enable faster program spread and sustainability, as well as effective use of resources.

Finally, with rapid growth and uptake, close attention is given to fidelity. RNAO has and will continue to build its quality-assurance program, increasingly involving BPSOs. The strong quality-improvement strategies that are currently in use have a number of benefits that all BPSOs have experienced. Knowledge exchange, cross-country sharing, and growing better together are signature values of the BPG Program and foundational to the collective identity that we have built as BPSOs.

KEY MESSAGES

- Both the widespread implementation of RNAO BPGs and uptake of the BPSO Designation reflect key elements of the theory of diffusion.
- The BPSO Designation, both the BPSO Direct and BPSO Host Models, has positively impacted the quality of educational, clinical, and managerial practices and outcomes. It has also directly influenced enrichments in scope of practice, nurse-to-nurse and nurse-physician communication and collaboration, standards of practice excellence, the image of nursing and nurses, patient-centred care, organizational policy, and closing the research-to-practice gap.
- The BPSO Host Model supports “in country” capacity development in the area of EBP and has enabled RNAO to maximize diffusion and sustainability of the BPG Program and BPSO Designation at the global level, while ensuring effective use of resources.
- A standardized BPSO Orientation Program, certified trainers, annual in-person audits, and ongoing requirements and opportunities have enabled RNAO to maximize spread, sustainability, and BPSO Designation fidelity.
- The RNAO BPSO TOT Model augments the human resources necessary to support global spread of the BPSO Designation, while at the same time contributes to engagement in uptake and sustained use of BPGs.

- The collective identity of BPSOs around the world has contributed to dynamic spread, sustainability, and fidelity of the program.
- The future includes a focus on expanding and spreading resources to meet the global demand for the BPSO Designation. Increased engagement with BPSOs as full partners will build on the program's strengths, tackle areas for improvement, and extend cross-border communication and knowledge exchange through technology.

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